

IN THE COURT OF APPEALS OF OHIO  
TENTH APPELLATE DISTRICT

NOV 18 PM 3:36  
CLERK OF COURTS

Larry Little, M D.,

:

Appellant-Appellant,

v

:

No. 10AP-220  
(C P C No 08CVF-01-416)

State Medical Board of Ohio,

:

(REGULAR CALENDAR)

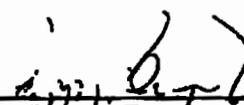
Appellee-Appellee.

:

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on November 18, 2010, and having overruled appellant's four assignments of error, it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs assessed to appellant

BRYANT, J. TYACK, P.J., & BROWN, J

By   
Judge Peggy Bryant

W

IN THE COURT OF APPEALS OF OHIO  
TENTH APPELLATE DISTRICT

FILED  
APPEALS  
NOV 18 PM 2:52  
CLERK OF COURTS  
15

Larry Little, M.D.,	:	Sheena,
Appellant-Appellant,	:	
v.	:	No. 10AP-220
State Medical Board of Ohio,	:	(C P C No 09CVF-01-416)
Appellee-Appellee.	:	(REGULAR CALENDAR)

DECISION

Rendered on November 18, 2010

*Dinsmore & Shohl, LLP, Eric J. Plinke and Nicole M. Loucks,*  
for appellant.

*Richard Cordray, Attorney General, and Melinda Snyder*  
*Osgood,* for appellee.

APPEAL from the Franklin County Court of Common Pleas.

BRYANT, J

{¶1} Appellant, Larry Little, M.D., appeals from a judgment of the Franklin County Court of Common Pleas affirming the order of appellee, State Medical Board of Ohio ("the Board"), that indefinitely suspended appellant's license to practice medicine in Ohio and, by permanently limiting appellant's ability to read the slides of his patients' biopsies and tumors, required appellant to use an outside dermatopathologist to read all

such slides. Because (1) the common pleas court did not abuse its discretion in determining substantial, reliable, and probative evidence supports the Board's order, (2) appellant received adequate notice of the allegations against him and the possible sanctions he faced, (3) the Board, and subsequently the common pleas court, did not err in determining appellant's conduct fell below the minimal standard of care, and (4) the common pleas court did not rely on allegedly improper conclusions of the Board, we affirm.

### **I. Facts and Procedural History**

{¶2} On June 14, 2006, the Board issued a notice letter to appellant informing him it proposed to take disciplinary action against his license to practice medicine and surgery in Ohio. The Board alleged, pursuant to R.C. 4731.22(B)(6), that appellant's conduct as to 12 patients constituted "a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established." (Notice Letter, Board's Exhibit 21-A.) As to eight of the 12 patients, the Board alleged appellant acted inappropriately in treating basal or squamous cell carcinomas with electrodesiccation and curettage ("ED&C") or cryosurgery instead of the treatment known as Mohs Micrographic Surgical procedure ("Mohs"). The Board further alleged that when appellant performed the Mohs procedure on various occasions, he inadequately did so.

{¶3} Appellant requested an administrative hearing that commenced March 27, 2007. The record before the hearing examiner included the medical records of the 12 patients at issue, as well as a report and deposition testimony of the Board's expert, Dr.

Marlene Willen, a board-certified dermatologist. Dr. Willen examined appellant's medical records for the care and treatment of all 12 patients, including any treatment subsequent treating physicians rendered. Dr. Willen found various instances where appellant's conduct fell below the minimal standard of care.

{¶4} In response, appellant presented the report and expert testimony of Dr Jennifer Ridge, a board-certified dermatologist. Dr Ridge agreed "with several of the allegations" of the Board "that several of the patients would have benefited from a much earlier use of Mohs' on their recurrent tumors." (Ridge Report, Appellant's Exhibit A-A at 7.) Dr. Ridge ultimately concluded, however, appellant's conduct did not fall below the minimal standard of care. Appellant also testified on his own behalf.

{¶5} In a report and recommendation issued November 3, 2008, the hearing examiner concluded appellant's conduct fell below the minimal standard of care for nine of the patients and recommended the Board permanently revoke appellant's license to practice medicine and surgery in the state of Ohio. After reviewing the record from the hearing, the Board, at its December 10, 2008 meeting, issued an Entry of Order modifying appellant's sanction to an indefinite suspension of appellant's license for not less than one year. The Board further permanently limited appellant's license to practice, requiring that a dermatopathologist read all slides of biopsies and tumors of appellant's patients. Appellant appealed to the Franklin County Court of Common Pleas.

{¶6} On February 8, 2010, the common pleas court issued a decision and entry affirming the Board's decision. Appellant timely appeals.

---

## II. Assignments of Error

{¶7} On appeal, appellant assigns four errors:

Assignment of Error One. The trial court erred in affirming the Board's Order to permanently limit Dr. Little's ability to read his patients' slides because its ruling was based upon evidence rejected by the Board, and as such, was arbitrary, unreasonable, and not supported by the record.

Assignment of Error Two: The trial court erred and abused its discretion in affirming the Board's Order imposing a permanent limitation requiring slides of all biopsies and tumors to be read by a dermatopathologist because the Board's notice letter did not provide the requisite legal notice in violation of R.C. 119.07 and Dr. Little's due process rights.

Assignment of Error Three: The trial court erred by basing its affirmance of the Board's Order to permanently restrict Dr. Little from reading his patients' slides on conduct that does not constitute a departure from the minimal standard of care and was not found by the Board to constitute a departure from the minimal standard of care.

Assignment of Error Four: The trial court erred by relying upon the Board's improper conclusion that the practice of reading patients' biopsy slides was outside Dr. Little's scope of practice and by incorrectly interpreting the Board's expert's testimony to be the same, which is arbitrary, unreasonable and is not supported by the evidence.

## III. Standard of Review

{¶8} Under R.C. 119.12, a common pleas court, in reviewing an order of an administrative agency, must consider the entire record to determine whether reliable, probative, and substantial evidence supports the agency's order and the order is in accordance with law. *Univ. of Cincinnati v. Conrad* (1980), 63 Ohio St.2d 108, 110-11. The common pleas court's "review of the administrative record is neither a trial *de novo* nor an appeal on questions of law only, but a hybrid review in which the court 'must

appraise all the evidence as to the credibility of the witnesses, the probative character of the evidence, and the weight thereof.' " *Lies v. Veterinary Med. Bd.* (1981), 2 Ohio App.3d 204, 207, quoting *Andrews v. Bd. of Liquor Control* (1955), 164 Ohio St. 275, 280. The common pleas court must give due deference to the administrative agency's resolution of evidentiary conflicts, but "the findings of the agency are by no means conclusive " *Conrad* at 111. The common pleas court conducts a de novo review of questions of law, exercising its independent judgment in determining whether the administrative order is "in accordance with law." *Ohio Historical Soc. v State Emp. Relations Bd.* (1993), 66 Ohio St.3d 466, 471.

{¶9} An appellate court's review of an administrative decision is more limited than that of a common pleas court. *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St 3d 619, 621. The appellate court is to determine only whether the common pleas court abused its discretion. *Id.*; *Blakemore v. Blakemore* (1983), 5 Ohio St.3d 217, 219 (defining an abuse of discretion). Absent an abuse of discretion, a court of appeals may not substitute its judgment for that of an administrative agency or the common pleas court. *Pons* at 621. An appellate court, however, has plenary review of purely legal questions. *Big Bob's, Inc. v. Ohio Liquor Control Comm.*, 151 Ohio App.3d 498, 2003-Ohio-418, ¶15.

#### **IV. First Assignment of Error – Evidence and Penalty**

{¶10} In his first assignment of error, appellant asserts the common pleas court erred in upholding the Board's order imposing a sanction permanently limiting appellant's ability to read the slides of his own patients. Without directing his argument to any

particular patient, appellant challenges both the adequacy of the evidence and the validity of the sanction.

{¶11} The action of the various tribunals belies appellant's contentions regarding the adequacy of the evidence. In reaching her legal conclusions, the hearing examiner included a detailed recitation of the supporting evidence from the administrative hearing in her report and recommendation. The common pleas court, in turn, conducted its own review of the entire record. The court analyzed the expert testimony, compared the testimony of Dr. Willen and Dr. Ridge, and specifically noted only Dr. Willen reviewed the medical records of the 12 patients' subsequent treating physicians in reaching her conclusion. Correctly acknowledging the Board members are "experts in their own right," the common pleas court did not abuse its discretion in giving deference to the Board's findings or in concluding reliable, probative, and substantial evidence in the report and testimony of Dr. Willen supports the Board's order. See *Dahlquist v. Ohio State Med. Bd.*, 10th Dist. No. 04AP-811, 2005-Ohio-2298, ¶21, quoting *Arlen v. State Med. Bd. of Ohio* (1980), 61 Ohio St.2d 168, 172 (stating "the board may rely on its own expertise to determine whether a physician failed to conform to minimum standards of care").

{¶12} Appellant argues that, even if that be true, the common pleas court erred because it relied on evidence the Board expressly rejected. Appellant in particular asserts the common pleas court relied on Dr. Willen's expert report concerning Patient 7 even though both the hearing officer and the Board specifically rejected Dr. Willen's testimony concerning Patient 7. Dr. Willen stated that even though the margins on the tissue sample taken from Patient 7 were not clear, appellant failed to re-biopsy the patient, thus

---

suggesting appellant departed from the minimal standard of care. The hearing examiner, and subsequently the Board, found the "evidence is insufficient" to support the conclusions of Dr. Willen in that regard. (Report and Recommendation, 56.) With that premise, appellant contends the common pleas court abused its discretion in basing its decision upon such evidence. See *Liss v. State Med. Bd. of Ohio* (Sept. 24, 1992), 10th Dist. No. 91AP-1281.

{¶13} Appellant's argument takes the common pleas court's statement out of context. Although the court refers to Dr. Willen's expert report regarding Patient 7, it does not do so in the context of determining whether reliable, probative, and substantial evidence supports the Board's order that appellant fell below the minimal standard of care. Instead, the court noted that portion of Dr. Willen's expert report to respond to appellant's allegations he was not properly advised that his ability to read his patients' slides was at issue. Cf. *Barnett v. Sexten*, 10th Dist. No. 05AP-871, 2006-Ohio-2271, ¶14 (stating "[e]vidence that is inadmissible for one purpose may be admissible for another purpose"), citing *State ex rel. Brown v. Dayton Malleable, Inc.* (1982), 1 Ohio St.3d 151, 156. Further, even if the common pleas court erroneously relied on the noted portion of Dr. Willen's testimony, other evidence in the record, cited in the hearing examiner's report and the common pleas court's decision and entry, amply supports the Board's order that appellant fell below the minimal standard of care.

{¶14} To the extent appellant challenges the validity of the sanction the Board imposed, his contentions fail under prevailing Supreme Court of Ohio decisions. Where the evidence supports an administrative agency's decision, the common pleas court is

without authority to modify the penalty. *Miller v. Columbus City Pub. Schools*, 10th Dist. No. 08AP-1082, 2009-Ohio-2756, ¶11, citing *State ex rel. Ogan v. Teater* (1978), 54 Ohio St 2d 235, 246-47; *Henry's Café, Inc. v. Bd. of Liquor Control* (1959), 170 Ohio St. 233; *Ohio State Univ. v. Kyle*, 10th Dist. No. 06AP-168, 2006-Ohio-5517, ¶27. Here, the Board had available a full range of sanctions available to it, from limiting appellant's license to revoking it altogether. See R.C. 4731.22(B). With reliable, probative, and substantial evidence to conclude appellant's conduct fell below the standard of care for nine of the 12 patients at issue, one of whom died after appellant's shortcomings in reading the patient's diagnostic slides, the hearing examiner initially recommended the Board permanently revoke appellant's license to practice medicine. The Board modified the sanction to require appellant to obtain an outside dermatopathologist to read the slides of appellant's patients in the future. Because substantial, reliable, and probative evidence supports the Board's order, neither the common pleas court nor this court can modify the statutorily authorized penalty the Board imposed

{¶15} Appellant's first assignment of error is overruled.

#### **V. Second Assignment of Error – Notice**

{¶16} Appellant's second assignment of error asserts the common pleas court violated his due process rights in affirming the Board's order because the notice provided him was not sufficient under R.C. 119.07.

{¶17} When an administrative agency proposes to take disciplinary action against a party, R.C. 119.07 requires the agency to "give notice to the party informing the party of the party's right to a hearing." The notice "shall include the charges or other reasons for

the proposed action, the law or rule directly involved, and a statement informing the party that the party is entitled to a hearing if the party requests it within thirty days." R.C. 119.07. Appellant contends he did not receive adequate notice of charges that his practice in dermatopathology fell below the minimal standard of care. Appellant further argues the notice was deficient in failing to inform him that his practice of dermatopathology could be permanently limited as a result of the proceedings.

{¶18} "The fundamental requirement of procedural due process is notice and hearing, that is, an opportunity to be heard." *Korn v. Ohio State Med. Bd.* (1988), 61 Ohio App.3d 677, 684, citing *Luff v. State* (1927), 117 Ohio St. 102. "An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Althof v. Ohio State Bd. of Psychology*, 10th Dist. No. 05AP-1169, 2007-Ohio-1010, ¶19, quoting *Mullane v. Cent. Hanover Bank & Trust Co.* (1950), 339 U.S. 306, 314, 70 S.Ct. 652, 657 (internal quotation marks omitted). "The right to a hearing embraces not only the right to present evidence, but also a reasonable opportunity to know the claims of the opposing party and to meet them." *Id.*, quoting *Gonzales v. United States* (1955), 348 U.S. 407, 414, fn. 5, 75 S.Ct. 409, 413, quoting *Morgan v. United States* (1938), 304 U.S. 1, 18, 58 S.Ct. 773, 776.

{¶19} Here, the issue resolves to whether appellant had a reasonable opportunity to know the Board's claims against him concerning his conduct in reading and evaluating his patients' slides related to his treatment of various types of skin cancer. In informing

appellant of the allegations against him, the notice letter provided to appellant expressly stated that "[i]n your dermatological medical care of Patients 1-12, you failed to accurately diagnose and/or document the accurate diagnosis of skin cancers[.]" (Notice Letter, Board's Exhibit 21-A.) It further stated appellant "obtained inappropriate samples for histological examination of skin cancers; and/or \* \* \* failed to identify and/or document the identification of the subtype of skin cancer and/or failed to identify and/or document the identification of the extent of skin cancer invasion. (Notice Letter, Board's Exhibit 21-A.) As relevant here, the notice letter lastly stated appellant "provided inappropriate treatments for skin cancers and other skin disorders and/or \* \* \* inadequately performed Mohs procedures for skin cancers." (Notice Letter, Board's Exhibit 21-A.) The notice letter provided specific examples of appellant's conduct regarding each of the 12 patients.

{¶20} Despite the language of the notice letter, appellant asserts that because the letter never used the term "dermatopathology," appellant was not advised his conduct in practicing dermatopathology allegedly fell below the minimal standard of care. Appellant's brief, however, describes dermatopathology as "the study of skin disease at a microscopic level." (Appellant's brief, 3.) The statements in the notice letter pertaining to appellant's failure to "identify" the subtype of skin cancer are reasonably calculated to put appellant on notice that his ability to read a slide and determine the type of skin cancer was at issue.

{¶21} Indeed, the notice letter not only specifically pointed to appellant's failure to identify and document the subtype of skin cancer of Patient 9 who died, but further referred to appellant's deficiencies on several instances when he performed the Mohs

procedure. Appellant does not allege that, as a dermatologist, he was unfamiliar with what the Mohs procedure entailed, including using microscopic samples of skin on slides to accurately determine the subtype of skin cancer. To the contrary, appellant testified in detail about how to perform the Mohs procedure, testimony that included an explanation of reading the resulting slides. (Hearing Tr., 111-124.) Appellant's expert witness, Dr. Ridge supported appellant's explanation when she, too, explained that "[i]n traditional Mohs' the surgeon acts as the pathologist as well." (Ridge Report, Appellant's Exhibit A-A, at 1.)

{¶22} In the final analysis, appellant offers no alternative explanation for the repeated references in the notice letter to his failure to identify subtypes of skin cancer and to adequately perform the Mohs procedure, if not his failure to accurately read slides. The notice letter was reasonably calculated to place appellant on notice his dermatology practice, including his practice of acting as his own dermatopathologist in reading his patients' slides, was at issue in the proposed disciplinary action. See, e.g., *Althof* at ¶29 (concluding psychologist had fair notice he was accused of "sexual misconduct" with his patients even though the notice letter referred to "sexual intercourse" with patients without expressly referring to that behavior as "inappropriate"). Appellant's own testimony, the testimony and report of his expert witness regarding reading slides, and the undeniable fact that the Mohs procedure involves reading slides, all combine to support the conclusion appellant received adequate notice.

{¶23} As to whether appellant had notice of possible sanctions, the notice provided to appellant expressly stated "the State Medical Board of Ohio [Board] intends to

determine whether or not to *limit*, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery." (Emphasis added.) (Notice Letter, Board's Exhibit 21-A, at 1.) Appellant thus received notice a possible sanction against him could include a limitation on his license to practice medicine, a result consistent with the wide latitude granted to administrative bodies in imposing a sanction for an appropriately charged violation. See, e.g., *Macheret v. State Med. Bd. of Ohio*, 10th Dist. No. 09AP-849, 2010-Ohio-3483, ¶27, citing *Columbus Bar Assn. v. Farmer*, 111 Ohio St.3d 137, 2006-Ohio-5342, ¶49.

{¶24} Because appellant received proper notice both in the form of the charges against him including his ability to read his patients' slides, as well as the range of sanctions he could face, we overrule his second assignment of error.

#### VI. Third Assignment of Error – Standard of Care

{¶25} In his third assignment of error, appellant contends the common pleas court erred in affirming the Board's order based on appellant's conduct that, he asserts, does not depart from the minimal standard of care.

{¶26} Although the Board may not be required to present expert testimony to support a charge against a physician under R.C. Chapter 4731, other reliable, probative, and substantial evidence must support the charge. *Griffin v. State Med. Bd. of Ohio*, 10th Dist. No. 09AP-276, 2009-Ohio-4849, ¶13, citing *In re Williams* (1991), 60 Ohio St.3d 85, syllabus. When the Board presents expert testimony, "the expert must be capable of expressing an opinion in terms of the particular standard of care that applies to the

physician whose license is at issue." *Id.*, citing *Lawrence v. State Med. Bd. of Ohio* (Mar. 11, 1993), 10th Dist. No 92AP-1018

{¶27} Here, the Board's expert unequivocally applied the minimal standard of care multiple times. For example, Dr. Willen concluded in her report with regard to Patient 3 that "it is below the minimal standard of care to treat recurrent [subtypes of skin cancer] with [ED&C] as these tumors have already shown to be aggressive." (Willen Report, Board's Exhibit 15, at 6.) As to Patient 6, Dr. Willen stated in her report that "ED&C is not the standard of care for a multiple recurrent [subtype of skin cancer,] this is below the minimal standard of care." (Willen Report, Board's Exhibit 15, at 6.) Dr. Willen's report included similar opinions as to the minimal standard of care for Patients 7, 8, 10, and 12. (Willen Report, Board's Exhibit 15, at 24, 26, 40.) She further opined the manner in which appellant performed the Mohs procedure was below the minimal standard of care for multiple patients. In her deposition, Dr. Willen testified appellant's treatment of Patient 9 was below the minimal standard of care, explaining in detail what the minimal standard of care entails. (Willen Depo., Board's Exhibit 19 at 84-86.)

{¶28} Appellant nonetheless contends the common pleas court erroneously relied on Dr. Willen's statements regarding the optimal standard of care in determining the minimal standard of care. Appellant argues that even though the evidence demonstrates appellant's failure to obtain an outside reviewer for his slides did not violate the minimal standard of care, the common pleas court nonetheless relied on Dr. Willen's opinion, which concluded "quality assurance dictates that a certain number of slides be reviewed by an outside unbiased reviewer." (Decision and Entry, 18.) Because her statement,

appellant argues, reflects the optimal standard of care rather than the minimal standard of care, the common pleas court erred in affirming the Board's order based on her statement.

{¶29} Appellant's argument again takes a portion of the common pleas court's decision out of context. Read in context, the court's decision referred to Dr. Willen's statement not to determine the applicable standard of care but to determine whether the notice provided to appellant adequately notified him regarding his continued ability to read his own patients' slides. The common pleas court did not conclude appellant fell below the minimal standard of care for failure to employ an outside reviewer but because his ability to read his own patients' slides was inadequate.

{¶30} Accordingly, appellant's third assignment of error is overruled.

#### **VII. Fourth Assignment of Error – Scope of Practice**

{¶31} Appellant's fourth and final assignment of error asserts the common pleas court erred in affirming the Board's order because the Board improperly concluded a dermatologist exceeds the scope of practice in reading his own patients' slides.

{¶32} Contrary to appellant's assertion, the Board did not charge appellant with, nor penalize appellant for, practicing outside the scope of his practice. Rather, the Board charged and penalized appellant for practicing dermatology below the minimal standard of care, including his inadequacies in reading the slides of his own patients. Appellant's attempts to apply the common pleas court's statements regarding the adequacy of appellant's notice to the merits of the Board's order is unpersuasive. Appellant's fourth assignment of error is overruled.

X

**VIII. Disposition**

{¶33} In summation, the common pleas court did not abuse its discretion in affirming the Board's order, as substantial, reliable, and probative evidence supports that order, and it is in accordance with law. Further, appellant had adequate notice of the allegations against him and the possible sanctions he faced. Having overruled appellant's four assignments of error, we affirm the judgment of the Franklin County Court of Common Pleas.

*Judgment affirmed.*

TYACK, P.J., and BROWN, J., concur.

---

**ORIGINAL**

**IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO  
CIVIL DIVISION**

**FILED  
COURT OF  
FRANKLIN CO.  
MAR -9 PM 3:22  
CLERK OF COURTS**

**LARRY LITTLE, M.D.,** : Case No. 09CVF-01-416

**Appellant,** : JUDGE SHEERAN

**vs.** :

**THE STATE MEDICAL BOARD  
OF OHIO,** : **ON COMPUTER 8**

**Appellee.**

**NOTICE OF APPEAL**

Notice is hereby given that Appellant Larry Little, M.D., hereby appeals to the Court of Appeals, Tenth Appellate District of Franklin County, Ohio, from the Decision and Entry of the Court of Common Pleas, Franklin County, Ohio, filed on February 8, 2010, which affirmed the State Medical Board of Ohio's Order staying the permanent revocation of his license to practice medicine and placing Appellant's medical license on indefinite suspension in the State of Ohio for not less than one year, as well as permanently restricting Appellant's ability to practice dermatopathology. The Decision and Entry was issued as a final and appealable order on February 8, 2010.

Respectfully submitted,



Eric J. Plinke (0059463)  
Nicole M. Loucks (0076912)  
**DINSMORE & SHOHL, LLP**  
191 West Nationwide Blvd., Suite 300  
Columbus, Ohio 43215  
Tel: (614) 221-8448/ Fax: (614) 221-8590  
E-Mail: eric.plinke@dinalaw.com  
nicole.loucks@dinalaw.com  
Counsel for Appellant Larry Little, M.D.

**FILED  
COMMON PLEAS COURT  
FRANKLIN CO. OHIO  
MAR -9 PM 3:06  
CLERK OF COURTS**

**10APE03**

**0220**

**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that a true and accurate copy of the foregoing Notice of Appeal was served upon the following by ordinary U.S. mail this 9<sup>th</sup> day of March, 2010:

Barbara Pfeiffer, Esq.  
Assistant Attorney General  
Health & Human Services Section  
Ohio Attorney General  
30 East Broad Street, 26<sup>th</sup> Floor  
Columbus, Ohio 43215-3428

  
Eric J. Pinke

nr

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO  
GENERAL DIVISION

LARRY LITTLE, M.D., :  
 Appellant, : CASE NO. 09CVF-01-416  
 vs. : JUDGE SHEERAN  
 THE STATE MEDICAL BOARD : FINAL APPEALABLE ORDER  
 OF OHIO :  
 Appellee. :

TERMINATION NO. 16
BY: 2-8-10

**DECISION AND ENTRY AFFIRMING THE DECEMBER 10, 2008  
ORDER OF THE STATE MEDICAL BOARD OF OHIO**

Rendered this 8<sup>th</sup> day of February 2010

**SHEERAN, J.**

This matter is before this Court pursuant to Revised Code 119.12 from a December 10, 2008 Order of the State Medical Board of Ohio ("Board") imposing a "stayed" permanent revocation of appellant's license to practice medicine and surgery in the state of Ohio and imposing an indefinite suspension for a period of at least one year with conditions for reinstatement. The Board alleged that appellant violated R.C. 4731.22 when he fell below the standard of care as a dermatologist in his documentation, treatment and care of twelve (12) patients.<sup>1</sup> See State's Exhibit 21-A. The Board concluded that these violations were as a result of Dr. Little's inappropriate treatment of recurrent basal cell carcinomas and squamous cell carcinomas as well as his inadequate performance of numerous Mohs Micrographic Surgical procedures.

<sup>1</sup> The record protects the identity of these patients and refers to them by number through a patient key.

(21)

FILED  
COMMON PLEAS COURT  
FRANKLIN CO. OHIO  
2010 FEB - 8 PM 2:05  
CLERK OF COURTS

## FACTS AND PROCEDURAL HISTORY

In a June 14, 2006 letter ("Notice letter"), the Board notified appellant that it had proposed to take disciplinary action against his license to practice medicine and surgery in Ohio. See State's Exhibit 21-A. The Board based its proposed action upon allegations of appellant's treatment of twelve (12) patients. The Board alleged that appellant's conduct as to the twelve patients constituted "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established." See R.C. 4731.22(B)(6).

The allegations related to eight (8) of the twelve (12) patients assert that Dr. Little acted inappropriately in the treatment of these patients' basal or squamous cell carcinomas in performing procedures such as electrodesiccation and curettage (ED&C) or cryosurgery instead of a more aggressive surgical treatment known as Mohs Micrographic Surgical procedure ("Mohs").

The evidence at the hearing focused on the documentation, treatment and care of twelve patients. In his report and recommendation the referee made the following findings of fact:

1. On January 16, 2004, based upon violations of Sections 4731.22(B)(2), (B)(6), (B)(10) and (B)(20), Ohio Revised Code, the Board entered an Order suspending the certificate of Larry John Little, M.D., to practice medicine and surgery in Ohio for an indefinite period, but not less than 180 days, and imposing terms and condition for reinstatement, as well as probationary terms and conditions. On July 14, 2004, the Board voted to reinstate Dr. Little's certificate subject to probation.
2. From about 1989 to 2004, in the routine course of his practice, Dr. Little undertook the treatment of Patients 1-12 as identified on a confidential Patient Key.

In his dermatological medical care of Patients 1, 3, 5 through 9, 11, and 12, Dr. Little failed to accurately diagnose and/or document the accurate diagnosis of skin

cancers; obtained inappropriate samples for histological examination of skin cancers; and/or failed to identify and/or document the identification of the subtype of skin cancer and/or failed to identify and/or document the identification of the extent of skin cancer invasion.

Further, Dr. Little provided inappropriate treatments for skin cancers and other skin disorders and/or inadequately performed Mohs procedures for skin cancers.

Moreover, Dr. Little failed to closely monitor a patient where required; permitted a patient to be falsely advised that squamous cell carcinoma does not spread; falsely advised patients that no further treatment was necessary for their skin cancers; failed to undertake and/or document the performance of appropriate work-ups; failed to timely follow up after providing treatments; and/or failed to document why work-ups were not performed.

Such conduct includes the following:

- (a) In Dr. Little's care of Patient 1, when performing Mohs surgery, he inadequately documented how the sample of tissue from the patient's upper lip had been sectioned and failed to document how many sections were reviewed in order to document clear margins. Further, Dr. Little inappropriately treated possible recurrent infiltrative facial basal cell carcinoma with Aldara, which led to a delay of proper diagnosis and appropriate treatment of Patient 1.
- (b) The evidence is insufficient to support a finding that Dr. Little inappropriately treated Patient 2's sebaceous hyperplasia with topical clindamycin, Sulfoxyl and Differin.
- (c) Patient 3 was previously treated for non-Hodgkin's lymphoma with chemotherapy and was at a higher risk of aggressive non-melanoma skin cancers due to his immunosuppression. In his care of Patient 3, Dr. Little inappropriately treated Patient 3's recurrent facial squamous cell carcinoma with electrodesiccation and curettage [ED&C]. Further, Dr. Little inappropriately informed Patient 3 that no further treatment was necessary without having documented clear margins.
  - (i.) The evidence is insufficient to support a finding that Dr. Little failed to initially treat Patient 3's squamous cell carcinoma with Mohs surgery. Dr. Willen testified that it had been acceptable for Dr. Little to treat the primary lesion with ED&C.
- (d) The evidence is insufficient to support a finding that, in Dr. Little's care of Patient 4, he inadequately performed a Mohs procedure; failed to re-biopsy a potentially recurrent basal cell carcinoma; inappropriately treated Patient 4 patient with Carac; and/or failed to accurately diagnose recurrent basal cell

carcinoma leading to a delay in diagnosis requiring further Mohs surgery resulting in a larger defect and repair. Some of Dr. Willen's statements during her deposition conflicted with statements she had made in her written reports. Accordingly, the Hearing Examiner finds that the evidence is not clear enough to support these allegations.

- (e) In his care of Patient 5, Dr. Little inadequately performed a Mohs procedure. With regard to this finding, Dr. Willen's testimony concerning Mohs surgery and whether certain Mohs surgeries documented by Dr. Little were adequately performed is deemed more persuasive than that of Dr. Little or Dr. Ridge. Dr. Willen's experience and background, including her completion of a fellowship in Mohs surgery, makes her expertise more compelling than the others.

In addition, with regard to Dr. Willen's criticism of Dr. Little's failure to divide large Mohs specimens into small specimens for analysis, Dr. Little presented an article that shows that it is possible and, in some cases, it may be preferable to examine large specimens without dividing them. However, that article confined its recommendation for such a procedure to large tumors. The tumor referred to in the article was 2.3 x 2.0 cm in size. In contrast, the tumor removed from Patient 5's nose was only 6 mm in size. Under that circumstance, Dr. Willen's opinion that Dr. Little should have used more conventional methodology in preparing his specimens is deemed persuasive.

Further, Dr. Little inappropriately treated Patient 5's recurrent basal cell carcinoma with ED&C; and inappropriately treated recurrent basal cell carcinoma with Aldara. In addition, Dr. Little failed to re-biopsy a potentially recurrent basal cell carcinoma, and, because clear margins were not documented following ED&C, inappropriately informed the patient that no further treatment was necessary.

Dr. Little asserted that Patient 5 had suffered from a "field effect" that led to a cluster of primary lesions that appeared near the site of the original tumor. This assertion is unconvincing based upon his lack of contemporaneous documentation in the medical record of such a condition, and based upon the information that he did document. The evidence shows the following treatment rendered to Patient 5 by Dr. Little:

- Dr. Little performed Mohs surgery on the dorsum of Patient 5's nose on May 4, 2000, to remove basal cell carcinoma. The final size of the surgical wound was 2.4 x 1.6 cm and Dr. Little repaired it with a full-thickness skin graft.
- In October 2000, he took a biopsy from the left lateral margin of the skin graft and found basal cell carcinoma. He treated it with abrasion.

- In November 2001, Patient 5 complained about a spot on her nose at the site of the skin graft. Dr. Little performed ED&C and the biopsy revealed fragments of the basal cell carcinoma.
- In June 2002, Patient 5 returned to Dr. Little's office at which time he observed a 1.8 cm recurrent basal cell carcinoma on her left dorsal nose. He performed ED&C and the biopsy confirmed basal cell carcinoma.
- In December 2002, Patient 5 returned. He performed ED&C on what he described as basal cell carcinoma of the left dorsal nose. Pathology confirmed basal cell surgical wound was 2.4 x 1.6 cm and Dr. Little repaired it with a full-thickness skin graft.
- Patient 5 returned in May 2003. Among other things, Dr. Little observed a 4 mm lesion on Patient 5's left dorsal nose. He performed ED&C and the biopsy revealed basal cell carcinoma.
- In November 2003, Patient 5 returned. She had been concerned about a "bump" at the May 2000 Mohs surgery site. Dr. Little prescribed Aldara cream and instructed Patient 5 to return in two months.
- Patient 5 returned January 2004 and Dr. Little's progress note indicates that no tumor remained and that Patient 5 was instructed to return in six months.

Based upon Dr. Little's documentation, it is reasonable to find that he repeatedly treated Patient 5 for six recurrences of basal cell carcinoma using skin abrasion on one occasion, ED&C on four occasions, and Aldara on one occasion. There is nothing documented that would support a finding that she had suffered from a "field effect." In fact, Dr. Little's medical record for Patient 5 contradicts that assertion, inasmuch as he had twice expressly determined a lesion to be recurrent rather than primary.

- (f) In Dr. Little's care of Patient 6, he inappropriately treated Patient 6's recurrent basal cell carcinoma with ED&C. He further treated Patient 6's recurrent basal cell carcinomas with cryosurgery and Aldara, which were inadequate therapies. As a result, a subsequent treating physician performed nine stages of Mohs surgery in order to obtain clear margins, leading to a large post-operative defect size of 7.1 cm by 6.5 cm.

As with Patient 5, Dr. Little's assertion that Patient 6 had suffered from a "field effect" is unconvincing because it was not documented in the medical record.

- (g) In his care of Patient 7, after performing ED&C on the patient's squamous cell carcinoma, Dr. Little inappropriately informed Patient 7 that further surgery was unnecessary when there was no confirmation of clear margins. Further, Dr. Little failed to perform an appropriate work-up of Patient 7's potentially invasive or metastatic squamous cell carcinoma. Further, he inappropriately treated Patient 7's recurrent squamous cell carcinoma with cryosurgery and ED&C.
- (i.) The evidence is insufficient to support a finding that Dr. Little had inappropriately informed Patient 7 that the margins were clear when only fragments of tissue had been submitted for pathology.
- (ii.) The evidence is insufficient to support a finding that Dr. Little failed to re-biopsy a potentially recurrent squamous cell carcinoma.
- (iii.) The evidence is insufficient to support a finding that Dr. Little's treatment of Patient 7's squamous cell carcinoma led to the patient's comorbidity. (as amended by the Board).
- (h) In Dr. Little's care of Patient 8, he inappropriately treated Patient 8's recurrent facial basal cell carcinoma with ED&C and cryosurgery, and inadequately performed a Mohs procedure.

Dr. Little's assertion that all of Patient 8's lesions had all been primary lesions is unconvincing. Such was not documented in the medical record, nor was a field effect documented in the medical record.

- (i) In his care of Patient 9, Dr. Little failed to perform an adequate Mohs procedure. Further, Dr. Little failed to identify and/or document the identification of the subtype of squamous cell carcinoma and failed to identify and/or document the depth of skin cancer invasion. Further, Dr. Little failed to work up and/or document a work up for local invasion and metastatic disease despite noting a very deep squamous cell carcinoma that went to the fascia.

Moreover, it is more likely than not that Dr. Little's failure to adequately perform the Mohs procedure and an appropriate work-up led to Patient 9's eventual demise. This finding is based upon the cause of death as set forth in the Certificate of Death, which states that Patient 9's death had been the result of squamous cell carcinoma whose onset was approximately October 2003. The squamous cell carcinoma that Dr. Little biopsied in September 2003 at the site of his previous Mohs surgery was diagnosed by Dr. Little as a recurrent squamous cell carcinoma. Furthermore:

- Although Dr. Little's medical record for Patient 9 indicates that the final stage of the Mohs surgery had been clear of tumor, there is reason to doubt Dr. Little's ability to reliably render such a determination.

First, the State presented convincing evidence that Dr. Little failed to divide the Mohs specimens into smaller specimens for analysis, and that such failure would have made it difficult to ensure that the specimens were free of tumor.

Second, the State presented convincing evidence that Dr. Little's abilities as a dermatopathologist are questionable. The evidence indicates that his dermatohistopathology reports often fail to document essential information – information concerning the dimensions of the specimen, a description of the sectioning of the specimen, a microscopic description, and/or a description of the grade and subtype of tumor present in the specimen. Instead, Dr. Little often documents only a final diagnosis.

Therefore, Dr. Little's determination that the final stage of Patient 9's Mohs surgery had been free of tumor is deemed questionable.

- The evidence indicates that the second and final stage of the Mohs surgery performed by Dr. Little was taken down to the fascia, indicating that the tumor was deeply invasive. The State presented convincing evidence that, based upon the depth of the invasion of the tumor, Dr. Little should have performed a work-up to determine whether there was further local invasion and whether the tumor had metastasized. Dr. Little failed to perform such a work-up.

Accordingly, the evidence is sufficient to support a finding that Dr. Little's failure to adequately perform the Mohs procedure and an appropriate work-up led to Patient 9's eventual demise.

- (i) The evidence is insufficient to support a finding that Dr. Little failed to work-up and/or document a work-up for local invasion and metastatic disease based upon patient complaints of facial numbness, facial weakness and the presence of nodules in the treated area. The evidence indicates that these complaints and/or findings had occurred during a time when Patient 9 was being treated by a radiation oncologist. Dr. Little testified that he had believed that these complaints arose as a result of radiation treatment and would have been addressed by the radiation oncologist. Dr. Little's belief appears reasonable.
- (j) The evidence is insufficient to support a finding that, in his care of Patient 10, Dr. Little failed to appropriately recommend a three-month follow-up after treating Patient 10 for squamous cell carcinoma. Dr. Willen testified that the

standard of care for this patient would be six months, as Dr. Little had instructed Patient 10, rather than three months as she had previously stated in her written report.

Further, the evidence is insufficient to support a finding that Dr. Little inappropriately treated Patient 10's recurrent microinvasive squamous cell carcinoma with ED&C. The medical record indicates that Dr. Little had originally treated a microinvasive squamous cell carcinoma on Patient 10's nose with ED&C. However, the second lesion was determined to be basal cell rather than squamous cell carcinoma. Accordingly, that lesion was not recurrent.

- (k) In his care of Patient 11, Dr. Little permitted this patient to be falsely advised that squamous cell carcinoma does not spread. Further, Dr. Little failed to appropriately treat and manage invasive squamous cell carcinoma.
  - (i) Based upon Dr. Willen's testimony concerning Patient 10, as set forth in paragraph (j), above, the evidence is insufficient to support a finding that Dr. Little failed to appropriately recommend a three-month follow-up after treating Patient 11 for squamous cell carcinoma.
- (l) In his care of Patient 12, Dr. Little inadequately performed a Mohs procedure.
  - (i) The evidence is insufficient to support a finding that Dr. Little inappropriately treated Patient 12's recurrent basal cell carcinoma with ED&C and cryosurgery:
    - The evidence indicates that Dr. Little performed ED&C on a basal cell carcinoma on Patient 12's right ala, and that Dr. Little's pathology report indicated that the tumor was basal cell carcinoma with fibrosis. Dr. Willen testified that fibrosis indicates that there had been scar tissue, leading her to conclude that that area had had previous surgery, and thus the tumor was recurrent. However, there is no evidence that the previous surgery had been performed to treat basal cell carcinoma. Therefore, the evidence is insufficient to support a finding that the basal cell carcinoma had been recurrent.
    - There is insufficient evidence that Dr. Little had treated Patient 12's recurrent basal cell carcinoma with cryosurgery.

Also in his Report and Recommendation the hearing examiner made the following conclusions of law:

1. The conduct of Larry John Little, M.D., as set forth in Findings of Fact 2, 2(a), 2(c) (except 2[c][i]), 2(e) through 2(i) (except 2[g][i] through 2[g][ii] and 2[i][i]), 2(k) (except 2[k][i]), and 2(l) (except 2[l][i]), above, constitutes "[a] departure from, or

the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code. (as amended by the Board).

2. The evidence is insufficient to support a conclusion that Dr. Little’s conduct as set forth in Findings of Fact 2(b), 2(c)(i), 2(d), 2(g)(i) through 2(g)(ii), 2(i)(i), 2(j), 2(k)(i), and 2(l)(i), above, constitutes “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code. Nevertheless, it is apparent that the Board based each of those allegations on the report of its expert, and those allegations are deemed not proven based upon all the evidence presented during hearing. Accordingly, the Board was substantially justified in making those allegations. (as amended by the Board).

See November 3, 2008 Report and Recommendation, p. 59.

The Hearing Examiner issued his Report and Recommendation on November 3, 2008, and recommended that the Board impose the sanction of permanently revoking appellant’s license to practice medicine and surgery in the state of Ohio. Thereafter, appellant filed objections. On December 10, 2008, the Board met to discuss appellant’s disciplinary action and determine whether it would adopt the hearing examiner’s Report and Recommendation. After some discussion, the Board issued a stay of the permanent revocation of appellant’s license to practice medicine and surgery in Ohio, and imposed a suspension of his license for an indefinite period of time, but not less than one year. Additionally, the Board limited appellant’s license to practice as follows: “Dr. Little shall have the slides of all biopsies and all tumors removed read by a dermapathologist in a timely fashion. Further, Dr. Little shall maintain in the patient record the written report from the dermatopathologist.” See December 10, 2008 Entry of Order. The Board also set forth conditions for reinstatement. See December 10, 2008 Entry of Order.

## STANDARD OF REVIEW

R.C. § 119.12 sets forth the standard of review a common pleas court must follow when reviewing an administrative appeal. R.C. 119.12 provides in pertinent part:

The court may affirm the order of the agency complained of in the appeal if it finds, upon consideration of the entire record and such additional evidence as the court has admitted, that the order is supported by reliable, probative and substantial evidence and is in accordance with law.

In *Our Place* the Ohio Supreme Court provided the following definition of reliable, probative and substantial evidence as:

(1) 'Reliable' evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) 'Probative' evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) 'Substantial' evidence is evidence with some weight; it must have importance and value.

*Our Place, Inc. v. Ohio Liquor Comm.* (1992), 63 Ohio St. 3d 570, 571.

Once the common pleas court has determined that the administrative agency's order is supported by reliable, probative and substantial evidence, the court must then determine whether the order is in accordance with law. See R.C. § 119.12. The reviewing court cannot substitute its judgment for the agency's decision where there is some evidence supporting the decision. See *Harris v. Lewis* (1982), 69 Ohio St. 2d 577, 579; see also *University of Cincinnati v. Conrad* (1980), 63 Ohio St. 2d 108.

## LAW AND ARGUMENT

Appellant has asserted the following four assignments of error:

THE BOARD'S ORDER STAYING THE PERMANENT REVOCATION OF APPELLANT'S LICENSE TO PRACTICE MEDICINE AND IMPOSING AN INDEFINITE SUSPENSION OF HIS MEDICAL LICENSE OF NOT LESS THAN ONE YEAR IS CONTRARY TO LAW AND NOT SUPPORTED BY THE REQUISITE QUANTUM OF RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE BECAUSE THE BOARD'S EXPERT WITNESS COULD NOT IDENTIFY THE MINIMAL STANDARD OF CARE TO BE IMPOSED ON A

SIMILAR PRACTITIONER TO APPELLANT UNDER THE SAME OR SIMILAR CIRCUMSTANCES AS THIS CASE, AND AS SUCH, THE BOARD BASED ITS ORDER ON TESTIMONY THAT WAS NOT LEGALLY SUFFICIENT.

THE BOARD'S ORDER STAYING THE PERMANENT REVOCATION OF APPELLANT'S LICENSE TO PRACTICE MEDICINE AND IMPOSING AN INDEFINITE SUSPENSION OF HIS MEDICAL LICENSE FOR NOT LESS THAN ONE YEAR IS CONTRARY TO LAW AND NOT SUPPORTED BY THE REQUISITE QUANTUM OF RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE BECAUSE THE BOARD ARBITRARILY AND UNREASONABLY FOUND ITS EXPERT MORE CREDIBLE.

THE BOARD'S ORDER STAYING THE PERMANENT REVOCATION OF APPELLANT'S LICENSE TO PRACTICE MEDICINE AND IMPOSING AN INDEFINITE SUSPENSION OF HIS MEDICAL LICENSE FOR NOT LESS THAN ONE YEAR IS CONTRARY TO LAW AND IS NOT SUPPORTED BY THE REQUISITE QUANTUM OF RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE BECAUSE THE BOARD'S CITE LETTER DATED JUNE 14, 2006 DID NOT CHARGE APPELLANT WITH A FAILURE TO PERFORM DERMATOPATHOLOGY TO MINIMAL STANDARDS OF CARE, NOR DID IT STATE ANY FACTUAL ALLEGATIONS REGARDING APPELLANT'S USE OF DERMATOPATHOLOGY AND AS SUCH, COULD NOT PERMANENTLY RESTRICT APPELLANT FROM PERFORMING DERMATOPATHOLOGY.

THE BOARD'S ORDER STAYING THE PERMANENT REVOCATION OF APPELLANT'S LICENSE TO PRACTICE MEDICINE IS CONTRARY TO LAW AND IS NOT SUPPORTED BY THE REQUISITE QUANTUM OF RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE BECAUSE THE BOARD ERRONEOUSLY REJECTED APPELLANT'S UNCHALLENGED TESTIMONY REGARDING HIS TREATMENT OF HIS PATIENTS AND THE EXISTENCE OF A "FIELD EFFECT" AND NON-RECURRENT TUMORS, AND AS SUCH ERRED IN CONCLUDING THAT APPELLANT'S TREATMENT OF HIS PATIENTS CONSTITUTED A DEPARTURE FROM, OR THE FAILURE TO CONFORM TO, MINIMAL STANDARDS OF CARE IN VIOLATION OF R.C. 4731.22(B)(6).

In his first assignment of error, appellant contends that the Board did not demonstrate "...that Dr. Willen's testimony was: (1) provided in the context of the minimal standards of care; or (2) that Dr. Little's conduct was measured against similar practitioners under the same or similar circumstances." Thus, it is appellant's contention that the Board did not prove that

appellant's conduct fell below the minimal standard of care as set forth in R.C. 4731.22(B)(6). The Court will note that the actual statutory language is a "departure from, or the failure to conform to" the minimal standards of care. See R.C. 4731.22(B)(6).

The evidence demonstrates that the Board's expert witness, Dr. Marlene Willen, reviewed not only Dr. Little's medical records of Patients 1-12, but also all the medical records of subsequent treating physicians, where applicable. Dr. Willen then prepared a 40 page written report in which she described the treatment of each individual patient, and thoroughly explains, in her opinion, what should have been done or how certain procedures should have been conducted for each patient's particular presentations. She then straightforwardly renders her opinion that certain instances of treatment by Dr. Little were a "deviation from the minimal standard of care." See State's Exhibit 15.

As to the allegations regarding Dr. Little's inappropriate use of electrodesiccation and curettage (ED&C) to treat recurrent basal or squamous cell carcinomas in Patients 3 and 5, Dr. Willen renders the following opinion.

[Patient 3] Furthermore, it is below the minimal standard of care to treat recurrent facial BCCs and SCC's with ED&DC as these tumors have already shown to be aggressive by already being recurrent. St Ex. P.6.

[Patient 6] ED&C is not the standard of care for a multiple recurrent BCC, this is below the minimal standard of care. The area was again noted to have a recurrence and had ED&C of the same site and was told to return in a year. This was below the minimal standard of care. State's Exhibit 15, p.6.

Dr. Willen set forth similar opinions regarding other patients:

As to Patient 7: "Dr. Little failed to perform and document lymph node and parotid gland examination and he failed to perform any imaging studies to work up the patient for potential invasive or metastatic SCC and this was below the minimal standard of care. Dr. Little provided inadequate treatment of the squamous cell carcinoma leading to the patient's comorbidity." (State's Exhibit 1, p. 24).

In regard to Patient 8: "Pt undergoes Mohs procedure to recurrent BCC left ear by Dr. Little which recurs and is treated again with cryo This was substandard care. Cryo is not

recommended treatment for a recurrent BCC of the ear. Treatment of recurrent facial BCCs with cryo and ED&C is below the minimal standard of care. Little's performance of the Mohs procedure was also below below the minimal standard of care. (State's Exhibit 15, p.26),

Evidence pertinent to Patient 12 is as follows: For the reasons stated in the patient CB, treatment of recurrent facial BCCs with ED&C is below the minimal standard of care. ... The Moh's procedure by Dr. Little to the right nasal ala was inadequate and below the minimal standard of care performed by a Mohs surgeon. (State's Exhibit 15, p. 40).

Additionally, Dr. Willen stated that it was her opinion that Dr. Little's inadequacy in performing the Mohs surgical procedure on Patients 4, 8, 9 and 12 was below the minimal standard of care. See State's Exhibit 15, at pps. 8, 26, 30 & 40. In regard to Patient 9, Dr. Willen stated as follows:

The standard of care in this patient presented that with a squamous cell carcinoma involving the left cheek that required Mohs micrographic surgery going down to the level of fascia indicates that this tumor was deeply invasive. As I explained before, knowing the depth of a squamous cell carcinoma gives us information to base the risk of recurrence and metastasis to the patient. The level of fascia is farther than, is deeper than 4mm. It is deeper than 6mm. That is the guideline for determining whether further work-up of this patient is indicated. The standard of care, knowing that this is a Mohs micrographic surgeon performing this procedure, and knowing that the lesion went to the fascia would have determined that further work up including MRI or CT of this patient's head and neck area would be reasonable because the risk of metastasis would be greater to indicate that that work-up was indicated. See State's Exhibit 19, at pp. 84-86.

Clearly, this evidence is reliable, probative and substantial evidence supporting that Dr. Willen not only knew and understood, but also articulated the standard of care in regard to the issues in this case. Moreover, appellant's expert agreed with some of the Board's findings of fact in regard to appellant's conduct. See November 3, 2008 Report and Recommendation, p. 20, 36, 37, 40, 139, 142; see also Respondent's Exhibit A-A (Discussions regarding Patient 5, Patient 6, Patient 7, Patient 8 and Patient 11), and December 10, 2008 Excerpt from Draft Minutes, p.8.

Appellant's reliance on the holding in *Lawrence v. State Med. Bd. of Ohio*, 1993 Ohio

App. LEXIS 1437, is misplaced. Clearly, the holding in *Lawrence* is not applicable for several reasons. Dr. Willen, Dr. Ridge and Dr. Little are all board certified specialists in dermatology. See November 3, 2008 Report and Recommendation, p. 4-6. Thus, the case *sub judice* is distinguishable from the facts set forth in *Lawrence*. More importantly, the majority of the Board's members are experts in their own right since they are doctors and already possess the specialized knowledge needed to determine the acceptable standard of general medical practice. See *Arlen v. The State Medical Board of Ohio* (1980), 61 Ohio St. 2d 168.<sup>2</sup> This Court concludes that a majority of the Board members themselves possess the expertise necessary to determine if the appellant fell below, or departed from or failed to conform to, the minimum standards of practice as set forth in the hearing examiner's first conclusion of law and corresponding findings of fact.

Accordingly, this Court concludes that there was reliable, probative and substantial evidence that appellant had a fair and impartial hearing, and that hearing was conducted in accordance with law. Moreover, the record is replete with reliable, substantial and probative evidence demonstrating that the appellant's conduct regarding his treatment and care of Patients 1, 3, 5 through 9, 11 and 12 violated R.C. 4731.22. Thus, appellant's first assignment of error is not well taken and is **OVERRULED**.

In his second assignment of error, appellant asserts that "The Board's Order ...Is Contrary to Law and Not Supported By The Requisite Quantum Of Reliable, Probative And Substantial Evidence Because the Board Arbitrarily And Unreasonably Found Its Expert More Credible." See Appellant's Brief, p. iv and 9. The appellant asserts that since the

---

<sup>2</sup> The Medical Board is comprised of twelve members: nine physicians and three non-physician public members. Each Board member is appointed by the Governor and serves a five-year term. Even though dermatology may not be a physician's specialty, physicians, and hair stylists for that matter, are trained to notice skin abnormalities and refer the patient/client to a specialist.

hearing examiner, in his second conclusion of law, determined that the evidence was insufficient to support a conclusion that Dr. Little's conduct fell below the minimal standards of care in the treatment of Patients 2, 4, and 10, the testimony of the Board's expert should not have been believed because her testimony conflicted with statements she made in her written reports.

Upon review, the record demonstrates that the hearing examiner concluded that as to Patients 4 and 11, that "[s]ome of Dr. Willen's statements during her deposition conflicted with statements she had made in her written reports." See November 3, 2008 Report and Recommendation, 2(d) and (2)(j). Thus, the hearing examiner found that the evidence as to Patients 4 and 10, as well as Patient 2, was not clear enough to support the allegations. Thus, the appellant's treatment and care of Patients 2, 4 and 10 was not considered by the hearing examiner or the Board as the basis for the sanctions imposed against his license to practice medicine in Ohio.

The record is clear that the Board's expert witness, Dr. Willen, reviewed all the medical records which were documented by Dr. Little regarding the treatment and care of Patients 1 through 12, and the applicable medical records of any subsequent treating physicians of Patients 1 through 12. However, the appellant ignores the fact that he did not provide his own expert with relevant medical records of subsequent treating physicians for Patients 1 through 12. Thus, the failure of Dr. Little and Dr. Ridge to review the medical records of the various subsequent treating physicians can be taken into consideration in evaluating the accuracy, reliability and thoroughness of their testimony. See Tr. 172-173, 181; see also State's Exhibit 4-C at p. 11.

The trier of fact may believe or disbelieve all or any part of the testimony of any

witness and “[i]t was the obligation of the hearing examiner, as with any finder of fact, to determine what testimony to believe using her observations, education and other skills.” See *Leo D’Souza v. State Medical Board of Ohio*, Franklin Co. Common Pleas Court, Case No. 08-CVF-05-7342. A review of the record demonstrates that the hearing examiner based his decision on evidence that he found trustworthy. Thus, the Board acted properly in relying upon the credibility determinations of the hearing examiner. Moreover, there is evidence that appellant’s own expert, Dr. Ridge, corroborated the testimony of Dr. Willen in several instances. See November 3, 2008 Report and Recommendation, p. 20, 36, 37, 40, 139, 142.

In an administrative proceeding, the facts and circumstances of each case must be considered independent of other cases. In respect to each case, the Board weighs the credibility of each witness independently, judges the integrity of that person, and makes a decision as to credibility on all or part of his or her testimony. For example, in one case, a hearing examiner may decide that an individual is capable of rehabilitating his or her conduct, and in another instance, with another individual presenting similar facts, that same hearing examiner may conclude that person is not credible and is incapable of any type of rehabilitation. See *Harris v. State of Ohio. Dept. of Education*, 2000 Ohio App. LEXIS 1738.

The legislature and the courts of Ohio have delegated comprehensive decision-making power to the Board. Such power includes, but is not limited to, the authority to rely on the Board’s own knowledge when making a decision. It is well established that the Board may rely on its own expertise to determine whether a physician failed to conform to the minimum standards of care. The eight physicians on the twelve person Board are capable of both interpreting the technical requirements of the medical profession and determining whether that physician’s conduct falls below the minimal standard of care. See *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St. 3d 619; see also *State Med. Bd. of Ohio v. Murray* (1993), 66 Ohio St. 3d 527. Based on the foregoing, appellants’ second assignment of error is hereby **OVERRULED.**

The appellant asserts in his third assignment of error that the June 14, 2006 letter sent to him by the Board did not specifically charge him and thus, place him on notice that his dermatopathology practice (the evaluation of his own patients' lab slides) fell below the standard of care in violation of R.C. 4731.22. See also R.C. 119.07. Furthermore, it is appellant's contention that the Board failed to present any expert testimony in regard to this subspecialty.

A review of the record indicates that the June 14, 2006 notice letter sets forth the following, in pertinent part:

In your dermatological medical care of Patients 1-12, you failed to accurately diagnose \*\*\*skin cancers; \*\*\* and/or you failed to identify\*\*\* the subtype of skin cancer and/or failed to identify \*\*\* the extent of skin cancer.

Further, \*\*\* you inadequately performed Mohs procedures for skin cancer.

See State's Exhibit 21-A.

Based on the testimony of all the expert witnesses, there is a consensus that dermatological medical care is an integral part of many of the procedures that Dr. Little performed not only on Patients 1 through 12, but on all of his patients. Dermatological medical care is particularly important during the Mohs surgical procedure. Most troubling to the Board's expert and several members of the Board itself, was the appellant's testimony that he does his own dermatopathology and reads and evaluates his own patients' tissue slides, and thus, does not rely on an independent evaluation of another qualified dermatopathologist. Tr. 128.

A review of the evidence demonstrates that the June 14, 2006 Notice letter alleges that as to Patient 9, Dr. Little "[f]ailed to identify and or document the identification of the subtype of SCC and failed to identify and/or document the depth of the skin cancer invasion." See

State's Exhibit 21-A, (2)(i). In regard to Patient 9, Dr. Willen stated that the appellant failed to do the following:

It would be within the standard of care for a dermatologist (sic) pathologist to subtype a squamous cell carcinoma

See State's Exhibit 19, p. 8.

Additionally, in regard to Dr. Little performing the task of dermatopathology in regard to his own patients, she stated: "\*\*\*\* quality assurance dictates that a certain number of slides be reviewed by an outside unbiased reviewer. This is done routinely to ensure that the information and quality assurance is appropriate." See St. Ex. 19, p. 8. The Board's expert also stated "A biopsy was obtained which showed SCC. No depth of invasion or subtype of SCC is mentioned. It is below the minimal standard of care to omit this information." See State's Exhibit 15, p. 30.

Regarding Patient 7, Dr. Willen wrote:

The pathology submitted is read by Dr. Little and he informs the patient that the margins are clear when only fragments of tissue are submitted and also tells the patient and his wife that no further surgery is needed when there is no confirmation of clear margins. It is below the minimal standard of care to inform the patient that no further surgery was needed. Dr. Little took an inadequate sample to make a diagnosis. This should have been rebiopsied. Therefore, this treatment was below the minimal standard of care.

State's Exhibit 15, p. 24.

Finally, the Board expressed its concern regarding Dr. Little's practice of reading and evaluating his own patients' slides. Specifically, Dr. Egner expressed her concern with the appellant reading his own patients' slides and stated "this is a terrible practice." Board President Dr. Varyani also stated that he "agrees with Dr. Egner that Dr. Little should not read his own slides. He would prefer that the slides be read by a dermatopathologist, who is not associated in business with [Dr.] Little \*\*\*." Excerpt of Draft Minutes, p. 20. Thus, in

fulfilling its role in protecting the public, the Board imposed the following condition upon appellant:

**PERMANENT LIMITATION/RESTRICTION:** The certificate of Dr. Little to practice medicine and surgery in the State of Ohio shall be permanently LIMITED and RESTRICTED as follows: Dr. Little shall have the slides of all biopsies and all tumors removed read by a dermatopathologist in a timely fashion. Further, Dr. Little shall maintain in the patient record the written report from the dermatopathologist.

See December 10, 2008 Entry of Order.

Based on the foregoing, there is reliable, probative and substantial evidence demonstrating that the appellant was given adequate notice of all charges asserted against him in the June 14, 2006 Notice letter and addressed throughout the different stages of this administrative proceeding. Accordingly, the appellant's third assignment of error has no merit and is hereby **OVERRULED**.

In his fourth assignment of error, the appellant asserts that the Board erroneously disregarded his unchallenged testimony regarding the "field effect" and non-recurrent tumors. He asserts that he provided a logical explanation for his treatment of Patients 5, 6 and 8 with a surgery other than Mohs because all of these patients had what is known as a "field effect"...

Upon a review of Dr. Little's medical records for Patients 1 through 12, nowhere in those records does he document a "field effect" regarding his findings. Tr. 197. Furthermore, Dr. Little's testimony on this terminology was so unclear that appellant's own expert, Dr. Ridge, had a differing point of view. Tr. 566-580. Furthermore, even though it was appellant's position that the term "field effect" altered the appropriate standard of care, Dr. Little never questioned Dr. Willen about this term and its effect on the standard of care.

As discussed in the first assignment of error, the holding in *Walker*, and not *Lawrence*, is applicable to this case. The Board has the authority to act as the final arbiter of evidence

and rulings and has the ability to make expert determinations. Moreover, the appellant's own expert, at times, rebutted many of appellant's explanations in regard to the appellant's treatment and care of his Patients 1 through 12. Accordingly, the appellant's fourth assignment of error is not well-taken and is hereby **OVERRULED**.

**DECISION**

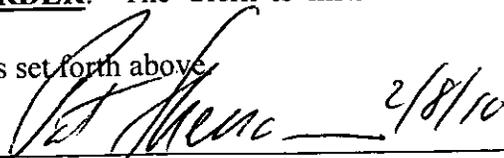
After a thorough review of the record, the Court finds that the State of Ohio Medical Board's December 10, 2008 Order is supported by reliable, probative, and substantial evidence, and is in accordance with law. Accordingly, the Court hereby **AFFIRMS** that order.

Rule 58(B) of the Ohio Rules of Civil Procedure provides the following:

**(B) Notice of filing.** When the court signs a judgment, the court shall endorse thereon a direction to the clerk to serve upon all parties not in default for failure to appear notice of the judgment and its date of entry upon the journal. Within three days of entering the judgment on the journal, the clerk shall serve the parties in a manner prescribed by Civ. R. 5(B) and note the service in the appearance docket. Upon serving the notice and notation of the service in the appearance docket, the service is complete. The failure of the clerk to serve notice does not affect the validity of the judgment or the running of the time for appeal except as provided in App. R. 4(A).

**THE COURT FINDS THAT THERE IS NO JUST REASON FOR DELAY.**

**THIS IS A FINAL APPEALABLE ORDER.** The Clerk is instructed to serve the parties in accordance with Civ. R. 58(B) as set forth above.

  
\_\_\_\_\_  
JUDGE PATRICK E. SHEERAN

COPIES TO:

Eric J. Plinke, Esq.  
Nicole M. Loucks, Esq.  
191 Nationwide Boulevard, Suite 300  
Columbus, Ohio 43215-8120  
Counsel for Appellant

Richard Cordray, Esq.  
Barbara J. Pfeiffer, Esq.  
Ohio Attorney General's Office  
Health and Human Services Section  
30 East Broad Street, 26<sup>th</sup> Floor  
Columbus, Ohio 43215-3400  
Counsel for Appellee

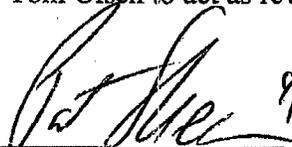
IN THE FRANKLIN COUNTY COURT OF COMMON PLEAS

Larry Little, M.D., :  
 Appellant, : Case No. 09-CV-416  
 vs. : Judge Pat Sheeran  
 State Medical Board of Ohio, :  
 Appellee. :

JOURNAL ENTRY

SHEERAN, J.

In accordance with the Court's March 3, 2009 Order granting a conditional stay of the underlying suspension and having reviewed the materials submitted by counsel, the Court hereby gives its approval to Dr. Joel Herron and Dr. Tom Olsen to act as reviewers in accordance with the Court's Order. It is so ORDERED.

 4/22/09  
 Patrick E. Sheeran, Judge

FILED  
 COMMON PLEAS COURT  
 FRANKLIN COUNTY, OHIO  
 2009 APR 22 PM 2:58  
 CLERK OF COURT

Copies to:

Eric J. Plinke, Esq.  
 Nicole M. Loucks, Esq.  
 DINSMORE & SHOHL, LLP  
 191 W. Nationwide Boulevard  
 Columbus, Ohio 43215-8120  
 FAX: 614-277-7334

Barbara Pfeiffer, Esq.  
 Assistant Attorney General  
 Health and Human Services Division  
 30 East Broad Street, 26<sup>th</sup> Floor  
 Columbus, Ohio 43215-3400  
 FAX: 614-466-6090

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO  
CIVIL DIVISION

FILED COURT  
COMMON PLEAS COURT  
FRANKLIN COUNTY, OHIO  
2009 MAR -3 AM 8:50  
CLERK OF COURTS

LARRY LITTLE, M.D. : Case No. 09 CVF-01-416

Appellant, : JUDGE SHEERAN

vs. :  
THE STATE MEDICAL BOARD OF OHIO:

TERMINATION NO. 17
BY: PA 2-27-09

Appellee.

**ORDER GRANTING APPELLANT'S MOTION FOR STAY OF SUSPENSION  
OF LICENSE TO PRACTICE MEDICINE  
AND  
ORDER OF CONDITIONS FOR STAY**

Upon motion of Appellant, Larry Little, M.D., and for good cause shown, the Court hereby GRANTS Appellant's Motion for Stay of Suspension of License to Practice Medicine under the following conditions stated in this Order:

1. Prior to engaging in the practice of medicine and surgery, Appellant must fulfill the requirements regarding a Post-Licensure Assessment (sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners) and satisfactory completion of all recommendations set forth in the written assessment issued after the assessment as described in and set forth in paragraph (C)(2)(a)-(e) of the Entry of Order issued by the State Medical Board of Ohio (hereafter Medical Board) on December 10, 2008. Appellant must file all documentation received pursuant to paragraph (C)(2) with the Court, with a copy to the Board's counsel.

2. Upon the filing of the documentation received pursuant to paragraph 1 of this Order indicating that Appellant has successfully completed the recommended educational activities set forth in the Education Plan, Appellant will be permitted to engage in the practice of medicine and surgery throughout the pendency of this appeal under the conditions set forth in Paragraphs 3 and 4

of this Order. If no Education Plan is required by the Post-Licensure Assessment written assessment Report, Appellant will be permitted to practice medicine and surgery throughout the pendency of this appeal under the further conditions set forth in Paragraphs 3 and 4 of this Order upon the filing of the Report with the Court, with a copy to the Board's counsel.

3. Upon completion of the requirements set forth in paragraph 1 of this Order, Appellant must submit to a monthly review of a random sampling of 20% of patient charts correlating to his current patients who have undergone Mohs surgery and other surgical procedures performed by Appellant, unless the Court otherwise determines that a different percentage is required. This monthly review is to be performed by a licensed physician specializing in dermatologic surgery, who has been approved in advance for this limited purpose of this Conditional Stay by this Court. Appellant shall submit the curriculum vitae of a physician willing to accept this role to the Court for approval. An approved physician must be in place prior to Dr. Little engaging in the practice of medicine and surgery.

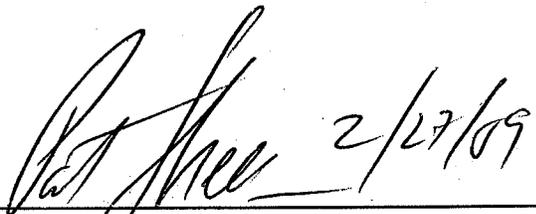
The approved physician shall select this random sampling from patients Appellant has treated in the previous six months. This random sampling will be selected by the approved physician on the first of each month. The results of each random monthly review will be reported to the Court, to Appellant, and to counsel for the Board within 20 days of the approved physician's selection of the sampling. If the approved physician finds that Appellant's conduct in performing these surgical procedures falls below the minimal standards of medical care, Appellant may request a hearing before the court to present evidence to rebut this finding in order to maintain the stay of the suspension of Appellant's license to practice medicine.

4. Upon completion of the requirements set forth in paragraph 1 of this Order, Appellant must submit to a monthly review of a random sampling of 20% of Appellant's average monthly

dermatopathologic slides, unless the Court otherwise determines that a different percentage of slides to be reviewed is required. This monthly dermatopathology review is to be performed by a licensed physician in the State of Ohio, specializing in dermatopathology, who has been approved in advance for this limited purpose of this Conditional Stay by this Court. Appellant shall submit the curriculum vitae of a dermatopathologist willing to accept this role to the Court for approval. An approved dermatopathologist must be in place prior to Dr. Little engaging in the practice of medicine and surgery.

The approved dermatopathologist shall select this random sampling from slides of patients Appellant has treated in the previous six months. The approved dermatopathologist will select this random sampling on the first of each month. The results of each random monthly review will be reported to the Court, to Appellant, and to counsel for the Board within 20 days of the approved dermatopathologist's selection of the sampling. If the approved dermatopathologist finds that Appellant's conduct in reading these slides falls below the minimal standards of medical care, Appellant may request a hearing to present evidence to rebut this finding in order to maintain the stay of the suspension of Appellant's license to practice medicine.

**IT IS SO ORDERED.**

 2/27/09  
\_\_\_\_\_  
JUDGE SHEERAN

Respectfully submitted,

*/s/ Nicole M. Loucks*

\_\_\_\_\_  
Eric J. Plinke (0059463)  
Nicole M. Loucks (0076912)  
**DINSMORE & SHOHL, LLP**  
191 West Nationwide Blvd., Suite 300

Columbus, Ohio 43215-8120  
Telephone: (614) 221-8448  
Facsimile: (614) 221-8590  
E-Mail: [eric.plinke@dinslaw.com](mailto:eric.plinke@dinslaw.com)  
[nicole.loucks@dinslaw.com](mailto:nicole.loucks@dinslaw.com)

Copy to:

Barbara Pfeiffer, Esq.  
Assistant Attorney General  
Health & Human Services Section  
Ohio Attorney General  
30 East Broad Street, 26<sup>th</sup> Floor  
Columbus, Ohio 43215-3428

BEFORE THE STATE MEDICAL BOARD OF OHIO

LARRY LITTLE, M.D.  
175 E. Deshler Avenue  
Columbus, Ohio 43206,

Appellant,

vs.

STATE MEDICAL BOARD OF OHIO  
30 East Broad Street, 3<sup>rd</sup> Floor  
Columbus, Ohio 43215

Appellee.

09 CVF 1 416

Case No. \_\_\_\_\_

Judge \_\_\_\_\_

Classification F

APPEAL FROM THE ENTRY  
OF ORDER OF DECEMBER 10, 2008  
AND MAILED JANUARY 7, 2009

FILED  
COMMON PLEAS COURT  
FRANKLIN CO., OHIO  
2009 JAN -9 PM 4:35  
CLERK OF COURTS

APPELLANT'S NOTICE OF APPEAL

Appellant, Larry Little, M.D., by and through counsel, and pursuant to Ohio Revised Code Section 119.12, hereby gives notice of his appeal of the Entry of Order of the Appellee, State Medical Board of Ohio ("Board"), which stayed the permanent revocation of his license to practice medicine and placed Appellant's medical license on indefinite suspension in the State of Ohio. The Entry of Order is dated December 10, 2008, and was mailed and effective on January 7, 2009. The basis of the Appellant's Appeal is that the Board's Entry of Order is not supported by substantial, probative, and reliable evidence nor is it in accordance with law. A copy of the Board's Entry of Order is attached as Exhibit A.

STATE MEDICAL BOARD  
OF OHIO  
2009 JAN -9 P 4: 10

STATE MEDICAL BOARD  
OF OHIO  
2009 JAN 20 P 12: 37

Respectfully submitted,

DINSMORE & SHOHL, LLP



---

Eric J. Plinke (0059463)  
Nicole M. Loucks (0076912)  
191 W. Nationwide Boulevard, Suite 300  
Columbus, Ohio 43215- 8120  
Phone: (614) 221-8448  
Facsimile: (614) 277-7334  
E-Mail: eplinke@bdblawn.com  
nloucks@bdblawn.com  
*Attorneys for Appellant Larry Little, M.D.*

**CERTIFICATE OF SERVICE**

I hereby certify that on this 9th day of January, 2009, the foregoing Notice of Appeal was filed via hand delivery with the State Medical Board of Ohio, was filed via hand delivery with the Court of Common Pleas of Franklin County, Ohio, and that a copy was served via ordinary U.S. mail, postage prepaid, upon the following:

Barbara J. Pfeiffer, Esq.  
Assistant Attorney Generals  
Ohio Attorney General's Office  
Health and Human Services  
30 East Broad Street, 26<sup>th</sup> Floor  
Columbus, Ohio 43215



---

Eric J. Plinke

STATE MEDICAL BOARD  
OF OHIO

2009 JAN 20 P 12:31

# State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127



Richard A. Whitehouse, Esq.  
Executive Director

(614) 466-3934  
med.ohio.gov

December 10, 2008

Larry John Little, M.D.  
175 E. Deshler Avenue  
Columbus, OH 43206

Dear Doctor Little:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 10, 2008, including motions modifying the Findings of Fact and Conclusions of the Hearing Examiner and Order, and adopting the Findings of Fact, Conclusions of Law and Order, as amended.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

*Lance A. Talmage, M.D.*  
Lance A. Talmage, M.D. *RW*  
Secretary

LAT:jam  
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3934 3686 5811  
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.  
CERTIFIED MAIL NO. 91 7108 2133 3934 3686 5828  
RETURN RECEIPT REQUESTED

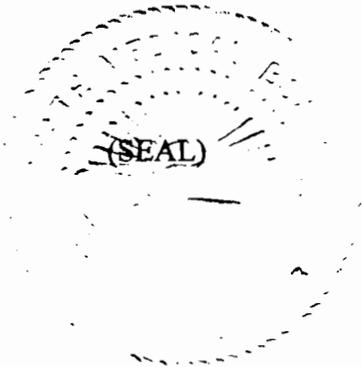
Michael Romanello, Esq.  
CERTIFIED MAIL NO. 91 7108 2133 3934 3686 5835  
RETURN RECEIPT REQUESTED

*Mailed 1-7-09*

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 10, 2008, including motions modifying the Findings of Fact and Conclusions of the Hearing Examiner and Order, as amended; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Larry John Little, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage MD  
Lance A. Talmage, M.D. RW  
Secretary

December 10, 2008  
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

\*

\*

LARRY JOHN LITTLE, M.D.

\*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on December 10, 2008.

Upon the Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

- A. **PERMANENT REVOCATION, STAYED; SUSPENSION:** The certificate of Larry John Little, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such revocation is STAYED, and Dr. Little's certificate shall be SUSPENDED for an indefinite period of time, but not less than one year.
- B. **PERMANENT LIMITATION/RESTRICTION:** The certificate of Dr. Little to practice medicine and surgery in the State of Ohio shall be permanently LIMITED and RESTRICTED as follows: Dr. Little shall have the slides of all biopsies and all tumors removed read by a dermatopathologist in a timely fashion. Further, Dr. Little shall maintain in the patient record the written report from the dermatopathologist.
- C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Little's certificate to practice medicine and surgery until all of the following conditions have been met:
  1. **Application for Reinstatement or Restoration:** Dr. Little shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Post-Licensure Assessment Program:** At the time he submits his application for reinstatement, Dr. Little shall submit a Learning Plan developed for Dr. Little by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners. The Learning Plan shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Little by the PLAS.
  - a. Prior to the initial assessment by the PLAS, Dr. Little shall furnish the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record which the Board may deem appropriate or helpful to that assessment.
  - b. Should the PLAS request patient records maintained by Dr. Little, Dr. Little shall include in that submission copies of the patient records at issue in this matter. Furthermore, Dr. Little shall ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.
  - c. Dr. Little shall assure that, within ten days of its completion, the written Assessment Report compiled by the PLAS is submitted to the Board. Moreover, Dr. Little shall ensure that the written Assessment Report includes the following:
    - A detailed plan of recommended practice limitations, if any;
    - Any recommended education;
    - Any recommended mentorship or preceptorship;
    - Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.
  - d. Dr. Little shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

Upon successful completion of the educational activities, including any assessment or evaluation recommended by PLAS, Dr. Little shall provide the Board with satisfactory documentation from PLAS indicating that Dr. Little has successfully completed the recommended educational activities.
  - e. Dr. Little's participation in the PLAS shall be at his own expense.
3. **Additional Evidence of Fitness To Resume Practice:** In the event that Dr. Little has not been engaged in the active practice of medicine and surgery for a period

in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.

- D. **PROBATION:** Upon reinstatement or restoration, Dr. Little's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:
1. **Obey the Law:** Dr. Little shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
  2. **Declarations of Compliance:** Dr. Little shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Little's certificate is reinstated or restored. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
  3. **Personal Appearances:** Dr. Little shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Little's certificate is reinstated or restored, or as otherwise directed by the Board. Subsequent personal appearances must occur every six months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
  4. **Post-Licensure Assessment Program:** Dr. Little shall practice in accordance with the Learning Plan developed by the PLAS, unless otherwise determined by the Board. Dr. Little shall cause to be submitted to the Board quarterly declarations from the PLAS documenting Dr. Little's continued compliance with the Learning Plan.

Dr. Little shall obtain the Board's prior approval for any deviation from the Learning Plan.

If, without permission from the Board, Dr. Little fails to comply with the Learning Plan, Dr. Little shall cease practicing medicine and surgery beginning the day following Dr. Little's receiving notice from the Board of such violation and shall refrain from practicing until the PLAS provides written notification to the Board that Dr. Little has reestablished compliance with the Learning Plan. Practice during the period of noncompliance shall be considered unlicensed practice in violation of Section 4731.41, Ohio Revised Code.

5. **Practice Plan:** Prior to Dr. Little's commencement of practice in Ohio, or as otherwise determined by the Board, Dr. Little shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless

otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Little's activities will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. Little shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

6. **Monitoring Physician:** Within thirty days of the date of Dr. Little's reinstatement or restoration and prior to Dr. Little's commencement of practice in Ohio, or as otherwise determined by the Board, he shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Little and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Little and his medical practice, and shall review Dr. Little's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Little and his medical practice, and on the review of Dr. Little's patient charts. Dr. Little shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Little's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Little must immediately so notify the Board in writing. In addition, Dr. Little shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Little shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

7. **Absence from Ohio:** In the event that Dr. Little should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Little must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of the probationary period under this Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.
8. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Little is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

- E. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Little's certificate will be fully restored.
- F. **VIOLATION OF THE TERMS OF THIS ORDER:** If Dr. Little violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
- G. **REQUIRED REPORTING AND DOCUMENTATION OF REPORTING:**
1. **Required Reporting to Employers and Hospitals:** Within 30 days of the effective date of this Board Order, Dr. Little shall provide a copy of this Board Order to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Little shall promptly provide a copy of this Board Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Little provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within 30 days of the effective date of this Board Order, Dr. Little shall provide a copy of this Board Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.  
  
This requirement shall continue until Dr. Little receives from the Board written notification of his successful completion of probation as set forth in paragraph 4, above.
  2. **Required Reporting to Other State Licensing Authorities:** Within 30 days of the effective date of this Board Order, Dr. Little shall provide a copy of this Board Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. Little further agrees to provide a copy of this Board Order at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license.  
  
This requirement shall continue until Dr. Little receives from the Board written notification of his successful completion of probation as set forth in paragraph 4, above.
  3. **Documentation that the Required Reporting Has Been Performed:** Dr. Little shall provide the Board with **one** of the following documents as proof of each

required notification within 30 days of the date of each notification required above: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was emailed.

This Order shall become effective thirty days from the date of mailing of the notification of approval by the Board. In the thirty-day interim, Dr. Little shall not undertake the care of any patient not already under his care.



*Lance A. Talmage MD*

Lance A. Talmage, M.D. *rw*  
Secretary

December 10, 2008

Date

**REPORT AND RECOMMENDATION  
IN THE MATTER OF LARRY JOHN LITTLE, M.D.**

The Matter of Larry John Little, M.D., was heard by R. Gregory Porter, Hearing Examiner for the State Medical Board of Ohio, on March 27, 28, and 29, 2007.

**INTRODUCTION**

Basis for Hearing

By letter dated June 14, 2006, the State Medical Board of Ohio [Board] notified Larry John Little, M.D., that it had proposed taking disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action upon allegations concerning Dr. Little's treatment of twelve patients identified in a confidential Patient Key.

The Board alleged that Dr. Little's conduct constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code."

The Board advised Dr. Little of his right to request a hearing in this matter, and received his written request for a hearing on July 7, 2006. (State's Exhibits 21A, 21B)

Appearances

Nancy H. Rogers, Attorney General, by Damion M. Clifford and Barbara J. Pfeiffer, Assistant Attorneys General, for the State.

Michael Romanello and Eric J. Plinke, Esqs., for Dr. Little.

**EVIDENCE EXAMINED**

Testimony Heard

Presented by the State

Marlene Willen, M.D., via deposition in lieu of live testimony  
Andie Little, R.N., as upon cross-examination

Presented by the Respondent

Larry John Little, M.D.  
Jennifer M. Ridge, M.D.

Exhibits Examined

Presented by the State

\* State's Exhibits 1A through 12C: Copies of medical records for Patients 1 through 12.

\* State's Exhibit 13: Patient Key.

State's Exhibit 14: Curriculum Vitae of Marlene Willen, M.D.

State's Exhibit 15: June 6, 2006, Report of Dr. Willen.

State's Exhibit 16: Undated Supplemental Report of Dr. Willen.

State's Exhibit 17: Stipulation of State Medical Board of Ohio and Larry John Little, M.D.

\* State's Exhibit 18: October 29, 2005, Certificate of Death for Patient 9.

State's Exhibit 19: Transcript of March 20, 2007, Deposition of Dr. Willen.

State's Exhibit 20: Certified copies of documents maintained by the Board in the Matter of Larry John Little, M.D.

State's Exhibits 21A through 21P and 21-R through 21-U: Procedural exhibits.

\* State's Exhibit 21-Q: Sealed procedural exhibit: State Medical Board's Request for Issuance of Subpoenas.

State's Exhibit 22: May 11, 2007, State's Closing Argument. (Note: This exhibit was received, marked, and admitted by the Hearing Examiner post-hearing.)

Presented by the Respondent

Respondent's Exhibit A-A: November 14, 2006, Report of Jennifer M. Ridge, M.D.

Respondent's Exhibit A-B: Curriculum Vitae of Dr. Ridge.

Respondent's Exhibit A-C: November 17, 2006, Responses to Allegations by Larry Little, M.D.

Respondent's Exhibit A-D: Curriculum Vitae of Dr. Little.

Respondent's Exhibit A-E: Copies of medical literature. (Note that a submitted "E-Medicine" article concerning Mohs micrographic surgery was not admitted because the copy was incomplete.)

- \* Respondent's Exhibit A-F: List of Mohs patients seen by Dr. Little after June 28, 2006.
- \* Respondent's Exhibit A-G: List of Mohs recurrences.

Respondent's Exhibits B, B-1, B-2, and B-4 through B-15, and B-17 through B-23: February 23, 2007, supplemental report and response of Dr. Little with copies of cited references (Note: Respondent's Exhibit B-3 was not admitted because the copy submitted was incomplete.)

- \* Respondent's Exhibit B-16: Collection of LabCorp Final Reports.
- \* Respondent's Exhibits C-1 and C-2: Photographs of Mohs surgery procedures.

Respondent's Exhibits D-1 through Substitute D-18: Photographs showing equipment and procedures used by Dr. Little in performing Mohs surgery.

- \* Respondent's Exhibits E-1 and E-2: Photographs used by Dr. Little during his testimony to demonstrate field effect and its impact in deciding whether or not to perform Mohs surgery.

Respondent's Exhibit F: June 8, 2007, Respondent's Closing Argument. (Note: This exhibit was received, marked, and admitted by the Hearing Examiner post-hearing.)

Respondent's Exhibit G: June 28, 2007, Respondent's Motion to Strike Comments in the State Medical Board of Ohio's Closing Argument or, in the Alternative, to Reopen the Record. (Note: This exhibit was received, marked, and admitted by the Hearing Examiner post-hearing.)

- \* Note: Exhibits marked with an asterisk (\*) have been sealed to protect patient confidentiality.

## **PROCEDURAL MATTERS**

1. Pursuant to an objection by the Respondent made at the deposition of Marlene Willen, M.D., and reaffirmed at the hearing, the Hearing Examiner redacted testimony of Dr. Willen from her deposition, appearing on page 77 of State's Exhibit 19, lines 18 to 25. All other objections made at the deposition were considered by the Hearing Examiner and overruled. (Hearing Transcript [Tr.] at 84-86)

2. The Hearing Examiner redacted the last eight words from a sentence on page six of Dr. Willen's expert report, State's Exhibit 15, first paragraph. The sentence begins: "He was treated with a course of radiation \* \* \*." (Tr. at 85)
3. After the parties filed their written Closing Arguments, the Respondent moved to strike certain comments from the State's submission, or alternatively to reopen the record so that the Respondent could respond to those comments. (Respondent's Exhibit G)

For the reasons given by the Respondent, his Motion to Strike is hereby granted. The State's Closing Argument, State's Exhibit 22, has been redacted accordingly.

### **SUMMARY OF THE EVIDENCE**

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

#### **Background Information**

##### *Larry John Little, M.D.*

1. Larry John Little, M.D., testified that he had received his medical degree in 1977 from the University of Nebraska. He then completed a one-year, rotating internship at Maricopa County Hospital in Phoenix, Arizona. Next, he completed a residency in dermatology through a combined program jointly offered by the University of Nebraska and Creighton University. (Hearing Transcript [Tr.] at 90-91)

Dr. Little testified that he had entered into private practice in 1981 with a multi-specialty group in Jacksonville, Florida. The group disbanded within about eight months, and he was recruited to Portsmouth, Ohio, where he practiced on his own for about one and one-half years. Since then, he has practiced in central Ohio. He practiced in Newark from approximately 1982 through 2004, but now practices in New Albany. He practices under the name "Dermatology and Skin Surgery Center, LLC." (Tr. at 91-93)

Dr. Little testified that he was board-certified in dermatology in 1981. He is a fellow of the American Academy of Dermatology; the American Society of Dermatologic Surgery, and the American Society of Cosmetic Surgery. He has been licensed to practice medicine in Ohio since "late '81, early '82." (Tr. at 93-95)

Dr. Little testified that 95 percent of his professional time is devoted to active clinical practice. His practice primarily consists of ambulatory patients, with emphases on surgery and on geriatric patients. He has provisional staff privileges at Mount Carmel West Hospital in Columbus, Ohio, but he performs his surgeries in his office. All of the surgeries at issue in this case were office-based procedures. (Tr. at 95-96)

*Marlene Willen, M.D.*

2. Marlene Willen, M.D., testified as an expert on behalf of the State. Dr. Willen received her medical degree in 1984 from the Wright State University School of Medicine in Dayton, Ohio. She testified that, from 1984 through 1989 she participated in a general surgery residency at University Hospitals of Cleveland in Cleveland, Ohio [UHC].<sup>1</sup> She was an Investigative Fellow at the Skin Disease Research Center of Case Western Reserve University from 1989-1990. She then completed a dermatology residency at MetroHealth Medical Center in Cleveland [MetroHealth] from 1990 to 1993. Finally, she completed a Mohs Surgery fellowship at The Cleveland Clinic Foundation from 1993 to 1995. (State's Exhibit [St. Ex.] 14; St. Ex. 19 at 4)

Dr. Willen was certified by the American Board of Dermatology in 1993, and recently recertified in 2003. In addition, since 1995, she has been a Fellow of the American College of Mohs Micrographic Surgery. Dr. Willen is licensed to practice medicine and surgery in Ohio. (St. Ex. 14; St. Ex. 19 at 5-6)

3. Dr. Willen is Chairperson of the Department of Dermatology at MetroHealth Medical Center [MetroHealth]. She oversees a staff that includes 14 dermatologists. Dr. Willen testified that her department trains 21 residents in a program jointly offered with University Hospitals of Cleveland. Dr. Willen further testified that she is also the Director of the Division of Dermatologic Surgery and Oncology at MetroHealth. Dr. Willen has privileges at MetroHealth Medical Center, where she is on the Quality Assurances Committee, the Laser Safety Committee, and the Medical Executive Committee. (St. Ex. 14; St. Ex. 19 at 5-7)

Dr. Willen testified that 80 percent of her practice is clinical. (St. Ex. 14; St. Ex. 19 at 6-7)

4. Dr. Willen testified that she is familiar with the standard of care for dermatologists in Ohio. (St. Ex. 19 at 24)

*Jennifer M. Ridge, M.D.*

5. Jennifer M. Ridge, M.D., testified as an expert on behalf of Dr. Little. She testified that she had received her medical degree from The Ohio State University College of Medicine [OSU] in 1989. She then completed a one-year internal medicine internship, also at OSU. She then engaged in a year of research at Wright State University. In 1994, she completed a three-year dermatology residency at Wright State University. (Respondent's Exhibit [Resp. Ex.] A-B; Tr. at 516-517)

Dr. Ridge testified that she had entered private practice immediately after completing her residency, and that she maintains a solo dermatology practice in Middletown, Ohio, with a broad cross-section of patients: "all age groups, all problems." Ninety-five percent of her

---

<sup>1</sup> Dr. Willen's curriculum vitae indicates that she had participated in an internship at UHC from 1984 to 1985, a surgical residency at UHC from 1985 to 1987, and a research fellowship at MetroHealth Medical Center from 1987 to 1989. (St. Ex. 14)

professional time is clinical; five percent is administrative. She devotes two and half days per week to general dermatology; one day to Mohs surgery; and one and a half days to non-Mohs surgery. She has admission privileges at Middletown Regional Hospital. (Tr. at 517-521)

Dr. Ridge testified that she became board-certified in dermatology in 1994, and that she has most recently been recertified in 2004. She advised that she is active in several dermatological societies, including the American Academy of Dermatology, the American Society of Mohs Surgery, the Ohio Dermatological Association, the Ohio Dermatological Surgery Association, the American Academy of Cosmetic Surgery, the American Academy of Liposuction Surgery, and the American Academy of Laser Surgery. (Tr. at 517-518)

6. Dr. Ridge described her training in Mohs surgery: “I partially trained in Columbus at Ohio State with Ron Siegel. And I trained at The Mayo Clinic. I trained with a Mohs surgeon in Dayton. So my training was kind of an accumulative effort.” (Tr. at 520)
7. Dr. Ridge advised that she had first met Dr. Little just prior to the hearing. She said that she did not know him personally, although she had recognized his name because they may have shared a patient. (Tr. at 521-522)

#### **Prior Board Action**

8. On January 16, 2004, based upon violations of Sections 4731.22(B)(2), (B)(6), (B)(10) and (B)(20), Ohio Revised Code, the Board entered an Order suspending the certificate of Dr. Little to practice medicine and surgery in Ohio for an indefinite period, but not less than 180 days, and imposing terms and conditions for reinstatement, as well as probationary terms and conditions. On July 14, 2004, the Board voted to reinstate Dr. Little’s certificate subject to the previously ordered probationary terms and conditions. (St. Ex. 20)

#### **Information Concerning Basal Cell and Squamous Cell Carcinomas**

9. Several of the allegations against Dr. Little involve basal cell carcinomas [sometimes referred to herein as “BCC”] and/or squamous cell carcinomas [sometimes referred to herein as “SCC”] and the procedures used for treating those conditions, including “Mohs micrographic surgery.” (St. Ex. 21-A)
10. Dr. Willen testified that, of all skin cancers that occur, about 75 percent are basal cell carcinomas, about 24 percent are squamous cell carcinomas, and the remaining 1 percent includes all other forms of skin cancer. (St. Ex. 19 at 12)

Dr. Willen advised that basal cell carcinoma is the most common type of skin cancer that she sees, and that it typically occurs on sun-exposed skin. There are approximately eight varieties, each with its own biological behavior. It is usually locally aggressive but rarely metastasizes. Dr. Willen testified that that is because “basal cell carcinoma is dependant on

the stroma<sup>2</sup> that it grows in and it can't be transplanted to another area because it is stromal dependent." Nevertheless, some varieties can spread locally and can metastasize, but metastasis occurs in "far less than 1% of all basal cells." (St. Ex. 19 at 11-13)

Dr. Willen further advised that squamous cell carcinoma can occur on sun-exposed or non-sun-exposed skin. Dr. Willen noted that squamous cell carcinoma is a "different biological actor" from basal cell carcinoma. There are many different subtypes of squamous cell carcinoma. Further, squamous cell carcinoma can be superficial or invasive. Dr. Willen testified that "there is a big difference between a superficial, or in situ squamous cell, versus an invasive squamous cell." With regard to invasive squamous cell, Dr. Willen testified that the risk of metastasis increases as the depth of the invasion increases. Dr. Willen explained:

Generally we feel like 4 mm of invasion is the cut-off, so under 4 mm a squamous cell is less likely to metastasize. Probably the risk is 7% to 10% whereas greater than 4 mm the risk can be from 15% to 40%. So knowing the depth of invasion is helpful in determining \* \* \* the patient's risk of metastatic disease or recurrent disease.

(St. Ex. 19 at 13) Moreover, Dr. Willen testified that squamous cell carcinoma is more likely to metastasize if it arises in a non-sun-exposed area, such as a scar or burn. In those cases, the rate of metastasis is 30 to 35 percent. Finally, Dr. Willen testified that "it is well known that squamous cell carcinoma on the lip and the ear and the scalp and even the hand can have a [higher] risk of metastasis." (St. Ex. 19 at 14)

## **Treatment Procedures**

### *Cryosurgery*

11. Dr. Willen testified that cryosurgery is the application of liquid nitrogen "to freeze and ultimately destroy a lesion." She further testified that it is often used to treat actinic keratosis, which is a pre-malignant skin lesion. In addition, Dr. Willen testified that cryosurgery "is used often to treat warts, [and] can be used to treat skin tags, either benign or malignant lesion." (St. Ex. 19 at 15)

Dr. Willen testified that the advantage of cryosurgery is that liquid nitrogen is readily available. Dr. Willen further testified that the disadvantages are that it can be painful, it can cause hyperpigmentation or depigmentation of the skin, it is usually applied superficially and, unless a cryo-probe is used, there is no precise way to determine the depth of the freeze, hence it is a blind, destructive technique. However, Dr. Willen testified, "If you are treating malignant lesions and using a cryo-probe, especially if you are treating on the ear and you can tell the depth of freeze on the ear, the [success rate] can be as high as 95%." (St. Ex. 19 at 15-16)

---

<sup>2</sup> Dorland's Illustrated Medical Dictionary, 27th Ed. (W.B. Saunders 1988), at page 1595, defines stroma as: "[T]he supporting tissue or matrix of an organ, as distinguished from its functional element, or parenchyma. \* \* \*"

*Electrodessication and Curettage*

12. Dr. Willen testified that curettage is a technique in which the physician uses a curette, which is an instrument with a long handle and a sharp loop at one end, to “scoop out tissue.” Dr. Willen testified that it can be used to obtain tissue for biopsies or to determine the depth of a tumor prior to “a more definitive procedure” to remove the tumor. (St. Ex. 19 at 14)

Dr. Willen testified that electrodesiccation and curettage [ED&C] is a procedure for removing lesions that combines curettage with the use of “an electrical device to dry out or remove the water from the skin and ultimately burn it.” Dr. Willen described the procedure:

ED&C is generally a very quick procedure to perform. You basically numb up the area you are going to perform it on, you identify the lesion, the size, and then you use a series of curette[s] and turns with the curette into the lesion and you curette what you feel is the clinical entity of the tumor. Then you desiccate with some type of cautery device to kind of burn the next layer, and you take a smaller curette and you scoop out the desiccate[d] skin. And you keep repeating that and you usually do it out to 3 mm beyond what you clinically observe as the lesion.

(St. Ex. 19 at 16-17) Dr. Willen testified concerning the disadvantages of ED&C:

It is \* \* \* a blind technique. There is no confirmation of clearance of tumors. And with tumors that are more infiltrative, such as an infiltrative or morpheaform basal cell, it is more difficult to get a curette into the microfoci in the tumor extensions of the skin and therefore not recommended for that type of tumor. It is more recommended for superficial skin lesions, and the problem is once your curette falls into the subcutaneous tissue or fat, it is no longer accurate \* \* \*. If your curette falls in deep into the deeper layers you can't curette anymore because everything is soft and there is no end point to the curette.

(St. Ex. 19 at 17-18)

*Mohs Micrographic Surgery*

13. Dr. Willen testified that Mohs micrographic surgery is used to treat many types of skin cancers, including squamous cell and basal cell. Dr. Willen described the Mohs surgery procedure as follows: First, the area with tumors is numbed, and then outlined with a marker, in case the anesthetic obscures the margins of the tumor. Then, the clinically observable tumor and approximately one millimeter of normal-appearing tissue is removed in a “saucerized fashion. Similar to what a half grapefruit or half orange looks like, so the rind being the margin you have taken and the pulp being the tumor.” The specimen is then cut into sections and the margins are inked with different dyes. The cut edge is marked and the sections removed during the first stage are identified in numerical order. A two-dimensional “map” is created showing where tissue has been removed, which is color

coded per the inked margins. The specimens are then submitted to the lab, where a histology technician, or “histotech,” prepares slides, labeled with identifying information. (St. Ex. 19 at 18-20, 22)

She further described:

The tissue is then imbedded on an OCT,<sup>3</sup> which is a mounting media. Chucks are used and OCT is applied to the chuck, and the chuck is frozen and the tissue is inverted on the chuck and flattened in such a way that the deepest part of the tumor is put up and the epidermis is then brought up to be in the same pla[ne] as the deepest part of the tumor.

(St. Ex. 19 at 20)

Dr. Willen testified that, next, the sections and chucks are placed into a cryostat.<sup>4</sup> Horizontal slices are serially removed and placed onto glass slides, which are then stained, dried, and cover-slipped. The slides are then submitted to the Mohs surgeon for review under a microscope. The Mohs surgeon reviews the slides and the map to determine if there is any tumor remaining at the margins of the removed sections (i.e., a “residual tumor”). If there is no residual tumor, then the procedure is complete and the physician moves forward to the reconstructive process. If there is residual tumor then stage two occurs, and a second layer of tissue is removed from the location where residual tumor was found which is then prepared and examined microscopically in the same manner as the first. Multiple stages may be required before a tumor is cleared. (St. Ex. 19 at 20-21)

Dr. Willen testified that, for primary basal cell and primary squamous cell tumors, Mohs micrographic surgery has a cure rate of 99 percent at five years. (St. Ex. 19 at 21)

14. Dr. Ridge advised that clear margins are essential in Mohs surgery to avoid recurrence of the tumor. Dr. Willen testified that a “recurrent tumor” is a tumor that returns after it appeared to have been cleared, and that a “residual tumor” is one that remains at the margins after the partial removal of the tumor. (St. Ex. 19 at 21-22)

### **Pathology Reports**

15. Dr. Little advised that he reads his own slides, rather than sending them to an outside lab. Dr. Little testified that he is certified by “CLIA, the lab-monitoring instrument of the federal government,” which monitors his lab on a regular basis. (Resp. Ex. B-17; Tr. at 130-131)
16. Dr. Willen expressed concern about whether there could be appropriate quality assurance under those circumstances. (St. Ex. 19 at 89)

---

<sup>3</sup> Optimal cutting temperature embedding compound. (Resp. Ex. B-1)

<sup>4</sup> Dr. Little testified that a cryostat is an instrument that slices tissue in micron-type sections and freezes them. (Tr. at 114)

## Evidence Concerning Patient 1

### *Patient 1's Initial Visit and Biopsy*

17. Patient 1, a male born in 1931, first presented to Dr. Little on November 20, 2001. Dr. Little's medical record for Patient 1 indicates that he had been referred by his primary care physician concerning a "spot" on his right upper lip. The medical record states that Patient 1 had reported that his lip was injured two years earlier when a piece of barbed-wire fence broke and hit him on the lip. Patient 1 further reported that it "itches at times" and "will not heal." The lesion was documented as "3 – 6 mm in size." Dr. Little took a biopsy sample from the site. The sample was evaluated by an outside laboratory. (St. Ex. 1A at 17, 21)

The dermatopathologist's report states:

DIAGNOSIS: SUPERFICIAL FRAGMENTS OF AN ATYPICAL SQUAMOUS PROLIFERATION

NOTE: Fragments of hypertrophic actinic keratosis and fragments of well-differentiated squamous cell carcinoma would be considered in the differential diagnosis. Clinical follow up to ensure complete removal and allow for further histologic study is advised.

(St. Ex. 1A at 21)

### Comments Concerning the Biopsy

18. Dr. Willen indicated that on November 20, 2001, Dr. Little had noted a 3-6 mm lesion, and that a "2 mm biopsy was done." Dr. Willen criticized Dr. Little for having taken too small of a tissue sample for biopsy, which resulted in an indeterminate diagnosis. (St. Ex. 15 at 1; St. Ex. 19 at 27, 30)
19. Dr. Little testified that the dermatopathologist who interpreted the biopsy found a well-differentiated squamous cell cancer, and recommended complete removal of it. (St. Ex. 19 at 27, 30; Tr. at 133-134)

### *Patient 1's January 7, 2002, Mohs Surgery*

20. On January 7, 2002, Dr. Little performed Mohs surgery on Patient 1's right upper lip. In his operative report, Dr. Little stated that his preoperative and postoperative diagnoses were infiltrative *basal* cell carcinoma. (St. Ex. 1A at 15, 19, 25)

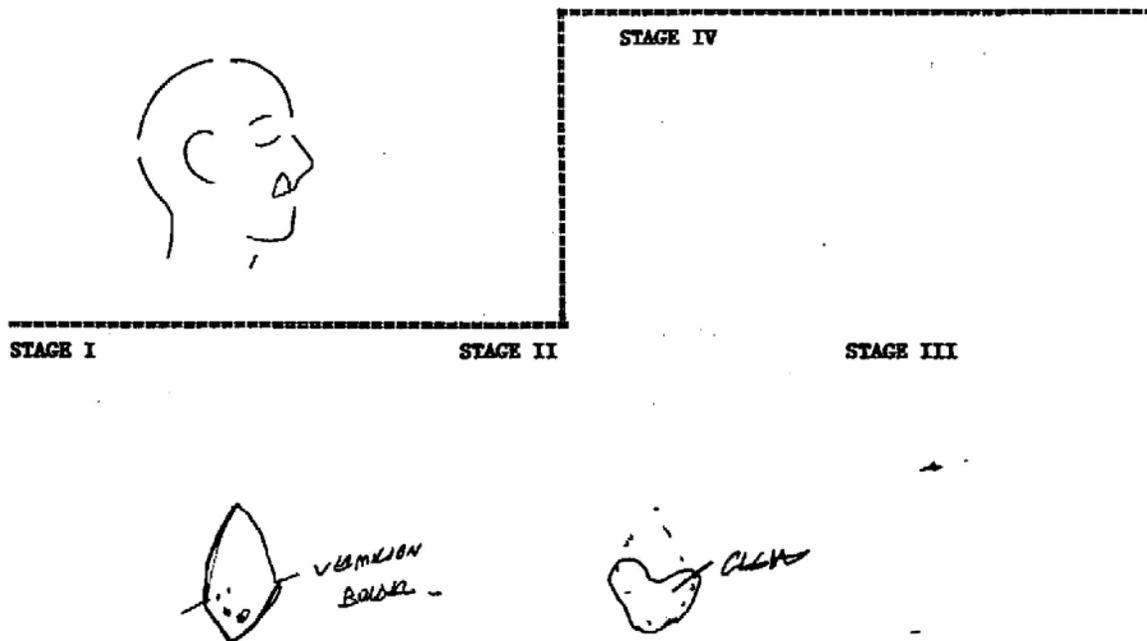
Dr. Little's Operative Report for that procedure includes the following information:

\* \* \* The pliable component of the tumor was initially debulked by curettage. The initial Moh's site was then obtained peripherally and beneath the tumor

with the scalpel blade \* \* \* to a preoperative diameter of 2.6 x 1.2 cm. \* \* \* The tissue was then divided into 1 section. These margins were color coded in the usual manner \* \* \* for accurate orientation. The tissue was then sent to the lab for frozen sectioning via oct embedding and cryostat 4 micron thickness horizontally oriented specimens. Staining was accomplished after formalin fixation \* \* \*. Three cuts were obtained for each section examined. Microscopic tumor was found persisting in 1 of the sections per the diagram. [See below.]

The patient was then returned to the surgical suite \* \* \*. The areas of residual tumor were then delineated and excised as a second stage with 1 section. This stage carried to the extent of excision into the orbicularis oris. \* \* \* The tissue section was then color coded, frozen sectioned and mounted. Microscopic tumor was not found in any of the sections. The final surgical defect measured 3.6 x 2.5 cm. The surgical defect will be repaired by a local flap repair.

(St. Ex. 1A at 25) Dr. Little's medical record for Patient 1 includes the following diagram referenced in his operative report:



(St. Ex. 1 at 19)

The medical record indicates that, after Mohs surgery, Patient 1 saw Dr. Little several times for suture removal and follow-up visits through January 27, 2002. Dr. Little's notes indicate that Patient 1 did well following surgery. (St. Ex. 1A at 11-13)

21. Dr. Little's medical record for Patient 1 indicates that he did not see Patient 1 again until October 2003. (St. Ex. 1A at 9-11)

Dr. Willen

22. In her testimony and written report, Dr. Willen indicated that the first stage had consisted of one section that measured 2.6 by [x] 1.2 cm. Dr. Willen noted that this specimen was nearly four times the size of the initial lesion in width. She further indicated that that specimen is too large to fit adequately on a glass slide for histological examination, yet there was no documentation that the specimen was divided into smaller sections. Dr. Willen indicated that it is below the minimal standard of care to fail to document how many sections were reviewed. Dr. Willen testified that Dr. Little examined three slices of the specimen and determined that there was residual tumor at the border of the vermilion [lip]. A second stage was then taken. (St. Ex. 15 at 1-2; St. Ex. 19 at 27-30)

In her written report, Dr. Willen stated:

The second layer [was] taken to the level of the orbicularis muscle with a final defect of 3.5 x 2.5 cm, which also indicates that a large section was taken, again no documentation of how many sections are reviewed to document clear margins. The failure to document the processing of these specimens and how many sections were reviewed is below the minimal standard of care provided by a Mohs surgeon.

(St. Ex. 15 at 2) Moreover, in her supplemental written report, Dr. Willen stated:

It is recommended specimens greater than one centimeter be divided in half and then each specimen mounted on slides. Most Mohs surgeons will require at least 5 sections to clear a margin, with each section being 5 [microns] in thickness, allowing 25 [microns] for a clear margin.

(St. Ex. 16 at 1) Finally, at hearing, Dr. Willen testified:

[Large sections such as these] would require a longer freeze time in liquid nitrogen [leading] to artifact, histological artifact in the processing. The entire margin may not have been evaluated due to the size. Unless Dr. Little used oversized slides, had large chucks to place the specimens on, large slides to cut the sections on to, and a cryostat that would adapt to that, those chucks and those slides, it would be very hard on a standard slide to put that section on and adequately measure it. Also the marking of the second stage going to the [orbicularis] muscle and no tumor seen, the concern whether he actually went back to the actual area where tumor was noted is in question.

(St. Ex. 19 at 30-31)

Dr. Little

23. In his February 23, 2007, supplemental report, Dr. Little expressed disagreement with Dr. Willen's opinion that Mohs specimens larger than one centimeter should be divided. Dr. Little stated:

This is not standard. The size of the sample to be processed is limited by the size of the mounting chuck in the cryostat and the microscope slide used for mounting the specimen. Larger than 1cm sizes of tissue can be mounted, provided that the margins can be adequately flattened for examination. There are multiple tools and techniques available which assist in accomplish[ing] this.

(Resp. Ex. B at 1) Further, Dr. Little testified that his office has large slides measuring 5 cm x 5 cm that he uses when the need arises. (Tr. at 124-125)

24. In support of his position, Dr. Little referenced the following article: Sukal S., Tudisco M., Strippoli B., Nehal K.: "Innovative Laboratory Techniques to Facilitate Processing of Large Mohs Cases" *Dermatol Surg* 31:763-765, 2005. The article states that "Mohs surgery for large tumors, such as dermatofibrosarcoma protuberans [DFSP] requires substantial planning of time and staffing for laboratory processing and microscopic evaluation of multiple tissue sections." The article suggests that efficiency of such procedures could be improved if larger specimens could be examined without being subdivided into smaller specimens. (Resp. Ex. B-1)

The article summarizes a Mohs procedure on a 2.3 x 2.0 cm DFSP tumor on a patient's back that was "excised with 1 cm beveled circumferential margins to the deep subcutaneous plane as a single saucerized specimen." The methodology for preserving orientation is described, and the specimen was divided in two. The article describes in detail how each piece was prepared and placed "onto large 50 x 75 mm glass slides." Staining and final preparation of the slides is described. It then states that the Mohs surgeon scanned the slides under a 1.25X objective lens [to provide a wider field of view than standard 2X or 4X lenses] and examined the slides under a higher power as necessary.

The article concludes that processing multiple, smaller specimens can present problems. For example, large number of subdivided specimens increases the risk of orientation and labeling errors. Processing the specimens may be delayed by the number of specimens to be processed, "thereby increasing the risk of tissue autolysis and swelling." Also, "[f]alse-positive margins can occur with the standard Mohs technique when sectioning inadvertently inoculates peripheral malignant tumor into the deep plane." The authors of the article conclude that examining larger specimens avoids those problems, helps avoid staff fatigue, and results in less wait time between stages for the patient. In addition, the Mohs surgeon is spared some time in microscope viewing and interpretation. (Resp. Ex. B-1)

Finally, the article notes the disadvantages of viewing larger specimens. Processing large specimens requires that the histotech possess a greater level of skill. Specialized equipment and supplies must be used. Further, although the use of a 1.25X lens “significantly enhances the ability to scan large tissue sections with ease owing to a wider field of view[,]” it also “requires the Mohs surgeon to more carefully scan the tissue to prevent missing a tumor focus within the large tissue section.” However, in the authors’ view, the Mohs surgeon can easily accustom himself or herself to view tissue at that level of magnification. (Resp. Ex. B-1)

#### Dr. Ridge

25. In contrast, Dr. Ridge testified that Dr. Little’s documentation had been correct, proper, “entirely consistent with what had been done,” and that it had met the minimal standard of care. (Tr. at 534-535)

#### *Patient 1’s October 9, 2003, Visit*

26. On October 9, 2003, nearly two years following the Mohs surgery, Patient 1 returned to Dr. Little’s office complaining of a spot on his right upper lip. Dr. Little diagnosed “Residual BCC” and prescribed Aldara cream. Dr. Little instructed Patient 1 to return in six weeks. (St. Ex. 1A at 9)

#### Dr. Willen

27. Dr. Willen testified that Aldara is an “immune modulating topical medication.” She noted that Aldara increases cells’ innate immunity. Dr. Willen stated that “it can up regulate interferon and interleukin-2 which are cytokine in the cell that can help the cell recognize a foreign entity” and attack it. (St. Ex. 19 at 22-23)

Dr. Willen testified that Dr. Little did not meet the standard of care because he had used Aldara to treat a *recurrent* basal cell carcinoma. She advised that the standard of care for a recurrent lesion would be to offer the patient options for treatment, such as an additional Mohs surgery or a re-biopsy, to determine if there was an infiltrating metatypical basal cell that would be considered an aggressive form of basal cell carcinoma. She further advised that Mohs surgery would have been the optimal solution, with a 95 percent cure rate as opposed to the 50 to 70 percent cure rate for other treatment options. (St. Ex. 19 at 32-33)

Dr. Willen further testified that Aldara does not treat deeper lesions, and is only now approved to treat superficial primary basal cell carcinomas, with about an 82 percent cure rate. Her report states that the use of Aldara may have only camouflaged the tumor, delaying its diagnosis and treatment. (St. Ex. 15; St. Ex. 19 at 32-33)

#### Dr. Little

28. Dr. Little testified that, on October 9, 2003, Patient 1 came to him with what appeared to be cancer in the same area that had previously been treated. He further testified that Patient 1

had stated a desire for no more surgery, scars, or incisions, despite Dr. Little's advice to re-biopsy the area. Dr. Little testified that he had asked Patient 1 to come back for a recheck in six weeks, and wrote him a prescription for topical Aldara cream. (Tr. at 143-144)

Dr. Little admitted that, at the time he had prescribed Aldara to Patient 1, it had not been approved by the United States Food and Drug Administration [FDA] for treatment of basal cell carcinomas. He explained that Aldara had been approved at that time for actinic keratosis and precancerous lesions, and that it had been later approved, in 2004, for treatment of superficial basal cell carcinomas. However, Dr. Little testified that he had seen the patient again on November 24, 2003, and that there had been complete healing of the area; he believed that the Aldara had had a therapeutic effect. He said that, contrary to the Board's allegation, the Aldara did not delay proper treatment; rather, it *was* a proper treatment. (Tr. at 142-147)

29. Dr. Little claimed that his October 9, 2003, progress note states, "No surgery and incision, nor cutting desired," which Dr. Little interpreted to mean that he had discussed treatment options with Patient 1 and that Patient 1 had been fully informed of his treatment options. (St. Ex. 1A at 9; Tr. at 149, 347-348)

#### Dr. Ridge

30. Dr. Ridge testified that Aldara could have been an appropriate treatment, depending upon the age and health condition of the patient, and whether other options were discussed with him. She disagreed with Dr. Willen that it had fallen below the standard of care to have prescribed Aldara as a topical treatment for skin cancer prior to its approval for such use by the FDA. She said that "it was greatly discussed in the medical literature well before it was FDA approved, as any new thing has to be. Somebody has to have a brainchild, and it has to be tried by many physicians before the FDA is going to approve it. I just see this as a trial." (Tr. at 536-537)

#### *Records of Subsequent Treating Physicians*

31. Subsequent treating records show that another physician treated Patient 1 for a recurrent basal cell carcinoma on his right upper lip via Mohs surgery in December 2004. (St. Ex. 1B at 9)

#### **Evidence Concerning Patient 2**

32. Patient 2 is a female born in 1943. Dr. Little testified that he had initially seen Patient 2 on August 15, 1996. She presented to him with senile sebaceous hyperplasia, a facial condition associated with extremely oily skin, resulting in plugged oil glands and papules on the face. He began treating Patient 2 with Accutane, which is a systemic retinoid prescribed for acne, among many other skin conditions. Dr. Little explained that Accutane has a drying effect, which would have had a beneficial effect on Patient 2's condition. (St. Ex. 2A at 25; Tr. at 150-152)

Dr. Little further testified that, after Patient 2 had completed a course of Accutane, he elected to add Differin Gel, a topical vitamin A. He advised that, in his experience, the topical vitamin A in addition to the Accutane “keep[s] the mechanism of action moving forward.” On May 29, 1997, he added Sulfoxyl, a “very drying” skin lotion, with benzoyl peroxide and a sulphur base. (St. Ex. 2A at 23; Tr. at 152)

33. Dr. Little stated that, on November 17, 1997, Patient 2 had presented to him with residual senile sebaceous hyperplasia, along with facial hirsutism (excessive hair growth). He prescribed Clindamycin Pledget, a topical Cleocin antibiotic in a 67% alcohol base, which has a drying and astringent base. He also prescribed Spironolactone, an anti-hypertensive agent that functions as an anti-androgen. He explained that Spironolactone is commonly used in adult women for acne, increased oil production, and hirsutism. (St. Ex. 2A at 17; Tr. at 152-153)

Dr. Little testified that his treatment had been successful in addressing the seborrhic component, but not the senile sebaceous hyperplasia. He suggested to Patient 2 that he buff the areas to flatten them, or cauterize or laser them to make them less obvious cosmetically. Patient 2 elected not to go forward with such treatment. (St. Ex. 2A; Tr. at 153-154)

34. In her report, Dr. Willen declared that the use of Accutane, topical clindamycin, Sulfoxyl, and Differin had been below the minimal standard of care for sebaceous hyperplasia. However, in her testimony, she changed her position, stating that she did not believe that Dr. Little’s treatment of Patient 2 had deviated from the standard of care. (St. Ex. 15; St. Ex. 19 at 34-35)
35. Dr. Ridge agreed with Dr. Willen’s testimony that the treatment of Patient 2 had complied with the minimal standard of care. (Tr. at 539)

### **Evidence Concerning Patient 3**

36. Patient 3, a male born in 1934, first saw Dr. Little on March 4, 2003. Dr. Little testified that he had first seen Patient 3 for spots on his right temple, right nose, and right jaw line at the neck. At the time, Patient 3 had Waldenström’s macroglobulinemia, non-Hodgkin’s lymphoma, and malignant tumors and a Cryptococcus lesion of the brain. He was also blind in his right eye due to an underlying tumor. Subsequent treating records show that Patient 3 had previously been treated with chemotherapy for his non-Hodgkin’s lymphoma, but Dr. Little testified that Patient 3 had not been receiving chemotherapy during the time period that Dr. Little had treated him. (St. Ex. 3A at 15; Tr. at 160-161, 355)

Dr. Little testified that, based upon his initial visual exam, he had tentatively diagnosed Patient 3 with superficial basal cell cancers. Because of Patient 3’s other medical issues, Dr. Little decided to review more of his medical records before performing a biopsy. He obtained and reviewed a CT scan from another of Patient 3’s physicians. Thereafter, he recommended to Patient 3 that the spots should be removed and biopsied. However,

Patient 3 decided to first address other medical problems before scheduling the biopsy.  
(Tr. at 160-162)

37. Approximately five months later, on August 11, 2003, Patient 3 returned to Dr. Little. At that time, Dr. Little performed a tangential excisional biopsy and ED&C on lesions located on Patient 3's right temple (2.6 cm), right nose (2.1 cm), and right jawline (1.1 cm). (St. Ex. 3A at 11-13) The slides were prepared by Dermatopathology Laboratory of Central States and were read by Dr. Little. On his Dermatohistopathology Report concerning the specimen from Patient 3's right temple, Dr. Little noted that the "representative skin specimen" was 15 x 15 x 1 mm. The area on the report entitled "Microscopic Description" included only a diagnosis of "[b]owenoid squamous cell carcinoma in situ." (St. Ex. 3A at 19)

Similarly, Dr. Little's Dermatohistopathology Report concerning the specimen from the right side of Patient 3's nose indicates that the representative skin specimen was 3 x 2 x 1 mm. The only information in the Microscopic Description was Dr. Little's diagnosis of "[b]owenoid squamous cell carcinoma." (St. Ex. 3A at 21) Moreover, Dr. Little's report concerning the specimen from Patient 3's right jawline indicates that the representative skin sample was 1 x 1 x 1 mm, and the Microscopic Description documented only Dr. Little's diagnosis, "[b]owenoid squamous cell carcinoma." (St. Ex. 3A at 23)

38. A progress note dated August 26, 2003, indicates that Patient 3 had been notified of the biopsy results and that no further surgery was needed. He was to return in 90 days. (St. Ex. 3A at 9-11)
39. Patient 3 next saw Dr. Little on November 13, 2003, for a re-check. Dr. Little noted in his progress note that Patient 3 had a lesion on his right temple. Dr. Little performed a tangential excisional biopsy and ED&C on that lesion, and the specimen measured 2.1 cm. Dr. Little also performed cryosurgery on 10 other lesions on Patient 3's temple, forehead, and ears. (St. Ex. 3A at 9)

As before, the slide preparation was performed by an outside laboratory and the slide was read by Dr. Little. In his Dermatohistopathology Report, Dr. Little noted that the representative skin specimen was 10 x 6 x 1 mm. His Microscopic Description included only his diagnosis, "Squamous cell carcinoma." (St. Ex. 3A at 17)

40. A progress note dated December 11, 2003, indicates that Patient 3 had been notified of the biopsy results and that no further surgery was needed. He was told to return in six months. (St. Ex. 3A at 7)

#### *Records of Subsequent Treating Physicians*

41. Medical records indicate that, following Dr. Little's treatment, Patient 3 had been treated by other physicians for recurrent lesions on his forehead, right nose, right temple, and a lesion on his right forearm. Mohs surgery was performed on the right temple, and the right

nose was treated with radiation. Patient 3 died on November 9, 2004.<sup>5</sup> (St. Ex. 3B at 13, 25; St. Ex. 3C at , 11, 15-19, 61)

*Dr. Willen*

42. With regard to Dr. Little's August 26, 2003, progress note, Dr. Willen wrote:

[Patient 3] is told that he had skin cancers and that no further treatment is needed and [to] return to the clinic as scheduled. Dr. Little reads his own biopsies which is somewhat controversial, there is no documentation that the margins are clear on the biopsy specimens. The fact that he informs the [patient] that no further treatment is needed is below the minimal standard of care. Patients with non-Hodgkins lymphoma are considered at higher risk for aggressive non melanoma skin cancers and should be treated with more definitive therapy than ED&C.

(St. Ex. 15 at 5) Dr. Willen stated that the correct approach would have been for Patient 3 to have had Mohs surgery performed initially. (St. Ex. 15 at 6; St. Ex. 19 at 38-41)

43. In her supplemental report, Dr. Willen wrote:

Dr. Little reads the initial biopsies of three lesions; right temple, right nose and right jawline as Bowenoid SCC in situ. The procedure done on 8/11/03 indicates saucerized excisions to the reticular dermis followed by [an] additional curettage 2-3mm of the peripheral margin. (He actually performs a shave biopsy with [an] additional ED&C). The path specimens are very small specimens compared to the sizes mentioned clinically and on the procedure notes. The depths reported are 1 mm. There is no microscopic description of the specimens except a final diagnosis. This does not meet the standards of a complete pathology report.

\* \* \*

\* \* \* Although in situ or Bowenoid SCC is a superficial type of SCC and of low risk for metastasis, the fact that the patient was immunocompromised by his underlying medical condition, complete removal of the lesion on the right temple should have been offered to the patient. If Mohs had not been offered to the patient and a more subjective treatment was given, then the patient should have been told of the risks and that closer follow up (usually every three months) was needed. The fact that the same treatment was offered after a recurrence was noted is below [the] standard of care.

(St. Ex. 16 at 1-2)

---

<sup>5</sup> The record does not identify the cause of Patient 3's death.

44. Furthermore, Dr. Willen questioned why Dr. Little had, after the second ED&C procedure for the right temple, advised Patient 3 that no further treatment had been necessary. She advised that there had been no indication from the biopsy that the tumor had been completely eliminated, and that, because ED&C is a blind procedure, close observation for persistence or recurrence of the tumor would have been prudent. (St. Ex. 19 at 38, 42)

When asked if Dr. Little's treatment of Patient 3 had deviated from the standard of care by treating Patient 3's skin cancer tumors with ED&C, Dr. Willen responded:

Well, it is not a deviation from the standard of care, and it is acceptable to treat primary lesions with ED&C. When lesions become recurrent or persistent, and in light of the fact that this patient was immunocompromised and at risk for advanced disease, a more definitive approach to removing the tumors should have been advised to the patient.

(St. Ex. 19 at 42)

*Dr. Little*

45. Dr. Little stated that Patient 3 had returned for treatment on August 11, 2003. Upon visual examination, Dr. Little began to think that the spot on the right temple might be bowenoid squamous cell cancer in situ, but still believed the other spots were basal cell carcinomas. Dr. Little removed the lesions via ED&C. (Tr. at 162-163)

Dr. Little testified that an analysis of the tissue removed from Patient 3 returned with a diagnosis that all three samples were bowenoid squamous cell carcinomas in situ. Dr. Little advised that a squamous cell carcinoma in situ is confined to the epidermis, which is about 50 microns thick; in other words, it is very superficial. (St. Ex. 3A at 19-23; Tr. at 162-164)

Dr. Little testified that the patient had returned in 90 days, per Dr. Little's advice, for a recheck. Dr. Little noted no changes to the right nose, but that there had been additional actinic keratosis of the temple, forehead, and ears. Because of the previous diagnosis of squamous cell cancers in situ, Dr. Little treated these precancerous areas with liquid nitrogen. The right temple still had a shiny area that did not appear completely healed, so Dr. Little used the ED&C technique again to remove the area. The tissue was sent to a lab, and was diagnosed as squamous cell carcinoma.<sup>6</sup> Dr. Little testified that no further treatment had been required at that time because the carcinoma had been removed, so he had instructed Patient 3 to return in six months for a recheck. Dr. Little testified that Patient 3 had not returned, but that he had been due for his next appointment in December 2003. Dr. Little's license suspension began in January 2004. (St. Ex. 3A at 17; Tr. at 164-165, 169-170, 357)

---

<sup>6</sup> Dr. Little's pathology report indicates that the specimen had been sent to a lab for slide preparation, but that Dr. Little had performed the pathology examination himself. (St. Ex. 3A at 17)

46. Dr. Little acknowledged that, following ED&C, there is no histological method to determine whether the margins are clear. He testified that “[y]ou feel the edges and make sure it feels firm and not soft. Make sure it feels like you're back into regular skin.” (Tr. at 382-383) Additionally, Dr. Little stated:

Although ED&C is a technique that does not provide margin control by its nature, but offers the advantage of a less invasive and time-intensive procedure. ED&C provides the ability to feel the margins of atypical cells adjacent to normal tissue. Therefore, there is no dishonesty in informing patients that no further treatment is necessary based on the clinical appearance of the initial lesion, histology, feel of tumor and the patient’s underlying medical status at the time of removal. \* \* \*

(Resp. Ex. A-C at 3)

*Dr. Ridge*

47. Dr. Ridge testified that she had seen other dermatologists treat squamous cell carcinomas with ED&C, and that she did not believe that Dr. Little’s treatment of recurrent facial squamous cell carcinomas with ED&C had been inappropriate. She advised that bowenoid squamous cell carcinomas in situ are confined to the top layer of skin, and that ED&C was a “perfectly fine option” for treatment. She further testified that the use of Mohs surgery for such a condition is in the physician’s clinical judgment. However, she also testified that, although Dr. Little’s treatment fell within the standard of care, she would have treated the recurrent carcinoma with Mohs surgery. (Resp. Ex. AA; Tr. at 540-542, 606-607)

**Evidence Concerning Patient 4**

48. Patient 4, a female born in 1963, first saw Dr. Little on December 13, 2001. She had been referred by her primary care physician concerning, among other things, a lesion on her left upper lip. The lesion had been biopsied by her primary care physician and found to be consistent with basal cell carcinoma. At Patient 4’s first visit, among other things, Dr. Little diagnosed a recurrent basal cell carcinoma on Patient 4’s left upper lip and scheduled her for Mohs surgery. Dr. Little performed that procedure on January 15, 2002. (St. Ex. 4A at 11-23; St. Ex. 15 at 6)

Patient 4 returned to Dr. Little’s office on January 21, 2002, for suture removal. (St. Ex. 15 at 7)

49. On July 30, 2002, Patient 4 again visited Dr. Little to re-check the Mohs site on her left upper lip, among other things. She complained that the Mohs site had become scaly. No biopsy was documented. Dr. Little diagnosed actinic keratosis, performed cryosurgery on her left upper lip and chest, and prescribed Carac for her to apply to her left upper lip once per day for 10 days, and to her chest once per day for 12 days. He also prescribed ampicillin 500 mg, and desonide cream. (St. Ex. 4A at 5)

50. Patient 4 saw Dr. Little again on September 23, 2003, but nothing concerning the Mohs site was documented. (St. Ex. 4A at 3)

*Records of Subsequent Treating Physicians*

51. Subsequent treating records from another physician show that, three years after the Mohs surgery performed by Dr. Little, Patient 4 was diagnosed with a “lesion at the inferior pole of the old surgery scar.” Mohs surgery was performed, and seven stages were required to clear the area. The surgical wound [defect] measured 2.5 x 2.4 centimeters, and a rotation flap was used to repair the defect. (St. Ex. 4B at 33)

*Dr. Willen*

52. Dr. Willen described the January 15, 2002, Mohs surgery:

The initial size was noted to be 1.2x0.8cm. One stage of Mohs micrographic surgery was done removing one section. Dr. Little describes that the tissue was examined in one section, hash marks and dye were used to orient the section. The tissue was submitted for frozen section and placed on OCT medium and cut into 4 micron sections. Then it was formalin fixed and stained with rapid hematoxylin and eosin. Three cuts showed no tumor. The use of formalin in frozen sectioning is not a process that is normally used in Mohs tissue processing. \* \* \*

(St. Ex. 15 at 6) Dr. Willen noted the final defect to be 1.4 x 1.0 cm. (St. Ex. 15 at 6)

53. In her written report, with regard to Patient 4’s subsequent visit on July 30, 2002, Dr. Willen first stated:

The patient returned to Dr. Little for a recheck of her Mohs site complaining of scaling of the lesion \* \* \*. Assessment was that the scaling was an actinic keratosis of the left lip and chest area and [Patient 4] was placed on ampicillin 500mg and Carac (5FU) to the lip x 10 days, chest x 12 days and desonide cream after the Carac was discontinued. Since this was a potentially recurrent BCC, re-biopsy was indicated to determine if further surgical removal was needed and the lack of re-biopsy is below the minimal standard of care. Use of topical 5FU is not appropriate management of recurrent BCC of the lip and to do so is below the minimal standard of care.

(St. Ex. 15 at 7) Dr. Willen further stated, in part:

\* \* \* This was a multiple recurrent BCC of the lip that was inadequately removed with Mohs by Dr. Little and the inadequate Mohs procedure is below the minimal standard of care. When it recurred again he failed to accurately diagnose it and used an inadequate treatment. This delay in diagnosis and treatment led to further Mohs surgery with a larger defect and repair. Dr. Little provided treatment below the minimal standard of care. \* \* \*

(St. Ex. 15 at 8)

54. Subsequently, in her deposition testimony, Dr. Willen seemed to modify her opinion. For example, Dr. Willen was asked if the Mohs surgery performed by Dr. Little had deviated from the standard of care. Dr. Willen replied:

The Mohs procedure does not appear to be a deviation from [the] standard of care because this was a recurrent basal cell carcinoma and Mohs micrographic surgery should have been performed. The fact that one tissue specimen was taken may have been too large of a specimen to adequately examine all margins, and the review of only 3 cuts may not have been adequate to determine that margins were clear.

(St. Ex. 19 at 47)

In addition, Dr. Willen was asked if Dr. Little's diagnosis of a recurrent basal cell carcinoma as actinic keratosis had deviated from the standard of care. Dr. Willen replied:

Actinic keratosis can occur in an area adjacent to a previous Mohs surgery, so whereas that diagnosis was not a deviation from the standard of care, the failure to monitor the lesion for resolution following the use of Carac for the treatment of actinic keratosis was [a] deviation from the standard of care. To put a patient on a medication and not determine that the lesion totally resolved either by clinical examination or repeat biopsy is a deviation of the standard of care.

(St. Ex. 19 at 48)

*Dr. Little*

55. Dr. Little testified that Patient 4 had initially presented to him on December 13, 2001, with a history of keloids (excess scar tissue), numerous superficial basal cell carcinomas of her trunk, and a recurrent basal cell carcinoma of her left upper lip. On January 15, 2002, he performed Mohs surgery on Patient 4's upper lip. (Tr. at 172-174)

Dr. Little testified that, following the Mohs surgery, Patient 4 had called on February 7, 2002, to ask if she should take an antibiotic for a "bubble" at the Mohs site. Patient 4 worked for a physician, who had advised Patient 4 that the "bubble" was a pimple and had prescribed the antibiotic. Dr. Little approved the treatment and recommended continuing observation of the area. Patient 4 returned for a recheck at about five months, which had been about three months past the recommended recheck date of two months after surgery. Dr. Little diagnosed her with actinic keratosis of the left upper lip and chest area. He froze those sites and prescribed Carac, a topical chemotherapy product used primarily for actinic keratoses. Patient 4 returned about two months later, and Dr. Little determined that she required no further treatment of her upper lip at that time. (Tr. at 175-177)

56. Dr. Little defended his Mohs surgery technique by advising that his slides would accommodate a 2.5 x 5 centimeter specimen, and that the specimen at issue had been only 1.2 x 0.8 centimeters. He further advised that often only one stage is required to clear a tumor. He testified that the scaly area on Patient 4's upper lip that had appeared after the first Mohs surgery had "definitely not" been a recurrence; Patient 4 had a history of numerous actinic keratoses and he "can readily discern an actinic keratosis from a basal cell cancer." (Tr. at 181-182; 363)

*Dr. Ridge*

57. Dr. Ridge testified that Dr. Little had appropriately performed Mohs surgery on Patient 4; that he had appropriately documented the surgery; and that he had indicated clear margins. She further testified that his treatment of the scaly area with Carac, per a diagnosis of actinic keratosis, had been within the minimal standard of care, as there had been no lesion or "something more palpable indicating a malignancy." (Tr. at 543-548)

**Evidence Concerning Patient 5**

*Visits in 2000*

58. Patient 5, a female born in 1946, first saw Dr. Little on April 13, 2000. In her written report, Dr. Willen noted that Patient 5 had been referred to Dr. Little concerning a lesion on the dorsum of her nose that had been there for three years, a lesion on her right eyebrow that Dr. Little noted was 8 mm, and a lesion on the right lateral nose that Dr. Little noted was 6 mm. Dr. Little performed a shave biopsy on each lesion, and the pathology reports, authored by another physician, indicated that each lesion was "basal cell carcinoma, nodular." (St. Ex. 5A at 49-51; St. Ex. 15 at 9)

Dr. Willen

Dr. Willen stated in her written report:

A letter dated 5/8/00 to [Patient 5's primary care physician] states that the 7mm basal cell carcinoma on the dorsum of the nose will need Mohs. The 8mm basal cell carcinoma of the right eyebrow will need Mohs and that the lesion on the right lateral nose was an inflamed nevus and there was no basal cell carcinoma on the path and no mention of need for further treatment.

(St. Ex. 15 at 9)

59. On May 4, 2000, Dr. Little performed Mohs surgery on the dorsum of Patient 5's nose. Dr. Willen wrote:

Pre-operative diagnosis is invasive basal cell carcinoma when actually the pathology notes this to be a nodular basal cell carcinoma. The initial size of the lesion is 7mm, but layer one goes 2.2x1.0cm. One section is taken and noted to

have a positive margin. Layer B is said to go to the perichondrial layer and there is no residual tumor. The end size is 2.4x1.6cm. This is repaired with a full thickness skin graft harvested from the right post auricular ear.

(St. Ex. 15 at 9)

60. Following rechecks in May and July 2000, Patient 5 returned to Dr. Little's office on October 9, 2000. Dr. Willen's report describes the October 9, 2000, appointment thusly: "Patient is reported to have good healing. There is questionable left lateral margin [of skin graft] 1.1cm noted. A biopsy is sent. Path shows positive basal cell carcinoma of the left lateral margin, fragment 5x4x1mm in size and there is a comment about a 15 minute appointment for abrasion of [her] nose." (St. Ex. 15 at 9-10)

Dr. Willen further wrote that, on October 17, 2000:

Patient is notified of the biopsy report of 10/9/00 which shows a basal cell carcinoma, but no further surgery is needed and she is to return in six months. This is a recurrent BCC after Mohs surgery by Dr. Little done 5 months earlier. The minimal standard of care would be to recommend Mohs surgery not dermabrasion or 6 month follow up. The fact that this lesion recurred 5 months later, indicates inadequate Mohs surgery in that the lesion was never completely removed. The care that was provided was below the minimal standard of care.

(St. Ex. 15 at 10; See also St. Ex. 5A at 23)

Dr. Little rechecked Patient 5's nose on November 27, 2000. Dr. Willen wrote: "Dr. Little said there was no evidence of the recurrence of the basal cell of the nose. There is something about a peripheral abrasion to the graft of 2.8x4.5cm." (St. Ex. 15 at 10; see also St. Ex. 5A at 21)

#### Dr. Little

61. Dr. Little testified that he had initially seen Patient 5 on April 13, 2000, when she had presented to him with a papule of the right lateral nose, along with a history of dramatic sun damage. She had scarring from previous surgical treatment of lesions on her nose and cheek areas, and marked solar elastosis of the face and neck. Dr. Little further testified that, at the initial visit, he had removed a lesion from Patient 5's right lateral nose "in a tangential excisional biopsy fashion" and a lesion from her right brow region with curettage. Both lesions were sent for histologic exams. Moreover, Dr. Little testified that he had biopsied a papule on the dorsal nose on that date, rather than simply removing it, because it appeared infiltrative. All three samples were determined to be "basal cell cancer nodular" by a dermatopathologist. (St. Ex. 5A; Tr. at 184-185)

Dr. Little stated that, per his advice given after reviewing the dermatopathologist's report, Patient 5 had returned to his office on May 4, 2000, for Mohs surgery to remove the lesion on the dorsal nose. Two stages were taken, and clear margins were shown. A full thickness graft

from behind Patient 5's right ear was used to cover the area of the nose that had been removed. Dr. Little also removed tissue from the right alar region on that date, which had appeared to be sebaceous hyperplasia, and which was eventually determined to be a trichoepithelioma, which is a benign tumor that can be a precursor to basal cell cancer. (Tr. 186-187)

#### *Visits in 2001*

62. One year later, on November 27, 2001, Patient 5 complained of a spot on her nose where the skin graft had been performed that itches and sometimes bleeds. Dr. Little performed ED&C on that area as well as on a spot on her right cheek. His preoperative diagnosis was "Squamous cell carcinoma of the left lateral nose and right superior cheek." The specimens were examined by a dermatopathologist. The pathology report concerning the tissue taken from the nose states: "Sections demonstrate fragments of sun-damaged skin containing an atypical basaloid proliferation showing peripheral palisading and focal attachment to the epidermis" and gives a diagnosis of "Fragments of basal cell carcinoma." The specimen from the cheek was also diagnosed as fragments of basal cell carcinoma. (St. Ex. 5A at 19, 39, 67)

A note dated December 10, 2001, states that Patient 5 was notified of the biopsy results and told to return in six months. (St. Ex. 5A at 17)

#### Dr. Willen

63. Dr. Willen wrote in her report that telling the patient to return in six months was inappropriate care. Dr. Willen stated, "[T]his is a twice recurrent BCC and needs aggressive surgical management." (St. Ex. 15 at 10)

#### *Visits in 2002 and 2003*

64. On June 13, 2002, Patient 5 returned for a scheduled recheck of the May 2000 Mohs surgery site. Dr. Little noted a "small shiny area @ (L) dorsal nose margin." Dr. Little documented that his assessment was a 1.8 cm "[r]ecurrent BCC of [left] dorsal nose." A spot on Patient 5's back at her left shoulder was also noted. Dr. Little performed ED&C on Patient 5's left dorsal nose, and took a biopsy specimen from her back. The pathology report, which was authored by another physician, indicates a diagnosis of basal cell carcinoma fragments with regard to the specimen from Patient 5's left dorsal nose. The spot on Patient 5's back was diagnosed as seborrheic keratosis. (St. Ex. 5A at 17, 37, 55; Tr. at 379)

A note dated July 2, 2002, states that Patient 5 had been notified of the biopsy results, advised that no further surgery was required, and told to return in six months.<sup>7</sup> (St. Ex. 5A at 15)

65. This same scenario was repeated when Patient 5 returned for a recheck on December 16, 2002. Dr. Little's preoperative diagnosis was "[b]asal cell carcinoma of the left dorsal

---

<sup>7</sup> Dr. Willen wrote in her report, "Recurrent BCC x3, Dr. Little is still not advising appropriate care to the patient." Moreover, "ED&C is not the standard of care for multiple recurrent BCC on the nose. This is below the minimal standard of care." (St. Ex. 15 at 10)

nose.” He performed ED&C on the site, and the dermatopathologist diagnosed fragments of basal cell carcinoma. A note dated December 20, 2002, states that the patient was notified of the biopsy results, advised that no further treatment was necessary, and told to return in six months. (St. Ex. 5A at 13, 15, 35, 53)

66. Patient 5 returned for her six month recheck of her nose on May 28, 2003. A 4 mm lesion was noted on her left dorsal nose and an 8 mm lesion was noted on her right temple. Although the medical records do not include an operative report for that date, Dr. Little’s progress notes indicate that he had performed ED&C on both sites. The dermatopathologist diagnosed basal cell carcinoma at both sites. A note dated June 9, 2003, states that Patient 5 had been notified of the biopsy results, advised that no further surgery was required, and told to return in six months. (St. Ex. 5A at 13, 33)
67. Patient 5 returned for her six-month recheck of the Mohs graft site on November 4, 2003. Dr. Little’s progress note indicates that Patient 5 had been concerned about a “bump” at the site. Dr. Little’s assessment was recurrent basal cell carcinoma. He prescribed Aldara cream and told Patient 5 to return in two months. (St. Ex. 5A at 11)

#### Dr. Willen

68. With regard to Patient 5’s November 4, 2003, visit, Dr. Willen wrote: “This is a recurrence x5 of the BCC on the dorsum of the nose, Aldara is an inappropriate therapy and is not approved for treatment of a multiple recurrent BCC. This should have been treated with Mohs therefore below the minimal standard of care.” (St. Ex. 15 at 11)
69. Patient 5 returned for a recheck on January 13, 2004. According to Dr. Willen’s written report, Dr. Little’s note states that no residual basal cell carcinoma remained and that Patient 5 should follow-up in six months. (St. Ex. 5A at 11; St. Ex. 15 at 11)

In her written report, Dr. Willen opined, “A rebiopsy should have been done to confirm clearance of the tumor with Aldara, this was below the minimal standard of care.” (St. Ex. 15 at 11)

#### *Records of Subsequent Treating Physicians*

70. On October 29, 2004, Patient 5 requested that her medical records be sent to another physician. (St. Ex. 5A at 7)
71. Subsequent treatment records from another physician show that, in December 2004, another physician performed Mohs surgery on Patient 5’s left dorsal nose to remove a basal cell carcinoma. (St. Ex. 5B at 55-72)

#### *Dr. Willen*

72. Dr. Willen testified that, based upon her review of Dr. Little’s records, it appeared that Patient 5 had had a basal cell carcinoma on the dorsum of her nose which was initially

treated by Dr. Little with Mohs surgery, but which had recurred six times while Patient 5 was under his care. She testified that Dr. Little had treated the recurrences with ED&C and with topical Aldara. (St. Ex. 19 at 49-53)

Dr. Willen further testified that scar tissue cannot be treated with ED&C multiple times because it cannot be adequately curetted, and to do so is below the minimal standard of care. Dr. Willen testified that the minimal standard of care required that the patient be offered additional Mohs surgery at the first recurrence. Moreover, Dr. Willen testified that “any other reasonable dermatologist \* \* \* would have not only biopsied the lesion and determined that there was residual disease, but then would have repeated Mohs surgery and not performed ED&C.” (St. Ex. 19 at 54, 56-57)

*Dr. Little*

Dr. Little’s Testimony Regarding “Field Effect”

73. Dr. Little defended himself at hearing by explaining that none of the basal cell carcinomas that he had treated after Patient 5’s May 4, 2000, Mohs surgery developed in the perimeter of the Mohs surgery; that is, they had not been recurrences, but rather new tumors appearing as a “field effect.” Dr. Little described a field effect as “multiples nodes, multiple foci of carcinoma that are developing independently in a given area.” (St. Ex. 5A at 11; Tr. at 197, 203-208)

Dr. Little testified that treating a field effect is difficult, because it is virtually impossible to get clear margins, as there is no clear starting and stopping point between one carcinoma and the next. He advised that, in such a circumstance, “you have the tendency to just keep right on going” and “[y]ou create a big defect.” Accordingly, he would not undertake Mohs surgery on a patient with a field effect unless the patient had dramatic aggressive demonstrable skin cancer that was an immediate threat. (Tr. at 201-202)

Specifically with regard to Patient 5, Dr. Little testified that ED&C had been appropriate to treat the tumors on the nose that had appeared after Mohs surgery because none of them developed within the previous graft site and thus, scar tissue was not a problem. (Tr. at 211) He explained why, in his clinical judgment, additional Mohs surgery was not appropriate for Patient 5:

This lady already demonstrated that she had had previous skin cancers of the nose \* \* \*. I thought she was definitely at risk to not get clear margins because where are the margins. There’s new areas developing all the time with her.

Secondarily, I think, in my hands, I think that her cosmetic result was not optimum, given what kind of tissue she had on the nose and given the repair required. In her case, all of the basal cell cancers that were checked histologically were nodular. They were soft. [They] were noninfiltrating. None were squamous cell cancers. None of this was life-threatening disease.

99 percent of people with basal cell cancers are alive at five years whether you treat them or not.

So she had a nonlife-threatening disease. I was not—I was hesitant to proceed with something that would be disfiguring or unduly aggressive without having the result that I would desire.

(Tr. at 205-206) Finally, Dr. Little used photographs to demonstrate the appearance of field effect on a patient. The photographs show a gentleman with numerous lesions on his face and scalp. On Respondent's Exhibit E-2, Dr. Little testified that he had circled areas that he had previously biopsied and found either squamous cell carcinoma or squamous cell carcinoma in situ. (Resp. Exs. E-1, E-2; Tr. at 196-200)

74. Despite the foregoing, Dr. Little's medical record for Patient 5 and his testimony upon cross-examination indicate that he had assessed Patient 5 to have a recurrent basal cell carcinoma of the left dorsal nose on at least two occasions: June 13, 2002, and November 4, 2003. (St. Ex. 5 at 11, 17; Tr. at 379, 382)

#### Dr. Little's Testimony Regarding the Aldara Prescription

75. Dr. Little defended his prescription of Aldara by testifying that it had improved Patient 5's overall condition, and that it had been well documented in the literature at that time that Aldara had been effective in certain people with basal cell cancers. Further, he had had rather extensive experience with it in his own practice. He defended his decision not to perform a biopsy after the first round of Aldara treatment because he had known that there had been residual cancer, and chosen to continue to treat it with Aldara. (Tr. at 208-210)

#### Dr. Little's Testimony Regarding Advising Patient 5 that No Further Treatment was Necessary

76. Lastly, Dr. Little defended himself against the Board's allegation that he had wrongfully informed Patient 5 that no further treatment had been necessary. Dr. Little explained that, each time he had advised no further treatment, the cancers for which she had been treated had already been removed, and not just biopsied. (Tr. at 210)

#### *Dr. Ridge*

77. In her report and at hearing, Dr. Ridge stated that Dr. Little's performance of Mohs surgery upon Patient 5 had been within the minimal standard of care. In her report, Dr. Ridge had agreed with the Board's allegations that Dr. Little had inappropriately treated recurrent basal cell carcinoma with ED&C and with Aldara. At hearing, however, she testified that she would find Dr. Little's use of ED&C and Aldara to be within the minimal standard of care if he had been treating field-effect superficial basal cell carcinomas, which had not been located within the Mohs surgery scar or within a few millimeters of the scar circle. (Resp. Ex. A-A; Tr. at 551-554, 557)

Dr. Ridge also disagreed with the allegation that Dr. Little had inappropriately failed to re-biopsy a potential recurrent basal cell carcinoma, because his records show that he had re-biopsied the area and treated it with ED&C. (Resp. Ex. A-A; Tr. at 554-555)

Dr. Ridge had stated in her report that Dr. Little had inappropriately informed Patient 5 that no further treatment had been necessary because “the previous biopsy was done with an ED&C so it was an incomplete specimen.” However, she changed her opinion at hearing. She advised that it had been within the minimal standard of care to advise Patient 5 that no further treatment had been needed after the June 9, 2003, visit because there had only been one recurrence at that point. (Resp. Ex. A-A; Tr. at 554-555, 616-617)

### Evidence Concerning Patient 6

78. Patient 6, a male born in 1937, first saw Dr. Little on December 14, 1999. He continued to see Dr. Little through approximately December 2003. (St. Ex. 6A at 7-33) Dr. Little performed the following procedures on Patient 6:

Date	Procedure	Site	Pathology	Pages <sup>8</sup>
12/14/99	ED&C	R superior helix L temple	BCC BCC	33, 51
3/1/00	ED&C	R scalp L ala	BCC Epidermal cyst	31, 49
9/17/01	ED&C  Cryosurgery	L medial shoulder L superior shoulder L inferior shoulder  2 lesions: R scalp, L sideburn	BCC superficial Fragments of BCC BCC superficial  N/A	29, 45-47
1/15/02	ED&C  Cryosurgery	L sideburn  2 lesions: R scalp, L forehead	BCC with nodular and infiltrative features N/A	25, 43
2/26/02	Mohs surgery scheduled, but ED&C documented	L sideburn <sup>9</sup>	N/A	23, 57
8/19/02	ED&C  Cryosurgery	R scalp <sup>10</sup>  1 lesion: R cheek	BCC with squamous metaplasia N/A	19, 41
1/13/03	ED&C	L temple <sup>11</sup> L lateral forehead	BCC	17, 39

<sup>8</sup> The referenced pages are from State’s Exhibit 6A.

<sup>9</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 59)

<sup>10</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 59)

Date	Procedure	Site	Pathology	Pages <sup>8</sup>
2/24/03	ED&C	L lateral cheek	Superficial BCC	13, 39
	Cryosurgery	1 lesion: R inferior helix	N/A	
12/1/03	ED&C	L lateral canthus	BCC	9, 35

79. Dr. Little prescribed or dispensed Aldara to Patient 6 on January 13, February 24, and December 9, 2003. (St. Ex. 6A at 7-17)

*Records of Subsequent Treating Physicians*

80. Records from a subsequent treating physician show that, on July 15, 2004, Patient 6 had undergone Mohs surgery to remove a recurrent infiltrative basal cell carcinoma from his left sideburn area. The pre-operative size of the carcinoma was 3.7 x 2.5 centimeters. Nine layers were removed to clear the lesion, and the post-operative defect was 7.1 x 6.5 centimeters. (St. Ex. 6C at 99-101)

*Dr. Willen*

81. Dr. Willen testified that Patient 6 had been treated by Dr. Little repeatedly with either cryosurgery or ED&C for numerous recurrent tumors on the left temple, left sideburn area, and cheek, and that the repeated use of ED&C was a deviation from the standard of care. She further testified that the use of topical Aldara to treat the recurrent disease was also a deviation from the standard of care, because Aldara could not have penetrated the scar tissue left from the previous ED&Cs. Lastly, she testified that Dr. Little's failure to treat the recurrent disease adequately had allowed the tumor to continue to grow unchecked, ultimately leading to a larger defect after removal by another physician, and a more complex repair. (St. Ex. 19 at 61-62)

*Dr. Little*

82. Dr. Little defended his treatment choices for Patient 6 by advising that Mohs surgery is not indicated for superficial basal cell cancers unless there is a contributing factor. He stated that Patient 6's cancers, with the exception of one on the left sideburn with infiltrative features, had been nodular or very soft. Dr. Little stated that he had planned to use Mohs surgery for the infiltrative tumor, but had later determined that enough of the tumor had already been removed during the biopsy so that Mohs surgery would not have been appropriate. (Tr. at 220-221)

Dr. Little further testified that Patient 6 had been reluctant to endure surgical removal of his tumors because he had had a bad experience with a previous surgery performed by another physician. On cross-examination, Dr. Little admitted that he had made no record of this.

---

<sup>11</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 59)

He also admitted that Mohs surgery had indeed been indicated for Patient 6 per the Guidelines of Care for Mohs Micrographic Surgery, and that his use of ED&C on Patient 6 deviated from Practice Guidelines of Oncology. (Tr. at 223; 384-385, 387)

83. Dr. Little testified that Patient 6 had had a good response to Aldara treatment, and he disagreed with Dr. Willen's testimony that Aldara has no effect on scar tissue. He said that he had personally seen excellent results with Aldara "in very tough areas where scar tissue is present." He also advised that there had been studies showing long-term cure rates from Aldara use for infiltrative basal cell cancers and scar tissue, and that Aldara is commonly used as an adjunctive treatment after Mohs surgery or ED&C. Dr. Little testified that he would have changed his treatment of Patient 6 if he had thought that the Aldara had not been effective. (Tr. at 222, 230-232)
84. Dr. Little admitted that some of the carcinomas he had treated may have been recurrent, but that "it would be more appropriate to say [Patient 6] was having relapses in the disease of extreme sun damage, or relapses of his field effect." He explained that he had not considered Mohs surgery for Patient 6 because there had been so much activity that "there would be no definitive stop point, and there would be some significant morbidity." He testified that, with ED&C, he could palpate the edge and "feel where [the cancer] stopped to a better degree." (Tr. at 223-225)
85. Dr. Little disagreed that his treatment of Patient 6 had ultimately led to a more difficult Mohs surgery by another physician, because Dr. Little had been treating Patient 6 in an appropriate manner, and Patient 6 had been responding well to Dr. Little's treatment. (Tr. at 228)

#### *Dr. Ridge*

86. In her report, Dr. Ridge agreed that Dr. Little had inappropriately treated Patient 6's recurrent basal cell carcinomas with ED&C, and that Dr. Little had inappropriately treated recurrent basal cell carcinomas with inadequate therapies leading to a large post-operative defect size of 7.1 centimeters by 6.5 centimeters and numerous stages of Mohs' surgery by a subsequent treating physician to obtain clear margins. (Resp. Ex. A-A)

Dr. Ridge testified at hearing that, if the Patient 6's carcinomas had not been recurrences, then ED&C would have been an appropriate treatment. Dr. Ridge further testified that she would consider a recurrence to be a tumor appearing within the surgical scar of a previous excision, or within 2 to 3 mm of the periphery of the surgical scar. (Tr. at 578-579)

#### **Evidence Concerning Patient 7**

87. Patient 7, a male born in 1927, was treated by Dr. Little from December 1990 through December 2003. (St. Ex. 7A)

88. Dr. Little's treatment of Patient 7 included the following procedures:

Date	Procedure	Site	Pathology per Dr. Little	Pages <sup>12</sup>
6/1/93	ED&C	R inferior cheek	SCC	73, 117, 151
	Cryosurgery	12 lesions: face, ears	N/A	
7/20/93	Excision & repair	L lateral cheek	BCC	69, 115, 149
	Cryosurgery	4 lesions: R cheek and L preauricular area	N/A	
2/10/94	ED&C	R inferior cheek R distal nose R neck	SCC SCC in situ SCC	67, 113, 145
5/16/95	ED&C	L temple R inferior cheek <sup>13</sup>	BCC SCC in situ	57, 109, 143
	Cryosurgery	8 lesions: R temple, R ear, R chin	N/A	
7/9/96	ED&C	Dorsal nose <sup>14</sup> R inferior jawline <sup>15</sup> R posterior neck	SCC in situ SCC in situ Microinvasive SCC <sup>16</sup>	49, 103, 141
12/15/97	ED&C	L upper lip R jawline <sup>17</sup>	Microinvasive SCC Bowenoid SCC in situ	43, 99, 139
	Cryosurgery	6 lesions: L lateral cheek, R cheek, R temple	N/A	
3/12/98	Excision & repair	R jawline <sup>18</sup>	Bowenoid SCC "(Lateral and deep margins clear)"	41, 95, 137
	Cryosurgery	6 lesions: Forearms, R jawline, ears, brow	N/A	

<sup>12</sup> The referenced pages are from State's Exhibit 7A.

<sup>13</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 63)

<sup>14</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 64)

<sup>15</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 64)

<sup>16</sup> Dr. Willen defined microinvasive squamous cell carcinoma as a squamous cell carcinoma "that invades just beyond the dermo/epidermal junction which means its [the] full thickness of the epidermis and is going into the superficial aspect of the dermis." (St. Ex. 19 at 93, Errata at 4)

<sup>17</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 64)

<sup>18</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 64)

Date	Procedure	Site	Pathology per Dr. Little	Pages <sup>12</sup>
7/14/98	ED&C  Cryosurgery	R lateral cheek L lateral cheek  30 lesions: Neck, ears, temples, cheeks, L forearm	SCC SCC  N/A	37, 93, 135
11/16/98	ED&C  Cryosurgery	R inferior eyelid Proximal nose  28 lesions: neck, face, ears	SCC SCC  N/A	33, 91, 133
10/13/99	ED&C  Cryosurgery	R temple  9 lesions: R cheek, R neck, R lateral cheek	BCC  N/A	27, 87, 131
10/30/00	ED&C  Cryosurgery	R temple at sideburn L preauricular  10 lesions: vertex, cheeks	SCC SCC  N/A	17, 81, 129
9/17/01	ED&C  Cryosurgery	R inferior cheek L inferior cheek  18 lesions: temples, cheeks, scalp	Inflamed seb. keratosis SCC  N/A	19, 83, 127
3/19/02	ED&C  Cryosurgery	R temple <sup>19</sup> L wrist L malar L mid cheek  6 lesions: neck, forehead, cheeks, forearms	BCC Solid BCC Inflamed seb. keratosis Inflamed seb. keratosis  N/A	11, 15, 79, 125
4/23/02	Excision & repair  Cryosurgery	R temple <sup>20</sup>  2 lesions: R neck	BCC, margins clear  N/A	9, 77, 123
3/18/03	ED&C	R ear L volar L dorsal forearm L inferior neck	SCC SCC Actinic keratosis Stratum corneum orthokeratotic	169, 183-189

<sup>19</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 65)

<sup>20</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 65)

Date	Procedure	Site	Pathology per Dr. Little	Pages <sup>12</sup>
10/22/03	ED&C	R lateral cheek R lateral knee  L lateral cheek  R neck	SCC in situ Inflamed, necrotic serum crust with epidermal fragment Hypertrophic actinic keratosis and acanthotic SCC Nevus senilis with senile sebaceous hyperplasia	167, 175-181

89. Following each procedure and biopsy noted above, Patient 7 was notified of the results of the biopsy and advised that no further surgical treatment was necessary. (St. Ex. 7A at 5-69) However, the Hearing Examiner could find no documentation that Dr. Little had at any time informed Patient 7 “that the margins are clear.”

*Records of Subsequent Treating Physicians*

90. On June 15, 2004, another dermatologist excised a squamous cell carcinoma on Patient 7’s right sideburn area. The dermatopathologist identified the specimen as follows: “Ulcerated well differentiated invasive squamous cell carcinoma with perineural tracking and focal subcutaneous extension \* \* \*.” On June 29, 2004, Patient 7 was referred to another physician for Mohs surgery. (St. Ex. 7B at 33, 37, 43)

Records of another subsequent treating physician demonstrate that Patient 7 underwent Mohs surgery for an invasive squamous cell carcinoma to his right sideburn on July 21, 2004. The surgery ended after the fourth stage and the residual tumor was “identified in the deep/lateral as noted on the Mohs Map.” (St. Ex. 7C at 79, 93-94) Patient 7 returned to the surgeon’s office the following day and was scheduled for further Mohs surgery the following week. Patient 7 reported that he had been unable to lift his eyebrow since the surgery. (St. Ex. 7C at 91-92)

Patient 7 had further Mohs surgery on July 29, 2004. The Mohs surgeon noted in her operative report that the specimen taken at the seventh stage was clear of tumor. The surgeon also noted that the squamous cell carcinoma had extended into the parotid gland. In addition, she noted that Patient 7 had been temporarily unable to shut his right eye following the second Mohs procedure. (St. Ex. 7C at 77, 85-87)

91. A note in Dr. Little’s medical records dated December 8, 2004, states that Patient 7 is deceased. (St. Ex. 7A at 163) The Hearing Examiner was unable to find a certificate of death or other information regarding the cause of Patient 7’s death. (St. Exs. 7A – 7C)

*Dr. Willen*

92. Dr. Willen testified that Dr. Little had repeatedly used cryosurgery and ED&C to treat recurrent squamous cell carcinomas on Patient 7's face, and that such treatment fell below the minimal standard of care. She further testified that, because squamous cell carcinomas had recurred on multiple occasions over multiple years, Dr. Little should have determined whether the cancer had been spreading or metastasizing. She advised that a recurrence in a scar increases the risk of metastatic disease by 30 to 35 percent. Accordingly, Dr. Little's failure to examine the patient for evidence of spreading or progression had been a deviation from the minimal standard of care. Dr. Willen also remarked that Dr. Little had failed to document that there had been a deeply invasive tumor; he had only documented that it had occurred multiple times. (St. Ex. 19 at 66-71)

Dr. Willen also criticized Dr. Little's advice to Patient 7 and his wife that no further surgery had been necessary after ED&C on a recurrent lesion with scar tissue. She said that such advice would only be appropriate with close monitoring of a primary superficial lesion. It is not appropriate if a lesion had been recurrent, had been blindly treated, and there had been no confirmation that the lesion had been removed. (St. Ex. 19 at 67-68)

93. Furthermore, Dr. Willen stated in her summary of Patient 7's treatment that:

The pathology submitted is read by Dr. Little and he informs the patient that the margins are clear when only fragments of tissue are submitted and also tells the pt and his wife that no further surgery is needed when there is no confirmation of clear margins. It is below the standard of care to inform the patient that no further surgery was needed. Dr. Little took an inadequate sample to make a diagnosis. This should have been re biopsied. Therefore, this treatment was below the minimal standard of care.

(St. Ex. 15) (It is unclear to which particular incidents Dr. Willen is referring in these statements.)

94. With respect to the pathology reports, Dr. Willen stated:

Dr. Little biopsies several skin lesions and reads the path himself and again gives no microscopic description, only a diagnosis of SCC. The path report gives no tissue sizes, no gross or microscopic description of cellular detail or presence of previous scar etc. No subtype or grade of SCC (well differentiation vs poorly differentiated) is mentioned to indicate the need for more definitive treatment [than] ED&C. This is below the minimal standard of pathology reporting.

(St. Ex. 16 at 3)

95. When asked whether Dr. Little's treatment of Patient 7 had contributed to the patient's death, Dr. Willen testified that she did not know the cause of Patient 7's death. Pressed further on that issue, Dr. Willen testified: "All I can tell you is that the fact that this tumor recurred on multiple occasions, was then found to have perineural invasion, invaded the parotid gland and was aggressive and deeply invasive, that the likelihood that this lesion metastasized leading to a co-morbidity of the patient was high." (St. Ex. 19 at 69-70)

*Dr. Little*

96. Dr. Little testified that he had no reason to suspect that his care had anything to do with Patient 7's death; Patient 7 had not had any cancers which would cause a major health risk, or any lesions that Dr. Little had suspected to have metastatic potential. He also testified that the basis of Dr. Willen's opinion seemed to have been the carcinoma on Patient 7's right sideburn area that was subsequently treated with Mohs surgery. However, Dr. Little testified that he had appropriately treated a lesion in that area with ED&C which never reappeared during the three subsequent years that Patient 7 had been treated by Dr. Little. Dr. Little also denied treating any of Patient 7's squamous cell carcinomas with cryosurgery. (Tr. at 248-250, 412)

Dr. Little admitted on cross-examination that Patient 7 had had a high-risk basal cell carcinoma under the Practice Guidelines of Oncology, and that the Guidelines of Care for Mohs Micrographic Surgery state that Mohs is the appropriate therapy for basal cell carcinoma in the central third of the face. (Resp. Exs. B-10, B-19; Tr. at 408-410)

97. Dr. Little testified that he would tell a patient that margins "feel good" after ED&C, but he would never tell a patient that the margins were "clear histologically." He further stated that he would never tell a patient like Patient 7 that no further surgery is necessary without qualifications. He advised that, when he tells a patient no further surgery is necessary, he says that no further surgery is necessary at the time, but follow-up is needed. Accordingly, he denied telling Patient 7 that his margins were clear or that no further surgery would ever be needed. (Tr. at 244-246)

Dr. Little also denied failing to re-biopsy a potentially recurrent squamous cell cancer. He stated, "I don't see where this patient had a recurrent squamous cell carcinoma that was not addressed." (Resp. Ex. A-A; Tr. at 247)

*Dr. Ridge*

98. In her written report, Dr. Ridge agreed with Dr. Willen that Dr. Little had inappropriately treated Patient 7's recurrent squamous cell carcinoma with cryosurgery and ED&C, and that he had provided inadequate treatment of Patient 7's squamous cell carcinoma, leading to his comorbidity: "after so many times of treating the same tumor, Mohs' would have been appropriate." At hearing, she testified that her opinion would change if the tumors had not been recurrences, but that she would find it hard to believe that Patient 7 had not had recurrences, because of the excessive number of malignancies in the same general area. She otherwise affirmed the opinions in her report. (Resp. Ex. A-A; Tr. at 582-583, 625-627)

99. Dr. Ridge testified that she could not find anything in the medical records showing that Dr. Little had advised Patient 7 that he had had clear margins. Moreover, she he did not find fault with Dr. Little's practice of advising patients that "no further treatment or no further surgery is necessary." (Resp. Ex. A-A; Tr. at 579-580, 622)
100. Dr. Ridge testified that she had been unable to assess the Board's allegation that Dr. Little had failed to re-biopsy recurrent squamous cell carcinoma because she had not had a complete set of Dr. Little's records for this patient. (Resp. Ex. A-A; Tr. at 623-625)

### Evidence Concerning Patient 8

101. Patient 8, a male born in 1922, first saw Dr. Little on November 17, 1995, and continued to see him on a regular basis through October 2003. (St. Ex. 8A at 7, 13-39) During this period, Dr. Little performed the following procedures on Patient 8:

Date	Procedure	Site	Pathology per Dr. Little	Pages <sup>21</sup>
11/17/95	ED&C	L helix	SCC	39, 49, 61
	Cryosurgery	4 lesions: cheeks	N/A	
2/9/96	Cryosurgery	2 lesions: L ear, R ear	N/A	37
5/6/96	Cryosurgery	4 lesions: L lateral cheek, ears	N/A	35
7/16/96	Cryosurgery	8 lesions: R helix, L temple, cheeks	N/A	35
4/7/97	Cryosurgery	8 lesions: lateral cheeks, ears, temples	N/A	33
7/14/97	Cryosurgery	10 lesions: temples, cheeks	N/A	33
12/18/97	ED&C	L lateral cheek	BCC	31, 47
	Cryosurgery	Number of lesions not documented: temple, cheeks, L helix	N/A	
8/25/98	Cryosurgery	12 lesions: face, R ear, forehead	N/A	29
2/14/99 <sup>22</sup>	Cryosurgery	20 lesions: temples, ears, cheeks	N/A	27

<sup>21</sup> The referenced pages are from State's Exhibit 8A.

<sup>22</sup> The date is difficult to read and might be "7/14/99." (St. Ex. 27)

Date	Procedure	Site	Pathology per Dr. Little	Pages <sup>21</sup>
1/30/01	ED&C Cryosurgery	L preauricular 3 lesions: L temple	BCC N/A	23, 45
9/26/01	ED&C Cryosurgery	L helix and inferior sulcus <sup>23</sup> 10 lesions: ears, cheeks, temples, vertex	Sclerosing BCC N/A	21, 43
10/25/01	Mohs surgery: three stages	L anterior helix	Infiltrative BCC	19, 41, 51, 65

102. Patient 3 subsequently saw Dr. Little October 2002 and August 2003. No procedures were performed and/or documented for those visits. (St. Ex. 8A at 13-15)

103. With regard to the October 5, 2001, Mohs surgery performed by Dr. Little on Patient 8’s left anterior helix, Dr. Little noted in his operative report that, after residual tumor was found in the first stage specimen, the second stage “carried the extent of the excision down to the perichondrial layer.”<sup>24</sup> Tumor was found in the second stage specimen. Dr. Little noted that he then proceeded with a third stage that also “carried the extent of the excision to the perichondrial layer.” (St. Ex. 8A at 51)

*Records of Subsequent Treating Physicians*

104. Records from a subsequent treating dermatologist show that Patient 8 was diagnosed with recurrent infiltrative basal cell carcinoma on his left preauricular cheek. Patient 8 was scheduled for Mohs surgery to be performed by another physician. (St. Ex. 8C at 21)

105. The Mohs surgeon’s note dated November 2, 2004, states, in part, that Patient 8:

has been a patient of Dr. Little for years removing his sun related growths etc. [T]here is an area in front of his L ear that [Patient 8] reports has been frozen perhaps two times per year for six or so years but continues to recur. [A subsequent treating dermatologist] saw this recently and identified clinically what was consistent with a large skin cancer and has sent him here for further evaluation.

\* \* \*

\* \* \* We explained that in situations like this we may find only superficial cancer or at times we will find significant deeper roots. \* \* \*

<sup>23</sup> Dr. Willen testified that this was a recurrent lesion. (St. Ex. 19 at 72)

<sup>24</sup> Dorland’s Illustrated Medical Dictionary, 27th Ed. (W.B. Saunders 1988) defines “perichondrium” as “the layer of dense fibrous connective tissue which invests all cartilage except the articular cartilage of synovial joints.”

(St. Ex. 8B at 31) A shave biopsy was performed that revealed basal cell carcinoma. Mohs surgery was performed and the basal cell carcinoma was cleared after two stages. The final defect size was 2.1 x 1.3 x 0.4 cm. (St. Ex. 8B at 13, 15, 19, 31)

*Dr. Willen*

106. Dr. Willen testified that Dr. Little had inadequately treated Patient 8 for multiple recurrent basal cell carcinomas with cryosurgery and ED&C. Patient 8 further underwent Mohs surgery performed by Dr. Little to treat an infiltrative basal cell carcinoma on Patient 8's left helix. The carcinoma recurred, and was treated again by Dr. Little with cryosurgery. She further testified that Dr. Little's treatment of recurrent basal cell carcinomas with cryosurgery was a deviation from the minimal standard of care. She explained that it would not be below the standard of care to treat a recurrence once with ED&C or cryosurgery, but to do it on multiple occasions, as Dr. Little had, is below the standard of care. She further advised that, if other treatment options had been refused by Patient 8, then Dr. Little's treatment would not have deviated from the standard of care; however, there is no documentation in Dr. Little's records that Patient 8 was informed of alternative treatment. Finally, Dr. Willen testified that Dr. Little treated a basal cell carcinoma with Aldara, and that the basal cell carcinoma was noted to be recurrent. (St. Ex. 8A at 13; St. Ex. 19 at 73-77; see also St. Ex. 16 at 3-4)
107. Dr. Willen also testified that Dr. Little's performance of Mohs surgery on Patient 8 had deviated from the standard of care because he had evaluated the specimen in only one section. Dr. Willen advised that one section is too large to adequately evaluate the entire margin. She also advised that the operative report fails to mention nicking the section to flatten it, and fails to indicate how many sections at each layer had been examined. Moreover, Dr. Willen testified with regard to the Dr. Little's documentation of the second and third stages:

[Dr. Little] mentions one section at each layer and both layers, two and three, went to the perichondrium. If the perichondrium was positive, which he indicates in [stage] two, then the next layer that would be removed would be the chondrium, which is the cartilage.

(Tr. at 74-75)

*Dr. Little*

108. Dr. Little disputed Dr. Willen's contention that he had treated Patient 8 for any recurrent basal cell cancers. He testified that every cancer that he had treated was primary. Dr. Little also testified that cryosurgery had been a "well accepted and very appropriate way to treat superficial basal cell cancers in this patient," and that cryosurgery is a commonly used alternative in treating basal cell cancers. (Tr. at 256-258)

Dr. Little further disputed that he had inadequately performed Mohs surgery on Patient 8. He maintained that his procedure in this case was no different than his usual manner of performing Mohs surgery, and that he had had no difficulties in discerning whether or not he had clean margins, or in interpreting any of the tissue. He said that his tissue specimens easily fit on a conventional slide, and if they had not, he would have taken appropriate measures to address the problem. (Tr. at 258-261)

*Dr. Ridge*

109. Dr. Ridge agreed with Dr. Little that his Mohs' procedure was appropriate and adequate, but she also agreed with Dr. Willen that Dr. Little had inappropriately treated Patient 8's recurrent facial basal cell carcinoma with ED&C and cryosurgery. However, she advised that such treatment would have been appropriate if each of the cancers treated with ED&C and cryosurgery had been primary, rather than recurrent. (Resp. Ex. A; Tr. at 583-584, 627-628)

**Evidence Concerning Patient 9**

110. Dr. Little testified that he had first seen Patient 9 on December 27, 1999. Patient 9 was an avid golfer who had spent much time in the sun, and had had several previous basal cell carcinomas. He was referred to Dr. Little by his family physician concerning a lesion on his right earlobe. (Tr. at 261)

111. Dr. Little's medical records for Patient 9 document the following:

- a. At his initial visit, Patient 9 advised Dr. Little that a lesion on his right earlobe had been there for about one year, was growing, and bled occasionally. Dr. Little performed ED&C on Patient 9's suspected basal cell carcinoma on his right superior helix and on a lesion on his left lateral brow. He also performed an excision and repair of a suspected basal cell carcinoma on Patient 9's left lateral neck. In addition, he treated three lesions on Patient 9's left neck and forearm with cryosurgery. (St. Ex. 9A at 19, 37)

A dermatopathology report authored by another physician found the specimen from Patient 9's left lateral neck to be "basal cell carcinoma, nodular"; and the specimens from Patient 9's left lateral brow and right superior helix to be "basal cell carcinoma, fragments." (St. Ex. 9A at 27-29)

- b. Patient 9 returned to Dr. Little's office on January 3, 2000, for suture removal at the left lateral neck site. (St. Ex. 9A at 17)
- c. On January 6, 2000, Dr. Little's office notified Patient 9 of the biopsy results and advised that no further surgery would be required. He was instructed to return in one year. (St. Ex. 9A at 15)
- d. Patient 9 returned to Dr. Little's office for check-ups on February 27, 2001, and May 13, 2002. No events relevant to this matter occurred. (St. Ex. 9A at 13-15)

- e. Dr. Little next saw Patient 9 on February 25, 2003, and complained of a lesion on his left cheek. Dr. Little's progress note indicates that he had performed an ED&C that day. A Dermatohistopathology Frozen Section Report authored by Dr. Little states that the clinical data evidences an "[e]rosive nodule" on Patient 9's left cheek. Dr. Little's microscopic description stated, "Irregular islands of keratinocytes extend from the epidermis into the dermis. There are intercellular bridges. Cytologic atypia is present with scattered mitotic figures. A lymphohistiocytic dermal inflammatory reaction is present." Dr. Little diagnosed squamous cell carcinoma. (St. Ex. 9A at 11, 23)

A note dated February 26, 2003, indicates that Patient 9 was notified of the biopsy results and that Mohs surgery was recommended and scheduled. (St. Ex. 9A at 11)

- f. On March 10, 2003, Patient 9 underwent Mohs surgery on his left cheek performed by Dr. Little. Dr. Little removed two specimens in two stages and, according to his Mohs operative report, did not divide the specimens for microscopic examination, although the report states that the stage one specimen was "divided into 1 section." His report indicates that the second stage was excised to the fascial layer, and that "[m]icroscopic tumor was not found in any of the sections."<sup>25</sup> The final defect size was 2.6 x 2.4 cm. (St. Ex. 9A at 9, 31, 35, 45)
- g. Patient 9 returned to Dr. Little's office on March 26, 2003, at which time Dr. Little prescribed or dispensed Eucerin for Patient 9 to apply to "scar(s)." (St. Ex. 9A at 7)
- h. Dr. Little next saw Patient 9 on September 10, 2003, to recheck Patient 9's Mohs site. Patient 9 reported that he felt that the lesion on his left cheek was reappearing. Dr. Little performed a "[t]angential excisional biopsy & ED&C." The September 16, 2003, pathology report, which was authored by LabCorp, indicated a diagnosis of "squamous cell carcinoma, clinically recurrent." The specimen was noted to be "<0.1 cm in overall dimensions \* \* \*." (St. Ex. 9A at 7, 21)
- i. Dr. Little's medical records indicate that, based upon the results of the biopsy, he referred Patient 9 to a radiation oncologist for further treatment. Patient 9 was examined by a radiation oncologist on September 20, 2003, who reported to Dr. Little her recommendation that Patient 9 receive radiation therapy. She later reported by letter dated November 7, 2003, that Patient 9 had completed his course of radiation therapy and would be seen again for follow-up "in one month or sooner as needed." (St. Ex. 9A at 5, 47, 49, 55)

---

<sup>25</sup> The Hearing Examiner interprets Dr. Little's use of the word "sections" in this instance to refer to the thin, frozen pieces of tissue that are mounted on slides for microscopic examination during Mohs surgery. There is nothing in the operative report that documents division of the stage two specimen into smaller specimens. (St. Ex. 9A at 31)

- j. By letter dated December 2, 2003, a second radiation oncologist (a member of the same group as the first) reported to Dr. Little concerning Patient 9's one month follow-up. He reported, in part:

[Patient 9] has recovered well. He has a little numbness below the lesion. He has no problems with excessive tearing from the eye. He has noticed that he has white nodules in the treatment bed.

On examination, the skin has recovered well. He does have four, 3mm white nodules surrounding the periphery of the slight indentation of the squamous cell carcinoma. \* \* \*

I believe these changes are part of the healing process. However, I have asked to see him again in one month to monitor for any changes.

(St. Ex. 9A at 43)

Approximately one month later, in a letter dated January 6, 2004, the second radiation oncologist reported, in part:

[Patient 9] is doing well. He still has numbness in the treatment area. He has no problem with his eyes such as tearing or dryness.

On examination he has mild erythema within the treatment area. There is a central recurrent scar. There is no evidence of re-growth. He has no preauricular or cervical adenopathy.

[Patient 9] is doing well. I have asked to see him again in 6 months.

(St. Ex. 9A at 41)

- k. Dr. Little's medical record for Patient 9 does not document any further communication to Dr. Little from subsequent treating physicians following the radiation oncologist's January 6, 2004, letter. Further, Dr. Little saw Patient 9 on only one other occasion, on February 17, 2005. Patient 9 was seen at that time for a checkup, and reported no illness or surgery during the past year and that he had no concerns. Dr. Little prescribed or dispensed Carmol HC lotion for Patient 9 to use for dryness on his cheeks, and performed cryosurgery on six lesions on Patient 9's hands and forearms. (St. Ex. 9A at 3)

*Records from Subsequent Treating Physicians*

112. Progress notes from Patient 9's ophthalmologist state that on May 23, 2005, Patient 9 complained of "numbness on left side of face and 'an itch' that he can't seem to stop. [Patient 9] states tissues around eye are tender to touch." An MRI was scheduled for Patient 9. (St. Ex. 9C at 6)

Patient 9 underwent an MRI of the brain with contrast. The radiologist stated his impression:

Findings compatible with an aggressive tumor arising from the left maxillary sinus extending to the left orbit, pterygopalatine fossa, cavernous sinus, the foramina rotundum and ovale, the left malar subcutaneous soft tissues and the medial inferior aspect of the left middle cranial fossa. There appears to be either a cystic or necrotic component to the tumor in the sinus. It most likely corresponds to squamous cell carcinoma.

(St. Ex. 9C at 33)

Patient 9 saw his ophthalmologist again on June 1, 2005, to discuss the MRI results. The progress note indicates among other things that Patient 9 was scheduled to be seen at the Arthur G. James Cancer Hospital in Columbus, Ohio. (St. Ex. 9C at 7)

113. Patient 9 died on October 29, 2005, of a “[h]emorrhage [secondary] to brain and lung squamous cell [cancer].” The death certificate lists three conditions leading to the cause of death: “squamous cell cancer” (approximate onset 10/03); “lung face and brain” (approximate onset 5/05); and “smoker” (no date of onset). “Basal cell cancer of skin” is listed as another significant condition contributing to the death but not resulting in the underlying cause of death. (St. Ex. 18)

*Testimony Concerning Mohs Surgery Performed by Dr. Little on Patient 9*

114. Dr. Willen testified that Dr. Little had failed to perform an adequate Mohs procedure in removing the cancer from Patient 9. She explained that the tissue specimen removed by Dr. Little had been too large to adequately evaluate the margins in one section, and that Dr. Little should have divided the specimen for a more complete examination of the margins. (St. Ex. 19 at 87-88)

In addition, Dr. Willen testified that, because the lesion had extended to the fascia, he should have performed a work-up to ensure that the carcinoma had not progressed beyond the local area. (St. Ex. 19 at 139) Similarly, Dr. Willen stated:

Since the Mohs procedure indicates that the tumor went to the fascia, it infers that the SCC was very deep and the patient should have undergone a work up for metastatic disease. An MRI or CT of the head and neck were indicated as well as a baseline [chest x-ray] and labs. The lack of investigation was below the minimal standard of care.

(St. Ex. 15 at 27)

115. Dr. Little denied that his Mohs procedure was inadequate. He testified that he had used a standard procedure, that he had felt that the margins were clear, and that there had been no difficulty. (Tr. at 270)

116. Dr. Ridge testified that the Mohs procedure had been adequately performed and documented. (Tr. at 585, 589)

*Testimony Concerning Dr. Little's Alleged Failure to Identify the Subtype of SCC or to Identify or Document the Depth of Invasion*

Dr. Willen

117. In her supplemental report, Dr. Willen stated:

When the patient returns on 9/10/03 a clinical recurrent lesion is noted and a minute fragment of tissue is sent for path[ology] which is diagnosed as SCC recurrent\* \* \*. The amount of tissue sent for path was inadequate to determine the histological grade of the SCC (well differentiated vs poorly differentiated) nor could the depth of invasion be determined based on the small amount of tissue submitted to the pathologist. Had an adequate amount of tissue been sent the depth of invasion may have been noted. When an invasive SCC recurs, the metastatic potential increases. Further work up including evaluation of regional lymph nodes clinically and imaging studies were indicated. The patient was a heavy smoker and a baseline [chest x-ray] should have been obtained. Since the original tumor depth went to the fascia the need for imaging was apparent and a baseline [chest x-ray], CT of head and neck, and close clinical monitoring was indicated. Tumors greater than 6mm of depth have an increased metastatic potential.

(St. Ex. 16 at 4)

118. Dr. Willen testified that Dr. Little had failed to document the histological subtype of the squamous cell carcinoma and the depth of invasion of the tumor. (St. Ex. 19 at 88) When asked if this was a deviation from the minimal standard of care, she responded:

If the sample of tissue was inadequate to give that information, then noting the histological subtype would have been difficult. It would be within the standard of care for a [dermatopathologist] to subtype a squamous cell carcinoma and if given enough tissue to determine the depth of invasion of that tumor.

(St. Ex. 19 at 88-89)

Dr. Little

119. Dr. Little testified that, generally, he does not make a note of the subtype of a squamous cell carcinoma unless it is a special subtype for which the therapy options differed from the usual course of action. He further testified that he does not generally document the depth of invasion for squamous and basal cell carcinomas and that doing so was not standard

practice among the dermatopathology groups and practitioners that he coordinates with.  
(Tr. at 267-269)

Dr. Ridge

120. Dr. Ridge testified that she did not understand the significance of this particular allegation, and that a biopsy is not sufficient to ascertain the depth of a carcinoma. (Tr. at 585-586)

*Dr. Little's Alleged Failure to "work up and/or document a work up for local invasion and metastatic disease despite noting a very deep SCC that went to the fascia and despite patient complaints of facial numbness, facial weakness and the presence of nodules in the treated area"*

Dr. Willen

121. Dr. Willen's report states that Dr. Little should have worked up or documented a work up for local invasion and metastatic disease prior to radiation treatment because the squamous cell carcinoma was deep and went to the fascia, and because of Patient 9's complaints of facial numbness, facial weakness and the presence of nodules in the treated area. (St. Ex. 15)

Dr. Willen testified:

At the least the minimum [standard of care] would be to have clinically examined that patient for regional disease including examination of the parotid gland, the submandibular gland, the anterior cervical neck, the posterior cervical neck on both sides of the patient. To at least have done a thorough clinical exam of the patient. To order a chest x-ray and to obtain baseline laboratory studies. Based on the fact that the Mohs layer went to the fascia, obtain an MRI or CT as a baseline, which I then would have repeated in 3 months and closely monitored this patient for either the persistence or recurrence of this disease.

(St. Ex. 19 at 87)

122. Dr. Willen acknowledged that Patient 9's complaints concerning facial numbness and the presence of nodules had been documented by a radiation oncologist and not by Dr. Little. However, she testified that it had been a deviation of the standard of care for Dr. Little to fail to monitor Patient 9 as he had progressed through radiation treatment. (St. Ex. 19 at 89-90)

Dr. Little

123. Dr. Little testified that he had received a December 2, 2003, letter from the radiation oncologist about Patient 9, which had mentioned numbness below the lesion. The letter states at the bottom that "these changes are part of the healing process." Dr. Little stated that it had not been clear whether the referenced "changes" were the numbness or new nodules, but he had understood that any complications from the radiation therapy would

have been handled by the radiation oncologist. Dr. Little received another letter from the radiation oncologist, on January 6, 2004, which had again referenced numbness in the treated area. Dr. Little testified that the radiation oncologist had never suggested that the numbness was related to squamous cell cancer, and that it had been Dr. Little's understanding that the numbness had been associated with the radiation therapy. (St. Ex. 9D at 39, 41; Tr. at 273-275)

#### Dr. Ridge

124. Dr. Ridge testified that the radiation therapy could have caused Patient 9's numbness. She also stated that she "would feel that the radiation oncologist would have taken care of any further work up he felt was necessary." (Resp. Ex. A; Tr. at 587-588)

*Dr. Little's Alleged "failure to adequately perform the Mohs procedure and an appropriate work up led to Patient 9's eventual demise"*

125. Dr. Willen's report states that "[i]nadequate and below minimal standard of care by Dr. Little by failing to adequately perform the Mohs procedure and an appropriate work up led to the patient's eventual demise." (St. Ex. 15)

126. Dr. Little testified that, in his medical opinion, he had not contributed to Patient 9's death because "[t]he patient had an adequate Mohs treatment with good margins of the cancer of the left cheek with a recurrence that developed later. He was referred for consultation with a radiation oncologist. He underwent the treatment and had good clearing of the tumor under their guidance." (Tr. at 277-281)

127. Dr. Ridge testified that, in her medical opinion, Dr. Little had complied with the minimal standards of care in treating Patient 9, and that Dr. Little had not contributed to Patient 9's death. She said that Dr. Little had referred Patient 9 appropriately and that "it [w]as [not] directly attributable to his surgical skill that the man succumbed to his tumor." (Tr. at 589-590)

#### **Evidence Concerning Patient 10**

128. Patient 10, a female born in 1923, first saw Dr. Little on January 20, 2000, concerning an 8 mm lesion on her distal nose. Following biopsy and ED&C of the spot, Dr. Little determined the 8 mm lesion to be microinvasive squamous cell carcinoma. On January 31, 2000, Dr. Little's office contacted Patient 10 and notified her of the biopsy results, advised that no further surgery was needed, and instructed her to return in six months. (St. Ex. 10A at 7-11, 17, 22)

Patient 10 appeared for a re-check of her nose on July 10, 2000; no problem was found. (St. Ex. 10A at 7)

Patient 10 next visited Dr. Little two years later, on July 17, 2002. At that time, Dr. Little performed a biopsy and ED&C on a 1.2 cm lesion on Patient 10's left distal forearm, and

ED&C on a 1.1 cm lesion on her distal nose. Dr. Little determined the lesion on her forearm to be squamous cell carcinoma and the lesion on her distal nose to be basal cell carcinoma. On July 30, 2002, Dr. Little's office contacted Patient 10 and notified her of the biopsy results, advised that no further surgery was needed, and instructed her to return in one year. Dr. Little's medical records record no further visits. (St. Ex. 10A at 3-5, 11, 15)

*Dr. Little's Alleged Failure to Recommend Three-Month Follow-up*

129. In her written report, Dr. Willen stated that it had been below the minimal standard of care to recommend to Patient 10 to return to the clinic in six months for follow-up, rather than three months, after the removal of the microinvasive squamous cell cancer. Subsequently, however, during her deposition, Dr. Willen testified that the standard of care for this patient would have been to follow up in six months. (St. Ex. 15; St. Ex. 19 at 94-95)
130. Dr. Little testified that a rule for a three-month follow-up after removal of squamous cell cancer is inappropriate. He advised that he tells clients to call for an earlier checkup if anything unusual occurs. (Tr. at 285-286)
131. Dr. Ridge agreed that a six month follow-up was within the minimal standard of care. (Tr. at 590-591)

*Dr. Little's Alleged Treatment of Microinvasive Recurrent SCC with ED&C*

132. Dr. Willen testified that Dr. Little had failed to comply with the minimal standard of care in his treatment of the second lesion on Patient 10's nose. She testified that a recurrent microinvasive squamous cell carcinoma should not have been treated with a second ED&C without offering the patient other options for treatment. (St. Ex. 19 at 92-93)
133. Dr. Little disagreed with Dr. Willen's assessment, because the second lesion had been a basal cell carcinoma rather than a recurrent microinvasive squamous cell carcinoma. Dr. Little advised that this had been a separate tumor from the first one, and that it is not uncommon for multiple differing kinds of cancer to appear in a certain region. (Tr. at 282-284, 287)
134. Dr. Ridge testified that Dr. Little's care of Patient 10 had met the minimal standard of care because the second lesion had been a basal cell carcinoma, rather than a squamous cell carcinoma. (Tr. at 591)

### Evidence Concerning Patient 11

135. Patient 11, a male born in 1936, first saw Dr. Little in 1989 and continued to see him on a regular basis through November 2003. Dr. Little performed numerous procedures on Patient 11 during this time, including the following:

Date	Procedure	Site	Pathology (per Dr. Little unless noted otherwise)	Pages <sup>26</sup>
11/13/90	Excision and repair	L upper eyelid	Microinvasive SCC	57, 91
8/7/91	Excision and repair	L temple L lateral canthus	Both are SCC; lateral and deep margins appear clear	55, 89, 113
9/18/92	ED&C	L lateral canthus	Microinvasive SCC in situ	51, 85
3/5/93	ED&C	L dorsal hand	Well differentiated SCC, margins appear clear	49, 83
9/13/93	ED&C	L superior temple L lateral forehead	SCC in situ Actinic keratosis	49, 81, 111
5/14/97	ED&C	L dorsal hand	SCC	37, 77, 109
2/2/99	ED&C	Mid chin	SCC	31, 75, 107
9/21/99	ED&C	L preauricular	<i>By another physician:</i> Superficial and well differentiated SCC	29, 73
2/11/02	ED&C	R lateral forehead R lateral brow R lateral cheek	SCC SCC Bowenoid SCC in situ	23, 71, 105
6/19/03	ED&C	R lateral cheek R hand (2 lesions)	SCC SCC (2 lesions)	15, 67
11/6/03	Mohs surgery	R lateral cheek	<i>By another physician:</i> Invasive SCC (intermediate differentiation) <sup>27</sup>	9, 61, 103

136. The medical record indicates that Dr. Little recommended six-month follow-up visits for each procedure listed above except for the August 7, 2002, procedure, for which he recommended a three-month follow-up; the May 14, 1997, procedure, for which he recommended an eight-month follow-up; and the November 6, 2003, Mohs surgery. (St. Ex. 11A at 13-57, 115, 125)

<sup>26</sup> The referenced pages are from State's Exhibit 11A.

<sup>27</sup> The dermatopathologist indicated as follows in the microscopic description: "This is a malignant nodule consisting of epithelial cells expanding the dermis and fat. This tumor is inferior to a centrally placed scar. The tumor extends to the base of the sections. Individual cells are highly pleomorphic with abundant eosinophilic cytoplasm. The mitotic rate is high." (St. Ex. 11A at 61)

*Recurrent Carcinoma on Patient 11's Right Lateral Cheek*

137. Dr. Willen testified that Patient 11 had undergone two years of repeated ED&C and cryosurgery to treat a recurrent squamous cell carcinoma on Patient 11's right cheek. Dr. Willen opined that treating recurrent squamous cell carcinomas with ED&C had been below the minimal standard of care. She further opined that the minimal standard of care required the further removal of tissue after the Mohs surgery, based on the pathology report of an invasive squamous cell carcinoma with intermediate differentiation and high mitotic rate extending to the base of the excision. (St. Ex. 19 at 102)

Dr. Willen also testified that, before the Mohs surgery, Dr. Little had requested a consultation with an ear, nose, and throat physician for evaluation of Patient 11's history of bilateral parotid swelling, occasional dysphasia, and choking. In a report dated March 19, 2003, the consulting physician recommended a CT scan of the neck with contrast to further assess the status of the parotid swelling. Dr. Willen noted that the medical records showed no evidence that a CT scan had ever been performed. (St. Ex. 19 at 100-102)

Dr. Willen further testified that the failure to respond to the recommendation of a CT scan was below the minimal standard of care. Although Dr. Little was not required to order it directly, he should have at least referred Patient 11 to his primary care physician and forwarded the consulting physician's report to that physician. (St. Ex. 19 at 102-104)

138. Dr. Little testified that, in his opinion, his treatment of Patient 11 had complied with the minimal standard of care. In particular, he mentioned that he had addressed the recurrent tumor with Mohs surgery within one week of discovering it, and that the Mohs surgery had been successful. (Tr. at 299-300)

139. In her written report, Dr. Ridge agreed with the allegation that Dr. Little's care of Patient 11 had fallen below the minimal standard of care and that "several of the sites with multiple reoccurrence should have been treated with Mohs." (Resp. Ex. A-A at 6) At hearing, Dr. Ridge explained that she had been unable to determine from Dr. Little's medical record for Patient 11 where the squamous cell carcinomas had been appearing. Moreover, she testified that, based on the absence of good documentation, she had assumed that they had been in the same area. However, Dr. Ridge testified that, if that assumption were incorrect, then she would conclude that Dr. Little's treatment of the carcinomas had not been below the minimal standard of care. (Tr. at 592-594)

*Letters Advising that Squamous Cell Carcinomas do not Spread*

140. By letter dated June 4, 1997, Andie Little, R.N., advised Patient 11 as follows on behalf of Dr. Little:

I have been unable to reach you directly by telephone, but wish to inform you regarding the results of your recent surgical skin biopsy \* \* \*. The specimen

has been examined and demonstrates a squamous cell carcinoma of the left dorsal hand.

This particular type of skin cancer does not spread to other areas of the body, but can reappear locally in a small percentage of patients. No further surgery is required at this time; however, Dr. Little would like to re-evaluate you in 8 months to assure that healing is complete and satisfactory. \* \* \*

(St. Ex. 11A at 125)

Moreover, on February 22, 1999, a similar letter was sent to Patient 11 by Cindi Smith, R.N., on behalf of Dr. Little. As before, this letter advised Patient 11, among other things, that the biopsy revealed squamous cell carcinoma, and that “[t]his particular type of cancer does not spread to other areas of the body, but can reappear locally in a small percentage of patients.” (St. Ex. 11A at 115)

141. Dr. Willen testified that it had been a deviation from the standard of care to report to Patient 11 that squamous cell tumors do not spread because it is “a deviation from known biological behavior of these tumors.” (St. Ex. 19 at 102-103)
142. Dr. Ridge agreed that providing such information to Patient 11 had fallen below the minimal standard of care, because such tumors can spread, although infrequently. (Tr. at 629-633)
143. Dr. Little testified that the statements that squamous cell carcinomas do not spread had been accurate, because, statistically, this type of cancer has less than a 0.5 percent chance of metastasizing, and that he had never seen it happen in 25 years of practice. He said that he would not tell a patient that under all circumstances squamous cell carcinoma does not spread, metastasize, or recur. (Tr. at 297-298)

*Recommendation for Follow-up Treatment*

144. Dr. Willen’s report states that a three-month follow-up would have been the standard of care following Patient 11’s May 14, 1997, ED&C to remove a squamous cell carcinoma. (St. Ex. 15 at 33)
145. Dr. Little denied that he had failed to appropriately recommend follow-up treatment. He testified that Patient 11 had had very close follow-up with Dr. Little throughout the years that Dr. Little had treated him, due to the sheer amount of precancerous sun damage suffered by Patient 11. Dr. Little stated that, “this patient had very close, very accurate follow up throughout his care.” (Tr. at 298-299)
146. Dr. Ridge testified that Dr. Little’s recommendation for follow-up treatment had been appropriate. (St. Ex. 19 at 103; Tr. at 592)

**Evidence Concerning Patient 12**

147. Patient 12, a male born in 1926, first saw Dr. Little in June 1994, and continued to see Dr. Little on a regular basis through December 2003. (St. Ex. 12A) Dr. Little performed the following procedures on Patient 12:

Date	Procedure	Site	Pathology per Dr. Little	Pages <sup>28</sup>
6/27/94	ED&C	L lateral eyelid	BCC	51, 87
	Cryosurgery	12 lesions: L ear, L cheek, scalp	N/A	
4/18/96	ED&C	R posterior ear	Microinvasive SCC	45, 85
12/4/97	ED&C	L posterior shoulder	Multicentric BCC	39, 83
	Cryosurgery	6 lesions: scalp	N/A	
12/15/98	ED&C	L back	Inflamed seborrheic keratosis	35, 81
	Cryosurgery	4 lesions: L posterior ear, R neck	N/A	
4/8/99	ED&C	L anterior scalp	Microinvasive SCC	33, 79
12/12/00	Cryosurgery	4 lesions: back	N/A	27
12/4/01	ED&C	R ala	BCC with fibrosis	25, 69
1/24/02	Mohs surgery	R ala	BCC clear after 1 stage	23, 71
	Cryosurgery	R ear [possibly another site as well— illegible]	N/A	
9/16/02	ED&C	L lower lip	Granulation tissue	17, 61
5/8/03	ED&C	R lower lip Vertex	SCC in situ, margins clear Bowenoid SCC	13, 53
	Cryosurgery	10 lesions: scalp, hands, forearm	N/A	
12/30/03	Cryosurgery	12 lesions: hand, temples, scalp	N/A	9

*Dr. Willen*

148. Dr. Willen testified that the lesion on right ala had been recurrent, in that the pathology revealed fibrosis “which indicates scars which indicates a prior treatment of some sort which resulted in a scar \* \* \*.” (St. Ex. 19 at 107)

<sup>28</sup> The referenced pages are from State’s Exhibit 12A.

Dr. Willen further testified that subsequent treating records show that, on October 13, 2004, subsequent to Dr. Little's care of Patient 12, another physician had treated a recurrent basal cell cancer on Patient 12's right nasal ala. Six stages of Mohs surgery were required to clear the tumor. The Mohs surgeon also noted extensive subclinical spread which required a full thickness skin graft to repair. (St. Ex.12B at 3, 9-10; St. Ex. 19 at 107)

Dr. Willen stated that Dr. Little's Mohs surgery to the right ala region was inadequate and below the minimal standard of care performed by a Mohs surgeon. Further, she testified that Dr. Little's treatment of recurrent basal cell carcinomas with ED&C was a deviation from the standard of care. (St. Ex. 15; St. Ex. 19 at 108-109)

*Dr. Little*

149. Dr. Little denied that his Mohs surgery had been inadequate. He testified that it had been performed no differently than any of his other Mohs surgeries, and that he had obtained clear margins. He further denied treating recurrent basal cell carcinomas with ED&C. He had no recollection of doing so, and contended that there was no evidence of such treatment in his records. (Tr. at 307-309)

*Dr. Ridge*

150. Dr. Ridge testified that she did not believe that Dr. Little's Mohs surgery had been below the minimal standard of care. Further, she agreed with Dr. Little that there had been no evidence in the record to support a finding that Patient 12 had been treated for recurrent basal cell carcinomas with ED&C. (Tr. at 594-595)

**Articles Submitted by Dr. Little**

151. In addition to the article already summarized with regard to Patient 1, Dr. Little submitted literature in support of his positions. (Resp. Exs. A-C, A-E, B – B-2, B-4 – B23) At hearing, Dr. Little characterized the articles as follows:

I think the articles demonstrate a lot of—I guess speak to a lot of different issues. They're diverse as the Guidelines for Care by the National Comprehensive Cancer Network. There are Guidelines of Care from the American Academy of the Dermatology. They speak to—several articles speak to the field effect and the difficulty with margins. Articles speak to the appropriateness of staining techniques utilized. Articles speak to the amount of research done in regard to Aldara in treating nodular basal cell carcinomas and success rates associated. They speak to samples of dermatopathology reports provided to me by other dermatopathologists and their method of describing histopathologic specimens that's very similar to mine. CLIA certification. Several articles relating to the fact that dermatopathology is within the scope of practice for dermatology and is wholeheartedly supported by the Academy of Dermatology.

They speak to the fact that electrodesiccation and curettage is the number one method by dermatologists to treat non-melanoma skin cancers. It speaks to melanoma. It also refers back to the Academy of Dermatology Guidelines for Care for Mohs Micrographic Surgery, also submitted by the State's expert, and my points within that document that I feel support my quality of care.

It speaks as well to using medications off label as being a standard of practice and within the standard of care for dermatology, and some detail relating to that. That is supported by the American Society of Dermatologic Surgery, particularly as it pertains to oncology patients. It discusses information from the American Academy of Dermatology as to why curettage can be utilized in certain cancers and the variety of treatments available for non-melanoma skin cancers. There are articles that discuss in real life, in real clinical settings, how medical decisions are made based other than histology.

And I think basically the final several articles based on the fact that radiation oncology is a very viable option for squamous cell carcinomas as far as treatment. Also the fact that discussions that I may have with patients in regard to squamous cell cancers and melanoma cancers and how it pertains to discussions that one might have with the differing types of melanoma.

(Tr. at 311-313)

152. When asked on cross-examination if she had found the literature provided by Dr. Little to be reasonably reliable, Dr. Willen replied that she had not. Dr. Willen testified that some of the articles originate from non-peer-reviewed journals, and others come from peer-reviewed journals that are from outside the United States "where the practices of care are different \* \* \*." However, Dr. Willen acknowledged that she finds articles from peer-reviewed journals in the United States to be "[r]easonably reliable." (St. Ex. 19 at 128-130)

### **FINDINGS OF FACT**

1. On January 16, 2004, based upon violations of Sections 4731.22(B)(2), (B)(6), (B)(10) and (B)(20), Ohio Revised Code, the Board entered an Order suspending the certificate of Larry John Little, M.D., to practice medicine and surgery in Ohio for an indefinite period, but not less than 180 days, and imposing terms and conditions for reinstatement, as well as probationary terms and conditions. On July 14, 2004, the Board voted to reinstate Dr. Little's certificate subject to probation.
2. From about 1989 to 2004, in the routine course of his practice, Dr. Little undertook the treatment of Patients 1-12 as identified on a confidential Patient Key.

In his dermatological medical care of Patients 1, 3, 5 through 9, 11, and 12, Dr. Little failed to accurately diagnose and/or document the accurate diagnosis of skin cancers; obtained

inappropriate samples for histological examination of skin cancers; and/or failed to identify and/or document the identification of the subtype of skin cancer and/or failed to identify and/or document the identification of the extent of skin cancer invasion.

Further, Dr. Little provided inappropriate treatments for skin cancers and other skin disorders and/or inadequately performed Mohs procedures for skin cancers.

Moreover, Dr. Little failed to closely monitor a patient where required; permitted a patient to be falsely advised that squamous cell carcinoma does not spread; falsely advised patients that no further treatment was necessary for their skin cancers; failed to undertake and/or document the performance of appropriate work-ups; failed to timely follow up after providing treatments; and/or failed to document why work-ups were not performed.

Such conduct includes the following:

- (a) In Dr. Little's care of Patient 1, when performing Mohs surgery, he inadequately documented how the sample of tissue from the patient's upper lip had been sectioned and failed to document how many sections were reviewed in order to document clear margins. Further, Dr. Little inappropriately treated possible recurrent infiltrative facial basal cell carcinoma with Aldara, which led to a delay of proper diagnosis and appropriate treatment of Patient 1.
- (b) The evidence is insufficient to support a finding that Dr. Little inappropriately treated Patient 2's sebaceous hyperplasia with topical clindamycin, Sulfoxyl and Differin.
- (c) Patient 3 was previously treated for non-Hodgkin's lymphoma with chemotherapy and was at a higher risk of aggressive non-melanoma skin cancers due to his immunosuppression. In his care of Patient 3, Dr. Little inappropriately treated Patient 3's recurrent facial squamous cell carcinoma with electrodesiccation and curettage [ED&C]. Further, Dr. Little inappropriately informed Patient 3 that no further treatment was necessary without having documented clear margins.
  - (i) The evidence is insufficient to support a finding that Dr. Little failed to initially treat Patient 3's squamous cell carcinoma with Mohs surgery. Dr. Willen testified that it had been acceptable for Dr. Little to treat the primary lesion with ED&C.
- (d) The evidence is insufficient to support a finding that, in Dr. Little's care of Patient 4, he inadequately performed a Mohs procedure; failed to re-biopsy a potentially recurrent basal cell carcinoma; inappropriately treated Patient 4 patient with Carac; and/or failed to accurately diagnose recurrent basal cell carcinoma leading to a delay in diagnosis requiring further Mohs surgery resulting in a larger defect and repair. Some of Dr. Willen's statements during her deposition conflicted with statements she had made in her written reports. Accordingly, the Hearing Examiner finds that the evidence is not clear enough to support these allegations.

- (e) In his care of Patient 5, Dr. Little inadequately performed a Mohs procedure. With regard to this finding, Dr. Willen's testimony concerning Mohs surgery and whether certain Mohs surgeries documented by Dr. Little were adequately performed is deemed more persuasive than that of Dr. Little or Dr. Ridge. Dr. Willen's experience and background, including her completion of a fellowship in Mohs surgery, makes her expertise more compelling than the others.

In addition, with regard to Dr. Willen's criticism of Dr. Little's failure to divide large Mohs specimens into smaller specimens for analysis, Dr. Little presented an article that shows that it is possible and, in some cases, it may be preferable to examine large specimens without dividing them. However, that article confined its recommendation for such a procedure to large tumors. The tumor referred to in the article was 2.3 x 2.0 cm in size. In contrast, the tumor removed from Patient 5's nose was only 6 mm in size. Under that circumstance, Dr. Willen's opinion that Dr. Little should have used more conventional methodology in preparing his specimens is deemed persuasive.

Further, Dr. Little inappropriately treated Patient 5's recurrent basal cell carcinoma with ED&C; and inappropriately treated recurrent basal cell carcinoma with Aldara. In addition, Dr. Little failed to re-biopsy a potentially recurrent basal cell carcinoma, and, because clear margins were not documented following ED&C, inappropriately informed the patient that no further treatment was necessary.

Dr. Little asserted that Patient 5 had suffered from a "field effect" that led to a cluster of primary lesions that appeared near the site of the original tumor. This assertion is unconvincing based upon his lack of contemporaneous documentation in the medical record of such a condition, and based upon the information that he did document. The evidence shows the following treatment rendered to Patient 5 by Dr. Little:

- Dr. Little performed Mohs surgery on the dorsum of Patient 5's nose on May 4, 2000, to remove a basal cell carcinoma. The final size of the surgical wound was 2.4 x 1.6 cm and Dr. Little repaired it with a full-thickness skin graft.
- In October 2000, he took a biopsy from the left lateral margin of the skin graft and found basal cell carcinoma. He treated it with abrasion.
- In November 2001, Patient 5 complained about a spot on her nose at the site of the skin graft. Dr. Little performed ED&C and the biopsy revealed fragments of basal cell carcinoma.
- In June 2002, Patient 5 returned to Dr. Little's office at which time he observed a 1.8 cm recurrent basal cell carcinoma on her left dorsal nose. He performed ED&C and the biopsy confirmed basal cell carcinoma.

- In December 2002, Patient 5 returned. He performed ED&C on what he described as a basal cell carcinoma of the left dorsal nose. Pathology confirmed basal cell carcinoma.
- Patient 5 returned in May 2003. Among other things, Dr. Little observed a 4 mm lesion on Patient 5's left dorsal nose. He performed ED&C and the biopsy revealed basal cell carcinoma.
- In November 2003, Patient 5 returned. She had been concerned about a "bump" at the May 2000 Mohs surgery site. Dr. Little prescribed Aldara cream and instructed Patient 5 to return in two months.
- Patient 5 returned in January 2004 and Dr. Little's progress note indicates that no tumor remained and that Patient 5 was instructed to return in six months.

Based upon Dr. Little's documentation, it is reasonable to find that he repeatedly treated Patient 5 for six recurrences of basal cell carcinoma using skin abrasion on one occasion, ED&C on four occasions, and Aldara on one occasion. There is nothing documented that would support a finding that she had suffered from a "field effect." In fact, Dr. Little's medical record for Patient 5 contradicts that assertion, inasmuch as he had twice expressly determined a lesion to be recurrent rather than primary.

- (f) In Dr. Little's care of Patient 6, he inappropriately treated Patient 6's recurrent basal cell carcinoma with ED&C. He further treated Patient 6's recurrent basal cell carcinomas with cryosurgery and Aldara, which were inadequate therapies. As a result, a subsequent treating physician performed nine stages of Mohs surgery in order to obtain clear margins, leading to a large post-operative defect size of 7.1 cm by 6.5 cm.

As with Patient 5, Dr. Little's assertion that Patient 6 had suffered from a "field effect" is unconvincing because it was not documented in the medical record.

- (g) In his care of Patient 7, after performing ED&C on the patient's squamous cell carcinoma, Dr. Little inappropriately informed Patient 7 that further surgery was unnecessary when there was no confirmation of clear margins. Further, Dr. Little failed to perform an appropriate work-up of Patient 7's potentially invasive or metastatic squamous cell carcinoma. Further, he inappropriately treated Patient 7's recurrent squamous cell carcinoma with cryosurgery and ED&C.
- (i) The evidence is insufficient to support a finding that Dr. Little had inappropriately informed Patient 7 that the margins were clear when only fragments of tissue had been submitted for pathology.
- (ii) The evidence is insufficient to support a finding that Dr. Little failed to re-biopsy a potentially recurrent squamous cell carcinoma.

- (iii) No evidence was presented concerning the cause of Patient 7's death. Therefore, the evidence is insufficient to support a finding that Dr. Little's treatment of Patient 7's squamous cell carcinoma led to the patient's comorbidity.
- (h) In Dr. Little's care of Patient 8, he inappropriately treated Patient 8's recurrent facial basal cell carcinoma with ED&C and cryosurgery, and inadequately performed a Mohs procedure.

Dr. Little's assertion that all of Patient 8's lesions had all been primary lesions is unconvincing. Such was not documented in the medical record, nor was a field effect documented in the medical record.

- (i) In his care of Patient 9, Dr. Little failed to perform an adequate Mohs procedure. Further, Dr. Little failed to identify and/or document the identification of the subtype of squamous cell carcinoma and failed to identify and/or document the depth of skin cancer invasion. Further, Dr. Little failed to work up and/or document a work up for local invasion and metastatic disease despite noting a very deep squamous cell carcinoma that went to the fascia.

Moreover, it is more likely than not that Dr. Little's failure to adequately perform the Mohs procedure and an appropriate work-up led to Patient 9's eventual demise. This finding is based upon the cause of death as set forth in the Certificate of Death, which states that Patient 9's death had been the result of squamous cell carcinoma whose onset was approximately October 2003. The squamous cell carcinoma that Dr. Little biopsied in September 2003 at the site of his previous Mohs surgery was diagnosed by Dr. Little as a recurrent squamous cell carcinoma. Furthermore:

- Although Dr. Little's medical record for Patient 9 indicates that the final stage of the Mohs surgery had been clear of tumor, there is reason to doubt Dr. Little's ability to reliably render such a determination.

First, the State presented convincing evidence that Dr. Little failed to divide the Mohs specimens into smaller specimens for analysis, and that such failure would have made it difficult to ensure that the specimens were free of tumor.

Second, the State presented convincing evidence that Dr. Little's abilities as a dermatopathologist are questionable. The evidence indicates that his dermatohistopathology reports often fail to document essential information—information concerning the dimensions of the specimen, a description of the sectioning of the specimen, a microscopic description, and/or a description of the grade and subtype of tumor present in the specimen. Instead, Dr. Little often documents only a final diagnosis.

Therefore, Dr. Little's determination that the final stage of Patient 9's Mohs surgery had been free of tumor is deemed questionable.

- The evidence indicates that the second and final stage of the Mohs surgery performed by Dr. Little was taken down to the fascia, indicating that the tumor was deeply invasive. The State presented convincing evidence that, based upon the depth of the invasion of the tumor, Dr. Little should have performed a work-up to determine whether there was further local invasion and whether the tumor had metastasized. Dr. Little failed to perform such a work-up.

Accordingly, the evidence is sufficient to support a finding that Dr. Little's failure to adequately perform the Mohs procedure and an appropriate work-up led to Patient 9's eventual demise.

- (i) The evidence is insufficient to support a finding that Dr. Little failed to work-up and/or document a work-up for local invasion and metastatic disease based upon patient complaints of facial numbness, facial weakness and the presence of nodules in the treated area. The evidence indicates that these complaints and/or findings had occurred during a time when Patient 9 was being treated by a radiation oncologist. Dr. Little testified that he had believed that these complaints arose as a result of radiation treatment and would have been addressed by the radiation oncologist. Dr. Little's belief appears reasonable.
- (j) The evidence is insufficient to support a finding that, in his care of Patient 10, Dr. Little failed to appropriately recommend a three-month follow-up after treating Patient 10 for squamous cell carcinoma. Dr. Willen testified that the standard of care for this patient would be six months, as Dr. Little had instructed Patient 10, rather than three months as she had previously stated in her written report.

Further, the evidence is insufficient to support a finding that Dr. Little inappropriately treated Patient 10's recurrent microinvasive squamous cell carcinoma with ED&C. The medical record indicates that Dr. Little had originally treated a microinvasive squamous cell carcinoma on Patient 10's nose with ED&C. Approximately two years later, he again treated the same area with ED&C. However, the second lesion was determined to be basal cell rather than squamous cell carcinoma. Accordingly, that lesion was not recurrent.

- (k) In his care of Patient 11, Dr. Little permitted this patient to be falsely advised that squamous cell carcinoma does not spread. Further, Dr. Little failed to appropriately treat and manage invasive squamous cell carcinoma.
  - (i) Based upon Dr. Willen's testimony concerning Patient 10, as set forth in paragraph (j), above, the evidence is insufficient to support a finding that Dr. Little failed to appropriately recommend a three-month follow-up after treating Patient 11 for squamous cell carcinoma.

- (l) In his care of Patient 12, Dr. Little inadequately performed a Mohs procedure.
  - (i) The evidence is insufficient to support a finding that Dr. Little inappropriately treated Patient 12's recurrent basal cell carcinoma with ED&C and cryosurgery:
    - The evidence indicates that Dr. Little performed ED&C on a basal cell carcinoma on Patient 12's right ala, and that Dr. Little's pathology report indicated that the tumor was basal cell carcinoma with fibrosis. Dr. Willen testified that fibrosis indicates that there had been scar tissue, leading her to conclude that that area had had previous surgery, and thus the tumor was recurrent. However, there is no evidence that the previous surgery had been performed to treat basal cell carcinoma. Therefore, the evidence is insufficient to support a finding that the basal cell carcinoma had been recurrent.
    - There is insufficient evidence that Dr. Little had treated Patient 12's recurrent basal cell carcinoma with cryosurgery.

### CONCLUSIONS OF LAW

1. The conduct of Larry John Little, M.D., as set forth in Findings of Fact 2, 2(a), 2(c) (except 2[c][i]), 2(e) through 2(i) (except 2[g][i] through 2[g][iii] and 2[i][i]), 2(k) (except 2[k][i]), and 2(l) (except 2[l][i]), above, constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.
2. The evidence is insufficient to support a conclusion that Dr. Little's conduct as set forth in Findings of Fact 2(b), 2(c)(i), 2(d), 2(g)(i) through 2(g)(iii), 2(i)(i), 2(j), 2(k)(i), and 2(l)(i), above, constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code. Nevertheless, it is apparent that the Board based each of those allegations on the report of its expert, and those allegations are deemed not proven based upon all the evidence presented during hearing. Accordingly, the Board was substantially justified in making those allegations.

\* \* \* \* \*

Dr. Little's care of several of the patients presented in this matter seems to evidence a lack of medical knowledge, lack of sound medical judgment, and/or carelessness on his part. Particularly disturbing is Dr. Little's insistence that he did everything correctly, a position that even his own expert witness would not take with regard to Dr. Little's treatment of some patients. In summary, it appears unlikely that Dr. Little would be amenable to further education, and his continued practice presents a danger to the public.

**PROPOSED ORDER**

It is hereby ORDERED that:

The certificate of Larry John Little, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective thirty days from the date of mailing of the notification of approval by the Board. In the thirty-day interim, Dr. Little shall not undertake the care of any patient not already under his care.



R. Gregory Porter  
Hearing Examiner

# State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127



Richard A. Whitehouse, Esq.  
Executive Director

(614) 466-3934  
med.ohio.gov

## EXCERPT FROM THE DRAFT MINUTES OF DECEMBER 10, 2008

### REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Varyani announced that the Board would now consider the Reports and Recommendations appearing on its agenda. He asked whether each member of the Board had received, read and considered the hearing record; the findings of fact, conclusions and proposed orders; and any objections filed in the matters of: Larry John Little, M.D.; Donald E. Higgs, M.D.; Erica L. Berry; Sara C. Gorbett; Patricia Ann Hale; Leonid Macheret, M.D.; Ruba W. Nijmeh, M.D.; and Paul H. Volkman, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Madia	- aye
	Mr. Hairston	- aye
	Dr. Amato	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Varyani	- aye

Dr. Varyani asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Madia	- aye
	Mr. Hairston	- aye
	Dr. Amato	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye

Dr. Steinbergh - aye  
Dr. Varyani - aye

Dr. Varyani noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. They may, however, participate in the matters of Dr. Higgs and Dr. Nijmeh, as those cases are not disciplinary in nature and concern only the doctors' qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

The original Proposed Findings and Proposed Orders shall be maintained in the exhibits section of this Journal.

LARRY JOHN LITTLE, M.D.

Dr. Varyani directed the Board's attention to the matter of Larry John Little, M.D. He advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

Dr. Varyani continued that a request to address the Board has been timely filed on behalf of Dr. Little. Five minutes would be allowed for that address.

Dr. Little was accompanied by his attorney, Eric J. Plinke. Mr. Plinke stated that this case has been a long time pending, the hearing was held some time ago. He stated that he filed written objections, which he's sure that the Board has reviewed.

Mr. Plinke stated that there are cases that occasionally come before the Board where objections in pen and paper are not sufficient to demonstrate and identify the concerns expressed in those objections. Mr. Plinke stated that he thinks that this is one of those cases. He asked the Board to visualize how this case began. The Medical Board, internally, gets a written report from Marlene Willen, M.D., based on her review of the patient records. She writes that report, signs the report, sends it to the Board, and it's internally reviewed. The Secretary and Supervising Member formulate charges, the charges are issued, the hearing request is made, and the defense of the case is begun. When it comes to the actual hearing, and Dr. Willen testifies, it turns out that she's wrong. She contradicts her own report. Mr. Plinke stated that this is really extraordinary. It's not great lawyering, it's not anything other than a witness who, when she prepares her report containing her opinions, is wrong. Mr. Plinke stated that he knows it's wrong because when she came to the hearing and testified, she contradicted what she put in her report. Mr. Plinke stated that that is what the record contains; yet, that witness is deemed more credible than Jennifer M. Ridge, M.D., who testified, or Dr. Little, who testified.

Mr. Plinke stated that, based on that determination of Dr. Willen being more credible, this Board is poised to permanently revoke Dr. Little's license. Mr. Plinke stated that he thinks that it's a relatively rare occurrence for this Board to have an expert, who writes a report, that by their later own testimony is incorrect, and not in immaterial ways. He stated that these were substantive standard of care issues that are just flat-out wrong, in Dr. Willen's own report. Mr. Plinke stated that he thinks that that raises serious legal questions about the reliability of this witness. What was she thinking when she wrote the report? Did she actually know what the standard of care was when she wrote this report? Did she know what the standard of care was when she testified contrary to the report? Yet, this is the witness who was credible, according to the Report and Recommendation.

Mr. Plinke stated that the other issue he would like to bring to the Board's attention is that a number of Dr. Little's patients, unsolicited, have come here today. He stated that if the Board is uncomfortable with the state of the evidence, if it is uncertain whether the Board members can sit there and say, "yes, we should permanently revoke Dr. Little's license, based on Dr. Willen's testimony," he would encourage the Board to remand the case. Mr. Plinke stated that he feels that, based on this record, it's almost guesswork to actually discipline Dr. Little, based on Dr. Willen's credibility issues.

Dr. Little read the following statement into the record:

I respectfully (sic) sit before the State Medical Board twenty months after the hearing involving charges made against me was concluded. My treatment of patients is reflected in my charts and testimony. I take full responsibility for my treatment choices. I do, however, have problems with the way in which this case was prepared. This case was developed by the State's expert, pursued by the Attorney General's office, and reviewed by the Hearing Examiner with only the aid of paper, black and white patient charts. The case was developed without a definition of the minimal standard of care for dermatology by the State's expert, any microscopic slides, tissue or pathology material being examined by the State's expert or the Hearing Examiner, or any color coded diagrams related to Mohs surgery and tissue orientation being examined by the State's attorneys, Hearing Examiner, or the State's expert. This type of diagram is impossible to interpret without coloring in place. This resulted in many conjectures, guesses and false conclusions being made by the State's expert. Even when presented with clear-cut evidence to the contrary, the expert held to her conclusions. In other words, she contradicted her own report. Despite these basic errors, she was said to be more credible than me or my expert, Dr. Ridge.

Dermatology is a unique specialty in that, by its nature, it is almost purely a visual diagnostic specialty. To make assumptions in dermatology without examining the patient is misguided at best and arrogant at worst. One can armchair quarterback clinical decisions if one wishes, but you simply cannot imagine the precise nature and location of lesions years later on the ever-changing canvas that is the skin.

It is, and it has been, my usual and customary practice to examine all patients' lesions and faces under seven-power magnification with good lighting. I am very forward and I am very skilled in that regard. It is now my usual and customary practice to digitally photograph all suspicious skin lesions to document their location and their appearance accurately. This was not feasible even five years ago with the technology available at that time.

The state's expert stated during her deposition that she believed that peer review journals were not helpful to her in determining treatment modalities for patients. I disagree. I believe that they are a very helpful format for dissemination of knowledge. The State's expert presented only one article in support of her testimony. I presented numerous articles and references, which supported my treatment choices. Coincidentally, I presented the same article as the State's expert in support of my decisions. The document is the *American Academy of Dermatology Guidelines of Care for Mohs Micrographic Surgery*, which was prepared in 1995. To quote from these guidelines:

These guidelines are intended to assist those outside of our profession to understand the complexities and scope of care provided by dermatologists. Mohs Micrographic Surgery is not indicated for the treatment of all skin cancers. Skin cancer may be effectively treated by various modalities. Successful treatment of each individual lesion and patient is dependent on many factors, including the clinician's skill and familiarity with treatment, availability of treatment modalities, as well as tumor type and patient selection. The risk/benefit ratio must be considered on an individual basis. In some instances, the patient's general health would indicate palliation or observation only. Frequency and duration of patient follow-up is dependent on the individual case. The list of treatments may include agents that are not currently approved by the United States Food and Drug Administration. Further, these guidelines should not be deemed inclusive of all proper methods of care, or exclusive of other methods of care reasonably directed at achieving the same result. The ultimate judgment regarding any specific procedure must be made by the physician in light of all other circumstances presented by the individual patient.

I have and continue to follow these established guidelines. In treating skin cancer, the State's expert noted that she utilized Mohs micrographic surgery as her only treatment choice. I disagree with this cookie cutter approach. At no point in the deposition or written report by the State's expert was consideration given to alternate skin cancer treatment modalities outside of her first preference.

Dr. Varyani advised that he has given Dr. Little the benefit of nine minutes, rather than five. He advised Dr. Little that he has one minute to conclude his statement.

Dr. Little continued as follows:

In the course of a day, I see at least eight patients with new skin cancers. My staff or crew have undertaken a quality assurance study over the past four years of my previous surgical patients who have returned from Mohs surgery performed as far as eighteen years in the past. The number is presently 760 lesions with five histologic recurrences. I hold that number, including any patients among the twelve submitted up to comparison from any quarter. This is well within the standard. However, good care does not necessarily ensure that all patients have successful outcomes. Medicine is a life science, not an exact science. There is no more one way to do things than there is one type of patient. I've strived to do my best, knowing that I do a good job for my patients. Fortunately, I have been blessed with a wonderful staff of patients and exceptional staff. I love new developments in dermatology, and to suggest otherwise is untrue. This case involves differences of opinion in dermatology. I am not infallible and freely admit so. I welcome intellectual curiosity in medicine, I'm open to other opinions and have always viewed medicine as an area where there can be different views on professional judgments. I have and continue to learn, and I have learned from this process. I think that Dr. Ridge shares the view of a broad range of professional judgment and that there is spectrum of the standard of care. This case deals with those differences in clinical opinion and judgments that are made daily in clinical practice. Thank you.

Dr. Varyani asked whether the Assistant Attorney General wished to respond.

Ms. Pfeiffer advised that she does. Ms. Pfeiffer stated that there were three physicians who testified as experts in this matter: Dr. Willen, who testified as a witness on behalf of the Board; Dr. Ridge, who was retained by Dr. Little as an expert witness; and Dr. Little, himself. Ms. Pfeiffer stated that she wants to focus on the allegations, primarily related to the inappropriate treatment of the recurrent basal cell carcinomas (BCC) and squamous cell carcinomas (SCC), by using either topical medications or electrodesiccation and curettage (ED&C) versus the Mohs surgical procedure.

Ms. Pfeiffer stated that before she does that, she would like to briefly tell the Board about Dr. Willen, to refresh their recollection. When Dr. Willen testified, she was Chairperson of Dermatology at MetroHealth Medical Center, and the Director of Dermatology. She oversaw fourteen dermatologists and 21 residents in the combined program with University Hospital. She was also Director of Dermatologic Surgery and Oncology at MetroHealth. Ms. Pfeiffer stated that the Board's expert is not only board-certified in dermatology, she is a fellow in the American College of Mohs Micrographic Surgery. She achieved membership in that fellowship by successfully completing a two-year Mohs Micrographic Fellowship at

the Cleveland Clinic. Ms. Pfeiffer stated that this is a highly credentialed expert witness, which speaks to her competence and her ability to testify as an expert, particularly as to the adequacy of the surgical procedure of Mohs surgery.

Ms. Pfeiffer stated that Dr. Willen opined, repeatedly, on the deviation from the standard of care by Dr. Little in treating recurrent BCCs and SCCs with procedures other than Mohs. Ms. Pfeiffer stressed that she is referring to recurrent cancers. Ms. Pfeiffer commented that what really stands out to her is that Dr. Ridge, Dr. Little's expert, on numerous occasions in her report also opined repeatedly that Dr. Little deviated from the standard of care in his treatment of these recurrent cancers. Ms. Pfeiffer referred to Respondent's Exhibit A-A, Dr. Ridge's report, which was admitted into evidence by Dr. Little. She noted that Dr. Ridge responded by patient, and the allegations related to each patient.

Concerning allegations made by the Board relating to Patient #5, Ms. Pfeiffer noted that Dr. Ridge responded as follows:

- Dr. Little inappropriately treated Patient 5's recurrent BCC with ED&C;

**Response:** I agree with this allegation.

- Dr. Little inappropriately treated recurrent BCC with Aldara;

**Response:** I agree again that after so many recurrences, Aldara should have been used for a less aggressive case.

- Dr. Little inappropriately informed the patient that no further treatment was necessary.

**Response:** I agree.

Concerning allegations made by the Board relating to Patient #6, Ms. Pfeiffer noted that Dr. Ridge responded as follows:

- Dr. Little inappropriately treated Patient 6's recurrent BCC with ED&C;

**Response:** Agree.

- Dr. Little inappropriately treated recurrent BCC with inadequate therapies

**Response:** Agree.

Ms. Pfeiffer stated that there are similar allegations and responses as to Patients 7, 8 and 11. She advised that, concerning Patient 7, one of the allegations was that Dr. Little inappropriately treated Patient 7's

recurrent SCC with cryosurgery and ED&C. Ms. Pfeiffer stated that Dr. Ridge's response was, "I agree. After an excessive number of reoccurrences, a work up would be in order." In response to the allegation that Dr. Little provided inadequate treatment of Patient 7's SCC leading to the patient's comorbidity, Dr. Ridge stated, "I agree."

Ms. Pfeiffer stated that in her testimony at hearing, Dr. Ridge, in her response regarding Patient 7, went on to say, "I would like to go on record in this case and say that Patient No. 7 had an excessive number of many, many malignancies in the same general area. I would find it hard to believe that there were not recurrences in this." Ms. Pfeiffer stated that Dr. Ridge is finding recurrent carcinomas that are being treated inappropriately.

Ms. Pfeiffer advised that, ultimately, Dr. Ridge concluded her report. She stated:

Where I do agree with several of the allegations, is in the repeated use of electrodesiccation and curettage in what I felt were the same general areas of tumor involvement. I felt that several of the patients would have benefited from a much earlier use of Mohs' on their recurrent tumors. In these cases, I didn't understand why Dr. Little, who knew the Mohs' technique, chose electrodesiccation and curettage.

Ms. Pfeiffer referred to Patient # 9. She noted that the allegation was that Dr. Little's inappropriate performance or conduct of the Mohs procedure led to that patient's death. This was supported by Dr. Willen, the Board's expert, who obtained a fellowship in Mohs micrographic surgery. She knows the proper way to do Mohs.

Ms. Pfeiffer also reminded the Board that this is not the first time that Dr. Little has been before the Board. The Board suspended Dr. Little's license for a six-month period in 2004 for prescribing issues. She stated that it is appropriate for the Board to take that into consideration.

Ms. Pfeiffer noted the comments by Respondent's Counsel about the credibility issues of the State's expert witness. She stated that there were some inconsistencies in Dr. Willen's report and testimony, and she believes that the Hearing Examiner appropriately addressed those. In certain instances, the hearing Examiner made a finding of an insufficient evidence as to certain allegations. Ms. Pfeiffer stated, however, that when you combine the rest of it, especially with Dr. Little's own expert's testimony, she thinks that the Board can find that the balance of the allegations have been proven as demonstrated or reflected in the Hearing Examiner's Report and Recommendation.

Ms. Pfeiffer asked the Board to take into consideration the State's objections regarding Patient 7; that, in fact, there should have been a finding that Dr. Little's treatment led to the patient's comorbidity. There was no issue on that particular allegation amongst the experts.

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF**

**FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF LARRY JOHN LITTLE, M.D. DR. MADIA SECONDED THE MOTION.**

Dr. Varyani stated that he would now entertain discussion in the above matter.

Dr. Egner stated that she would like to thank Mr. Porter, stating that she thinks that he did an excellent job in writing the Report and Recommendation. She noted that it is a very technical Report and Recommendation and one that certainly is not her specialty. She found it to be both informative and easy to follow.

Dr. Egner stated that one of the things that has helped her to form her conclusions is the first part in the Report and Recommendation that talks about the incidents of skin cancers with which dermatologists deal. She noted that the Report and Recommendation indicates that, of all the skin cancers that occur, 75% are BCCs, 24% are SCCs and the remaining 1% includes all other forms of skin cancer. Dr. Egner stated that, as she reads this entire case, and patient after patient, of the cancerous conditions that a dermatologist sees, and they see a lot, this is their bread and butter. Dr. Egner stated that it would kind of be akin to her not knowing how to appropriately handle an abnormal pap smear. It's her life and what she does, and skin cancer is a dermatologist's life and what he or she does. Dr. Egner stated that she does see a pattern of poor evaluation and poor treatment of these recurring cancers.

Dr. Egner stated that she agrees with the Assistant Attorney General's assessment of the expert witnesses. She did not find Dr. Willen's testimony to be egregiously contradictory. There were some things that she changed when she came to hearing. Dr. Egner commented that she thinks that that shows an honest presentation of her testimony. Dr. Little's own expert, Dr. Ridge, on numerous occasions found that the care had been below minimal standards. The Board has seen that on other cases. Those are experts doing their jobs, and that's what this Board wants.

Dr. Egner stated that she does think that this case rises to the level of a failure to practice by minimal standards. She added that she agrees with Mr. Porter's assessment that it appears unlikely that Dr. Little will be amenable to further education, and that his continued practice presents a danger to the public. She added that that's not to say that she doesn't take into account the number of patients who have taken time to come here. She commented that that is pretty remarkable. However, the Board's job is to protect the public and she agrees with the Report and Recommendation.

Dr. Steinbergh stated that she found this Report and Recommendation very technical and tedious to get through. She stated that she would disagree with Mr. Plinke's argument about Dr. Willen. Dr. Steinbergh stated that when she reads a case, she appreciates the expertise of both experts. She would agree with Dr. Egner that Dr. Willen did change her mind sometimes, which is not an inappropriate thing. Dr. Ridge also testified that there were times when Dr. Little did not meet the standard of care.

Dr. Steinbergh stated that she would also like to comment on Dr. Little's objections when it comes to the

concept of standards of care. What is the definition? Dr. Willen, during her testimony, asked whether the questioner could be more specific about how the questioner wants her to define standards of care. Dr. Steinbergh stated that those who are physicians understand “minimal standard of care.” They know it when they see it. If it doesn’t feel right, you see red flags, you know that it’s just not right, that you wouldn’t practice this way and most of your colleagues wouldn’t practice this way. So, when it comes to the point of minimal standards of care, it can be defined in very specific cases. She stated that if someone says to her, “well, the person came to me and she had acute tonsillitis, she had a very red throat, she had pus on her tonsils, and I sent her out with nothing and said to call me back in two or three weeks if it persists,” that would be below the standard of care for what Dr. Steinbergh does as a primary care physician. She needs to assess those tonsils, she needs to culture those tonsils or do a rapid strep test. She needs to do something if the patient that has a syndrome with a fever and swelling glands and a sore throat. She needs to be certain that that person doesn’t have streptococcal infection because if that person walks away and isn’t treated, we know that after a certain period of time, that person is at risk for streptococcal disease of the kidneys and other parts of the body. Dr. Steinbergh stated that, as a physician trained in primary care, she knows what to do with that strep throat. If she persistently or continuously does not appreciate why a patient presented to her, and if she lets the patient go and doesn’t do what she has been trained to do, that would be below the minimal standards of care.

Dr. Steinbergh stated that there is a definition of what the minimal standard of care is, but you have to take a look at each individual case. You have to define the case, what’s acceptable, what’s not acceptable, and you have to understand what happens in the long run if you don’t treat that patient correctly. Dr. Steinbergh stated that all physicians know that there are times when they can let it go for a while and watch, you have a reliable patient, the patient is going to come back for follow-up, you explain to the patient the importance of the follow-up, and the patient comes back and you’re able to follow up. There are cases when you don’t explain and you don’t monitor closely, and you know you can get in trouble because of the danger of the disease.

Dr. Steinbergh stated that it’s true that she’s not a dermatologist. She added, however, that, as a primary physician, she knows enough about dermatology because she sees these patients. She sends patients to dermatologists. If she does a biopsy and she gets a biopsy report back that is inconsistent with what she’s looking at, she will send it to a Mohs surgeon. She will insist the patient takes the slide, the slide is sent to the surgeon, now we have a dermatopathologist who’s read it, now we have a Mohs surgeon who’s looking at it, and her expectation as a primary care physician is that that doctor better be reliable. Sometimes she must act as a quarterback. The specialist had better be good, because, not only is the patient at risk, but everything that Dr. Steinbergh does relies on how that person down the field catches the ball and whether he or she takes it into the end zone, so to speak. Dr. Steinbergh stated that she relies heavily on the dermatologist to do that and to be accurate.

Dr. Steinbergh stated that she’s not going to get into the technicality of all those things, except she does agree with Dr. Egner about the bread and butter of dermatologists and dermatologic surgeons who see this every single day, along with a variety of other dermatoses. These are the important ones that you cannot let

go.

Dr. Steinbergh stated that she does agree with the State's objections, concerning Patient 7. It has been suggested, and she agrees with the suggestion, that the Board modify the language of Finding of Fact 2(g)(iii), which reads:

No evidence was presented concerning the cause of Patient 7's death. Therefore, the evidence is insufficient to support a finding that Dr. Little's treatment of Patient 7's squamous cell carcinoma led to the patient's comorbidity.

Dr. Steinbergh stated that the Assistant Attorney General speaks appropriately about this that, perhaps, there was a misunderstanding about mortality and comorbidity. In fact, there was evidence that was presented regarding Patient 7's comorbidity. Dr. Steinbergh explained that "comorbidity" means more than one disease going on at the same time. Based upon the testimony from Dr. Little's expert witness, Dr. Ridge, as well as the Board's expert's report regarding Dr. Little's treatment of patient 7's SCC, the evidence is sufficient to support a finding that Dr. Little's treatment of Patient 7's SCC led to the patient's comorbidity, versus mortality.

**DR. STEINBERGH MOVED TO AMEND FINDING OF FACT 2(G)(III) TO STATE AS FOLLOWS:**

2(g)(iii) The evidence is sufficient to support a finding that Dr. Little's inappropriate treatment of Patient 7's squamous cell carcinoma led to the patient's comorbidity.

**DR. STEINBERGH FURTHER MOVED TO AMEND CONCLUSIONS OF LAW 1 TO READ AS FOLLOWS:**

1. The conduct of Larry John Little, M.D., as set forth in Finding of Fact 2, 2(a), 2(c) (except 2[c][i]), 2(e) through 2(i) (except 2[g][i], 2[g][ii] and 2[i][i]), 2(k) (except 2[k][i]), and 2(l) (except 2[l][i]), above, constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Dr. Steinbergh stated that she would focus her last statements on Patient 9. She stated that her concern for this particular patient is that this patient had ultimately succumbed to metastatic disease from the SCC. As Dr. Little worked up this patient, removed the lesion and subsequently gave direction to the patient, it is her opinion that Dr. Little did not appropriately monitor this patient. She stated that Dr. Little did ultimately refer this patient to radiation oncology and treatment was ongoing, but no one looked any further into the disease process. Dr. Steinbergh stated that dermatologists in today's health care system want to be primary

care doctors of the skin, so that you have the right, as a patient, to go directly to the dermatologist for care of your skin. So, when a dermatologist requests that, and we agree that they have a specialty that we don't have, they are to continue with that patient, as a primary care physician would, for any of the other disease entities that we treat as primary care doctors. The doctor takes on the patient, monitors the patient, and manages the disease. In this case, Dr. Little did not manage the disease. He assumed that at some point the radiation oncologist, who's treating a very specific piece of the cancer, was going to go on to do a metastatic workup. Dr. Steinbergh stated that she believes that it was Dr. Little's responsibility to do that metastatic workup. He knows the disease process of SCC, like she knows the possibility of what will happen to that patient if she does not treat that strep throat or any other disease that can be serious. It's Dr. Little's responsibility to monitor the patient, make certain the patient is following up with him, make certain that the disease process is going on, when there are problems, whether it is facial numbness in this case and other things that indicated to this doctor that, possibly, this was a piece of radiation – there's no question that it could have been part of radiation therapy – but the doctor has to have the suspicion of the ongoing disease process. He or she has to understand that there are other things that it can be and there has to be an appropriate workup. Dr. Steinbergh stated that the appropriate workup in the case of Patient 9 was not done. It was neglectful, in her mind.

Dr. Steinbergh stated that she is going to agree with the Report and Recommendation.

Dr. Amato stated that he agrees with some of what has been said, but he disagrees with other aspects of what Dr. Egner and Dr. Steinbergh said. Dr. Amato stated that in his reading of the materials provided, there is certainly a situation where some diagnoses were inappropriately managed. There were other instances, from his reading, where there were differences of opinion on proper management. Dr. Amato stated that he has a problem with the Proposed Order. It leaves no chance for redemption of a practitioner who obviously sees a large number of patients and, by vast numbers, takes good care of his patients or he wouldn't be seeing them. Dr. Amato stated again that his big problem is with a permanent revocation with no chance of redemption. He would prefer to see a permanent revocation, stayed, perhaps a recertification examination, then probation in order to allow this physician the opportunity to polish his skills and to return to productive practice.

Dr. Stephens agreed with Dr. Amato. She stated that she doesn't think that this has risen to the level of permanent revocation. Looking at it from a mathematical standpoint, she thinks that every specialty has complications and bad outcomes. Part of this seems subjective to her. If Dr. Little has done over 800 biopsies and he has ten complications, or whatever the number is, that seems like a 90% success rate. Dr. Stephens stated that she would agree with Dr. Amato that maybe recertification or something like that is appropriate, but she does not agree with permanent revocation.

Dr. Suppan stated that she supports the viewpoints of Dr. Stephens and Dr. Amato. She also does not think that this rises to the level of a permanent revocation. Dr. Suppan stated that there was an important point that was raised, that, basically, the information that was provided was a subset of the patient's history or the patient's chart. Dr. Suppan stated that she does not have enough information, based on the record that the

Board members have that have swayed her in either direction with this. Dr. Suppan stated that she was not able to fully endorse either expert witness. What the Board doesn't have, nor does it ever have, is the patient in front of it to really know the full extent of the situations.

Dr. Suppan stated that, although it sounds like it's a great thing to have Dr. Willens as an expert in Mohs chemosurgery, there's kind of an old common sense thing that when you have a hammer, everything looks like a nail. Throughout the course of her 25 years of practice, she finds that people who are experts in certain areas tend to see that modality as the answer to every single question. Dr. Suppan noted that dermatology is not her specialty, but added that when she reviewed this information, she was not convinced that there were not other ways to treat these patients. The Board doesn't know whether Dr. Little had discussions with these patients and said, "we have treatments a, b and c," and the patient may have in some cases opted or elected to go with something that was less disfiguring. Perhaps the patients, because of their health, their ages or even sometimes their finances will participate in making decisions. Dr. Suppan stated that she's not convinced that alternatives weren't answered. All the Board knows is what was actually done. Dr. Suppan stated that, for that reason, she doesn't feel that she can support permanent revocation. She would recommend a modified order that would include re-education. Dr. Suppan stated that, because she's a relatively new Board member, she would ask her colleagues to help her with what's available in that regard. She would not want to recommend a certain type of re-education. She would like to see something along the lines of a mini-residency.

Dr. Egner stated that if the Board members feel that more education is necessary, she wouldn't be in favor of just a recertification examination. Dr. Egner stated that she doesn't think that a written exam really evaluates a physician's clinical judgment very well. Maybe CPEP should be written into this Report and Recommendation, if the Board is going to go in that direction. Dr. Egner stated that the Board should discuss this a little bit and then table the matter because it will be a very different Report and Recommendation from what is in front of the Board members. Then, the Board will rely on CPEP's evaluation to know where the Board should go from there. It won't be a definitive plan until the Board sees what CPEP's evaluation is.

Dr. Steinbergh stated that she agrees with tabling this to develop an alternative. She stated that she thinks that it would be in the form of a permanent revocation, with a stay of the revocation, a significant suspension, where Dr. Little could then be evaluated by CPEP and then abide by the recommendations of that group, and then he would go into a monitoring probationary phase. She stated that before she makes the motion, she would like to know whether the Board members agree to the amendments she previously discussed.

Dr. Suppan stated that she is still troubled by the stayed permanent revocation language, because she doesn't think that this case rises to that level.

Dr. Steinbergh suggested tabling to develop language.

Dr. Mahajan stated that he went through the records and he understands that Dr. Little has a large practice and has treated many patients, but some of the follow up, workups and treatments were bothersome. Dr. Mahajan stated that he doesn't feel that it is bad enough to permanently revoke the license.

Mr. Hairston stated that he agrees.

**DR. STEINBERGH MOVED TO TABLE THE MATTER OF LARRY JOHN LITTLE, M.D., TO DEVELOP ALTERNATIVE LANGUAGE. DR. MAHAJAN SECONDED THE MOTION. All members voted aye. The motion carried.**

When the matter was removed from the table, later in the meeting, Dr. Stephens was absent.

**DR. AMATO MOVED:**

**TO AMEND FINDING OF FACT 2(g)(iii) TO STATE AS FOLLOWS:**

2(g)(iii) The evidence is sufficient to support a finding that Dr. Little's inappropriate treatment of Patient 7's squamous cell carcinoma led to the patient's comorbidity.

**TO AMEND CONCLUSION OF LAW 1 TO STATE AS FOLLOWS:**

1. The conduct of Larry John Little, M.D., as set forth in Finding of Fact 2, 2(a), 2(c) (except 2[c][i]), 2(e) through 2(i) (except 2[g][i], 2[g][ii] and 2[i][i]), 2(k) (except 2[k][i]), and 2(l) (except 2[l][i]), above, constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

**TO AMEND CONCLUSION OF LAW 2 TO STATE AS FOLLOWS:**

2. The evidence is insufficient to support a conclusion that Dr. Little's conduct as set forth in Findings of Fact 2(b), 2(c)(i), 2(d), 2(g)(i), 2(g)(ii), 2(i)(i), 2(j), 2(k)(i), and 2(l)(i), above, constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code. Nevertheless, it is apparent that the Board based each of those allegations on the report of its expert, and those allegations are deemed not proven based upon all the evidence presented during hearing. Accordingly, the Board was substantially justified in making those allegations.

**TO DELETE THE PARAGRAPH FOLLOWING THE FIVE STARS.**

**DR. AMATO FURTHER MOVED TO AMEND THE PROPOSED ORDER IN THE MATTER OF LARRY JOHN LITTLE, M.D., BY SUBSTITUTING THE FOLLOWING:**

It is hereby ORDERED that:

- A. **PERMANENT REVOCATION, STAYED; SUSPENSION:** The certificate of Larry John Little, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such revocation is STAYED, and Dr. Little's certificate shall be SUSPENDED for an indefinite period of time, but not less than one year.
- B. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Little's certificate to practice medicine and surgery until all of the following conditions have been met:
  1. **Application for Reinstatement or Restoration:** Dr. Little shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
  2. **Post-Licensure Assessment Program:** At the time he submits his application for reinstatement, Dr. Little shall submit a Learning Plan developed for Dr. Little by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners. The Learning Plan shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Little by the PLAS.
    - a. Prior to the initial assessment by the PLAS, Dr. Little shall furnish the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record which the Board may deem appropriate or helpful to that assessment.
    - b. Should the PLAS request patient records maintained by Dr. Little, Dr. Little shall include in that submission copies of the patient records at issue in this matter. Furthermore, Dr. Little shall ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.

- c. Dr. Little shall assure that, within ten days of its completion, the written Assessment Report compiled by the PLAS is submitted to the Board. Moreover, Dr. Little shall ensure that the written Assessment Report includes the following:
  - A detailed plan of recommended practice limitations, if any;
  - Any recommended education;
  - Any recommended mentorship or preceptorship;
  - Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.
- d. Dr. Little shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

Upon successful completion of the educational activities, including any assessment or evaluation recommended by PLAS, Dr. Little shall provide the Board with satisfactory documentation from PLAS indicating that Dr. Little has successfully completed the recommended educational activities.

- e. Dr. Little's participation in the PLAS shall be at his own expense.
3. **Additional Evidence of Fitness To Resume Practice:** In the event that Dr. Little has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.
- C. **PROBATION:** Upon reinstatement or restoration, Dr. Little's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:
1. **Obey the Law:** Dr. Little shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance:** Dr. Little shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Little's certificate is reinstated or restored. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
3. **Personal Appearances:** Dr. Little shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Little's certificate is reinstated or restored, or as otherwise directed by the Board. Subsequent personal appearances must occur every six months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
4. **Post-Licensure Assessment Program:** Dr. Little shall practice in accordance with the Learning Plan developed by the PLAS, unless otherwise determined by the Board. Dr. Little shall cause to be submitted to the Board quarterly declarations from the PLAS documenting Dr. Little's continued compliance with the Learning Plan.

Dr. Little shall obtain the Board's prior approval for any deviation from the Learning Plan.

If, without permission from the Board, Dr. Little fails to comply with the Learning Plan, Dr. Little shall cease practicing medicine and surgery beginning the day following Dr. Little's receiving notice from the Board of such violation and shall refrain from practicing until the PLAS provides written notification to the Board that Dr. Little has reestablished compliance with the Learning Plan. Practice during the period of noncompliance shall be considered unlicensed practice in violation of Section 4731.41, Ohio Revised Code.

5. **Monitoring Physician:** Within thirty days of the date of Dr. Little's reinstatement or restoration and prior to Dr. Little's commencement of practice in Ohio, or as otherwise determined by the Board, he shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In

approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Little and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Little and his medical practice, and shall review Dr. Little's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Little and his medical practice, and on the review of Dr. Little's patient charts. Dr. Little shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Little's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Little must immediately so notify the Board in writing. In addition, Dr. Little shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Little shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

6. **Absence from Ohio:** In the event that Dr. Little should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Little must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of the probationary period under this Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.
7. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Little is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

D. **TERMINATION OF PROBATION:** Upon successful completion of probation,

as evidenced by a written release from the Board, Dr. Little's certificate will be fully restored.

- E. **VIOLATION OF THE TERMS OF THIS ORDER:** If Dr. Little violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
- F. **REQUIRED REPORTING AND DOCUMENTATION OF REPORTING:**
1. **Required Reporting to Employers and Hospitals:** Within 30 days of the effective date of this Board Order, Dr. Little shall provide a copy of this Board Order to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Little shall promptly provide a copy of this Board Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Little provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within 30 days of the effective date of this Board Order, Dr. Little shall provide a copy of this Board Order to the Ohio Department of Public Safety, Division of Emergency Medical Services.  
  
This requirement shall continue until Dr. Little receives from the Board written notification of his successful completion of probation as set forth in paragraph 4, above.
  2. **Required Reporting to Other State Licensing Authorities:** Within 30 days of the effective date of this Board Order, Dr. Little shall provide a copy of this Board Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. Little further agrees to provide a copy of this Board Order at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license.

This requirement shall continue until Dr. Little receives from the Board written notification of his successful completion of probation as set forth in paragraph 4, above.

3. **Documentation that the Required Reporting Has Been Performed:**  
Dr. Little shall provide the Board with one of the following documents as proof of each required notification within 30 days of the date of each notification required above: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was emailed.

This Order shall become effective thirty days from the date of mailing of the notification of approval by the Board. In the thirty-day interim, Dr. Little shall not undertake the care of any patient not already under his care.

#### **DR. MAHAJAN SECONDED THE MOTION.**

Dr. Egner spoke against the amended Order. She referred the Board to the Conclusions of Law, noting that this is a dermatologist whose cases involve the very thing he does on a daily basis. She stated that she feels that Dr. Little says that he can Mohs surgery when he can't. She also noted that Dr. Little reads his own slides, and she feels that that is a terrible practice. She added that there is a conclusion of law that says that Dr. Little's care led to a patient's death. She stated that she does not understand why the Board isn't permanently revoking this license. She stated that she thinks that this was a very well written, well thought-out case. It is a true minimal standards case. Dr. Egner asked whether the Board thinks that Dr. Little can be retrained to diagnose and treat something that should come to him like that [Dr. Egner snapped her fingers]. She stated that she thinks that the answer is, "no." She also noted that Dr. Little doesn't think that he needs to be retrained at all. Dr. Egner stated that she will vote against the amended Order.

Dr. Mahajan stated that he thinks that a reasonable amount of guidelines and a safety net have been built into this. Dr. Little will be monitored, and he will be out of practice for a year for him to learn.

Dr. Varyani stated that the amendment is for a stayed permanent revocation. Dr. Varyani stated that he agrees with Dr. Egner that Dr. Little should not read his own slides. He would prefer that the slides be read by a dermatopathologist, who is not associated in business with Little, and then he might be all right with

it. Dr. Varyani commented that he won't be practicing for a year anyway.

Dr. Amato stated that that will be covered by PLAS.

Dr. Steinbergh advised that if PLAS doesn't address that piece in its recommendation, the Board won't have the opportunity to require it, unless it does so in the amended Order. Dr. Steinbergh stated that Dr. Little should also have a practice plan approved by the Board prior to his returning to practice and in addition to having his practice monitored. Dr. Steinbergh stated that the Board needs to be able to say to this doctor that it feels confident that he can return to practice.

Dr. Amato stated that he doesn't disagree with that proposal, and asked Dr. Steinbergh where the requirement should be added.

Dr. Steinbergh stated that it should be placed after the PLAS requirement. She stated that the Board could require the practice plan as a reinstatement requirement. She added that the Board could also add the restriction that Dr. Little not read his own slides, and that the interpretation of any pathology specimens will be done by a licensed dermatopathologist.

Dr. Amato asked where that language should be placed.

Dr. Steinbergh stated that it should be placed in the same area as the requirement for a practice plan.

Ms. Thompson suggested that the practice plan requirement would work better as part of the probationary terms, as long as it says that it has to be approved prior his to commencing practice. She asked whether the Board wanted the requirement that a dermatopathologist read his slides to be only during probation, or as a permanent restriction.

Board members indicated that it should be a permanent restriction.

Dr. Mahajan asked whether the PLAS ever says that a doctor is not retrainable and shouldn't practice.

Ms. Thompson stated that PLAS did say, in reference to one physician this Board referred, that he needed to go all the way back to the beginning of his training.

A vote was taken on Dr. Amato's motion to amend.:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- nay
	Dr. Talmage	- abstain
	Dr. Suppan	- aye
	Dr. Madia	- aye

Mr. Hairston	- aye
Dr. Amato	- aye
Dr. Mahajan	- aye
Dr. Steinbergh	- aye
Dr. Varyani	- aye

The motion carried.

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF LARRY JOHN LITTLE, M.D. MR. HAIRSTON SECONDED THE MOTION.** A vote was taken:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- nay
	Dr. Talmage	- abstain
	Dr. Suppan	- aye
	Dr. Madia	- aye
	Mr. Hairston	- aye
	Dr. Amato	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Varyani	- aye

The motion carried.



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.med.ohio.gov](http://www.med.ohio.gov)

June 14, 2006

Larry John Little, M.D.  
175 East Deshler Avenue  
Columbus, OH 43206

Dear Doctor Little:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) On or about January 16, 2004, based upon violations of Sections 4731.22(B)(2), (B)(6), (B)(10) and (B)(20), Ohio Revised Code, the Board entered an Order suspending your certificate to practice medicine and surgery in Ohio for an indefinite period, but not less than 180 days, and imposing terms and conditions for reinstatement, as well as probationary terms and conditions. On or about July 14, 2004, your certificate to practice medicine and surgery in Ohio was reinstated subject to probation.
- (2) From in or about 1989 to 2004, in the routine course of your practice, you undertook the treatment of Patients 1-12 as identified on the attached Patient Key (key confidential to be withheld from public disclosure).

In your dermatological medical care of Patients 1-12, you failed to accurately diagnose and/or document the accurate diagnosis of skin cancers; you obtained inappropriate samples for histological examination of skin cancers; and/or you failed to identify and/or document the identification of the subtype of skin cancer and/or failed to identify and/or document the identification of the extent of skin cancer invasion.

Further, you provided inappropriate treatments for skin cancers and other skin disorders and/or you inadequately performed Mohs procedures for skin cancers.

Further, you failed to closely monitor a patient where required; you permitted a patient to be falsely advised that squamous cell carcinoma [SCC] does not spread; you falsely advised patients that no further treatment was necessary for their skin

*Mailed 6-15-06*

cancers; you failed to undertake and/or document the performance of appropriate work ups; you failed to timely follow up after providing treatments; you failed to re-biopsy potentially recurrent basal cell carcinoma [BCC]; and/or you failed to document why work ups were not performed.

Examples of such conduct include, but are not limited to, the following:

- (a) In your care of Patient 1, when performing Mohs surgery, you inadequately documented how the sample of tissue from the patient's upper lip was sectioned and failed to document how many sections were reviewed in order to document clear margins. Further, you inappropriately treated possible recurrent infiltrative facial BCC with Aldara, which led to a delay of proper diagnosis and appropriate treatment of Patient 1.
- (b) In your care of Patient 2, you inappropriately treated sebaceous hyperplasia with topical clindamycin, Sulfoxyl and Differin.
- (c) Patient 3 was previously treated for non-Hodgkins lymphoma with chemotherapy and was at a higher risk of aggressive non-melanoma skin cancers due to his immunosuppression. In your care of Patient 3, you inappropriately treated Patient 3's recurrent facial SCC with electrodesiccation and curettage [ED&C], and you failed to initially treat Patient 3's SCC with Mohs surgery. Further, you inappropriately informed the patient that no further treatment was necessary.
- (d) In your care of Patient 4, you inadequately performed a Mohs procedure; you failed to re-biopsy a potentially recurrent BCC; you inappropriately treated the patient with Carac; and you failed to accurately diagnose recurrent BCC leading to a delay in diagnosis requiring further Mohs surgery resulting in a larger defect and repair.
- (e) In your care of Patient 5, you inadequately performed a Mohs procedure; you inappropriately treated Patient 5's recurrent BCC with ED&C; you inappropriately treated recurrent BCC with Aldara. Further, you failed to re-biopsy a potentially recurrent BCC; and you inappropriately informed the patient that no further treatment was necessary.
- (f) In your care of Patient 6, you inappropriately treated Patient 6's recurrent BCC with ED&C and you inappropriately treated recurrent BCC with inadequate therapies leading to a large post-operative defect size of 7.1 cm by 6.5 cm and numerous stages of Mohs surgery by a subsequent treating physician to obtain clear margins.

- (g) In your care of Patient 7, after performing ED&C on the patient's SCC, you inappropriately informed Patient 7 that the margins were clear when only fragments of tissue were submitted for pathology, and that further surgery was unnecessary when there was no confirmation of clear margins. Further, you failed to re-biopsy a potentially recurrent SCC and you failed to perform an appropriate work up of Patient 7's potentially invasive or metastatic SCC. Further, you inappropriately treated Patient 7's recurrent SCC with cryosurgery and ED&C; and you provided inadequate treatment of Patient 7's SCC leading to the patient's comorbidity.
- (h) In your care of Patient 8, you inappropriately treated Patient 8's recurrent facial BCC with ED&C and cryosurgery; and you inadequately performed a Mohs procedure.
- (i) In your care of Patient 9, you failed to perform an adequate Mohs procedure. Further, you failed to identify and/or document the identification of the subtype of SCC and failed to identify and/or document the depth of skin cancer invasion. Further, you failed to work up and/or document a work up for local invasion and metastatic disease despite noting a very deep SCC that went to the fascia and despite patient complaints of facial numbness, facial weakness and the presence of nodules in the treated area. Your failure to adequately perform the Mohs procedure and an appropriate work up led to Patient 9's eventual demise.
- (j) In your care of Patient 10, you failed to appropriately recommend a three-month follow up after treatment for SCC; and you inappropriately treated Patient 10's recurrent microinvasive SCC with ED&C.
- (k) In your care of Patient 11, you permitted this patient to be falsely advised that SCC does not spread. Further, you failed to appropriately recommend a three-month follow up after treatment for SCC and you failed to appropriately treat and manage invasive SCC.
- (l) In your care of Patient 12, you inadequately performed a Mohs procedure and you inappropriately treated Patient 12's recurrent BCC with ED&C and cryosurgery.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink, appearing to read "Lance A. Talmage, M.D.", written in a cursive style.

Lance A. Talmage, M.D.  
Secretary

LAT/blt  
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4330 8957  
RETURN RECEIPT REQUESTED

Larry John Little, M.D.  
Page 5

cc: Eric Plinke, Esq.  
Porter, Wright, Morris & Arthur  
41 S. High St.  
Columbus, OH 43215-6194

CERTIFIED MAIL # 7003 0500 0002 4330 8940  
RETURN RECEIPT REQUESTED



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

January 14, 2004

Larry John Little, M.D.  
175 E. Deshler Avenue  
Columbus, OH 43206

Dear Doctor Little

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Sharon W. Murphy, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on January 14, 2004, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.  
Secretary

LAT:jam  
Enclosures

CERTIFIED MAIL NO. 7000 0600 0024 5150 0026  
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.  
CERTIFIED MAIL NO. 7000 0600 0024 5150 0019  
RETURN RECEIPT REQUESTED

Mary Jane McFadden, Esq.  
CERTIFIED MAIL NO. 7000 0600 0024 5150 0002  
RETURN RECEIPT REQUESTED

*Mailed 1-16-04*

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on January 14, 2004, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Larry John Little, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage, M.D.  
Secretary

(SEAL)

January 14, 2004  
Date

**BEFORE THE STATE MEDICAL BOARD OF OHIO**

IN THE MATTER OF

\*

\*

LARRY JOHN LITTLE, M.D.

\*

**ENTRY OF ORDER**

This matter came on for consideration before the State Medical Board of Ohio on January 14, 2004.

Upon the Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

- A. **SUSPENSION:** The certificate of Larry John Little, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 180 days.
  
- B. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Little's certificate to practice medicine and surgery until all of the following conditions have been met:
  - 1. **Application for Reinstatement or Restoration:** Dr. Little shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
  
  - 2. **Additional Evidence of Fitness To Resume Practice:** In the event that Dr. Little has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.

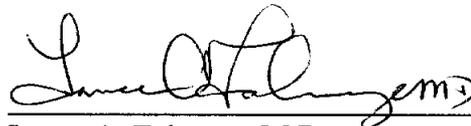
- C. **PROBATION:** Upon reinstatement or restoration, Dr. Little's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years.
1. **Obey the Law:** Dr. Little shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
  2. **Declarations of Compliance:** Dr. Little shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
  3. **Personal Appearances:** Dr. Little shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
  4. **Medical Records Course:** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Little shall complete a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which they are completed.
  5. **Tolling of Probationary Period While Out of State:** In the event that Dr. Little should leave Ohio for three consecutive months, or reside or practice outside the State, Dr. Little must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of this probationary period, unless otherwise determined by motion of the Board in instances where the Board can be assured that the purposes of the probationary monitoring are being fulfilled.
  6. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Little is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.
  7. **Violation of Terms of Probation:** If Dr. Little violates probation in any respect, the Board, after giving him notice and the opportunity to be heard,

may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

- D. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Little's certificate will be fully restored.
- E. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Order, Dr. Little shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Little shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments.
- F. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, Dr. Little shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Little shall also provide a copy of this Order by certified mail, return receipt requested, at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Little shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.

(SEAL)



Lance A. Talmage, M.D.  
Secretary

January 14, 2004  
Date

2004 DEC -4 A 9: 37

**REPORT AND RECOMMENDATION  
IN THE MATTER OF LARRY JOHN LITTLE, M.D.**

The Matter of Larry John Little, M.D., was heard by Sharon W. Murphy, Hearing Examiner for the State Medical Board of Ohio, on September 16, 2003.

**INTRODUCTION**

**I. Basis for Hearing**

- A. By letter dated July 9, 2003, the State Medical Board of Ohio [Board] notified Larry John Little, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board's action was based on allegations pertaining to Dr. Little's prescribing controlled substances to Patient 1, a family member; his signing otherwise blank bulk purchase forms that Patient 1 subsequently completed and used to purchase Demerol for her own use; and his failing to complete and maintain appropriate medical records regarding his prescribing controlled substances for Patient 1. Moreover, the Board's proposed action was based on Dr. Little's prescribing controlled substances for Patients 2 through 6, and his failure to complete and maintain adequate medical records regarding that prescribing.

Finally, the Board alleged that Dr. Little's conduct constitutes the following violations of law:

- "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-08, Ohio Administrative Code, as in effect from November 11, 1998, through March 14, 2001, and since March 15, 2001.
- "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(D), Ohio Administrative Code, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000. Moreover, the Board alleged that, pursuant to Rule 4731-11-02(F), Ohio Administrative Code, a violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.
- "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section

4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.03, Ohio Revised Code, Trafficking in drugs.

Accordingly, the Board advised Dr. Little of his right to request a hearing. (State's Exhibit 8A).

- B. On July 31, 2003, Eric J. Plinke, John P. Carney, and Mary Jane McFadden, Esqs., submitted a written hearing request on behalf of Dr. Little. (State's Exhibit 8B1).

## II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Mark A. Michael, Assistant Attorney General.
- B. On behalf of the Respondent: Eric J. Plinke and Mary Jane McFadden, Esqs.

## **EVIDENCE EXAMINED**

### I. Testimony Heard

Presented by the Respondent

- A. Larry John Little, M.D.
- B. Patient 3

### II. Exhibits Examined

A. Presented by the State

- \* 1. State's Exhibit 1: Medical records for Patient 1.
- \* 2. State's Exhibit 2: Medical records for Patient 2.
- \* 3. State's Exhibit 3: Medical records for Patient 3.
- \* 4. State's Exhibit 4: Medical records for Patients 4 and 5.
- \* 5. State's Exhibit 6: Medical records for Patient 6.
- \* 6. State's Exhibit 7: Confidential Patient Key.
- 7. State's Exhibits 8A, 8B, 8B1, 8C-8L: Procedural exhibits.

- \* 8. State's Exhibits 9 and 10: Documents pertaining to controlled substances maintained by Dr. Little's office.
- 9. State's Exhibits 11 and 12: Statements of employees of Dr. Little's office regarding Dr. Little's office policy concerning controlled substances.
- 10. State's Exhibit 13: Excerpts from the transcript of an April 25, 2002, deposition of Dr. Little.
- \* 11. State's Exhibit 13A: Patient Key for the April 25, 2002, deposition of Dr. Little. [Note: The patient numbers in the transcript differ from the patient numbers at hearing.]

B. Presented by the Respondent

- 1. Respondent's Exhibits A-C: Copies of documents pertaining to protocols for handling controlled substances in Dr. Little's office.
- \* 2. Respondent's Exhibit D: Copy of a March 24, 2002, letter to the Board from Mr. Plinke with attached document from Maged Hanna, B.S., CCDCI, Shepherd Hill Hospital.
- \* 3. Respondent's Exhibit E: Copy of an October 1, 2002, letter to the Board from Mr. Plinke with attached letter from Dr. Little to Richard Whitney, M.D., Medical Director, Shepherd Hill Hospital.
- 4. Respondent's Exhibit F: Copy of January 2, 2003, letter to the Board from Mr. Plinke with attached Certificate of Attendance for Continuing Medical Education.
- \* 5. Respondent's Exhibit G: Copies of letters written in support of Dr. Little.
- \* 6. Respondent's Exhibit H: Copy of an October 28, 2003, letter to the Board from Frederick N. Karaffa, M.D.

\* Note: Exhibits marked with an asterisk have been sealed to protect patient confidentiality.

### **PROCEDURAL MATTERS**

- 1. In its July 9, 2003, notice of opportunity for hearing, the Board alleged that Dr. Little had provided propoxyphene and lorazepam to Patient 2 on October 2, 2001. At hearing, the parties stipulated that those allegations pertained to a patient other than Patient 2 who had the same name as Patient 2. Accordingly, the Board chose not to present evidence regarding

those charges. Nevertheless, the parties stipulated that the Board had had substantial justification to bring the charges based on the information available to the Board at the time it issued the notice of opportunity for hearing. (Tr. 157-158).

2. The hearing record in this matter was held open until November 3, 2003, to give the parties an opportunity to submit additional evidence. These documents were timely submitted and entered into the record as Respondent's Exhibits G and H. (See Hearing Transcript at 21-25, 146-150).

### **SUMMARY OF THE EVIDENCE**

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

#### **General Background**

1. Larry John Little, M.D., testified that he had obtained his medical degree in 1977 from the University of Nebraska. Thereafter, Dr. Little completed a rotating internship at Maricopa County Hospital in Phoenix, Arizona. In 1981, Dr. Little completed a three-year dermatology residency at the University of Nebraska and Creighton University in Omaha, Nebraska. Dr. Little testified that he had become board certified in dermatology in 1981. (Hearing Transcript at [Tr.] 30-31).

After completing his residency, Dr. Little practiced for a short time in Jacksonville, Florida. Shortly thereafter, he opened a private practice in Portsmouth, Ohio. One year later, Dr. Little joined a dermatology practice in Newark and Lancaster, Ohio. Dr. Little remained in that practice for six years. In 1987, Dr. Little started a solo practice in Newark. (Tr. 31-33).

Dr. Little testified that his practice primarily provides services related to surgical dermatology, cosmetic dermatology, and treatment for skin cancers. He added that, although he holds hospital privileges, he performs most of his surgical procedures as outpatient procedures in his office. (Tr. 33-35).

#### **Stipulations**

2. At hearing, the parties stipulated to the following facts:
  - Dr. Little administered and/or personally furnished Demerol, a schedule II controlled substance, to Patient 1, a family member as defined by Rule 4731-11-08(C), Ohio Administrative Code, on at least sixty occasions between the years 1998 and 2002.

- Dr. Little dispensed Darvocet and diazepam to Patient 1 on at least two occasions, on or about September 22, 1993, and on or about January 31, 1994.
- On at least six occasions, Dr. Little signed otherwise blank bulk purchase forms that Patient 1 subsequently completed and used to purchase Demerol for her own use.
- Dr. Little failed to complete and maintain medical records reflecting any examination, evaluation, and/or treatment of Patient 1. Further, Dr. Little's medical records for Patient 1 fail to accurately reflect: the utilization of the above controlled substances in the treatment of Patient 1; any diagnosis and purpose for which the controlled substances reflected in the above administrations and/or personal furnishings were utilized; and any additional information upon which any diagnosis was based. Further, Dr. Little failed to document any justification for administering and/or personally furnishing the above controlled substances to Patient 1 that would constitute an emergency.
- During the period from in or about 1994 to in or about 2001, Dr. Little prescribed, administered and/or personally furnished and/or authorized another to administer and/or furnish schedule II, III and IV controlled substances to Patients 2 through 6.
- Of the medications Dr. Little prescribed, administered, personally furnished, or authorized another to administer or furnish to Patients 2 through 6, Dr. Little documented the following in a dispensing log, but not in a medical record for the patient:

<b>Date</b>	<b>Drug</b>	<b>Patient #</b>
07/05/94	diazepam 5 mg.	2
07/05/94	Darvon 100	2
03/16/95	Darvon N-100	3
01/15/96	Demerol 50 mg.	6
05/23/96	diazepam 10 mg. #2	2
01/02/97	Darvon N	3
03/04/97	Darvon	4
03/05/97	Darvon	4
03/11/97	diazepam 2.5 mg.	2
05/27/97	Darvocet N-100	4
07/17/97	Darvon	4
01/19/99	diazepam 10 mg.	4
10/28/99	diazepam 10 mg.	6
12/30/99	Lortab 5/500	4

- Moreover, of the medications Dr. Little prescribed, administered, personally furnished, or authorized another to administer or furnish to Patients 2 through 6, Dr. Little documented the diagnosis or purpose for prescribing the medication, but he did not document any examination or evaluation of the patient for the following controlled substances:

<b>Date</b>	<b>Drug</b>	<b>Patient #</b>
05/18/97	Vicodin	6
12/22/97	Demerol 75 mg.	6
01/20/98	Darvocet N-100	6
08/10/98	Lortab 10/500	6
05/12/99	Dalmane 15 mg.	4
12/30/99	Lortab 10/500	4
12/30/99	Lortab 10/500	6
01/31/00	Dalmane 15 mg.	4
03/16/00	Darvocet N-100	6
09/12/00	diazepam 5 mg.	4
01/08/01	flurazepam 15 mg.	4
03/08/01	Xanax 5 mg.	4
08/24/01	Valium 5 mg.	6
12/20/01	Lortab 10/500	4

- Furthermore, of the medications Dr. Little prescribed, administered, personally furnished, or authorized another to administer or furnish to Patients 2 through 6, Dr. Little did not adequately document in the patient chart the following prescriptions for controlled substances:

<b>Date</b>	<b>Drug</b>	<b>Patient #</b>
01/20/00	Phenergan w/ codeine 4 oz.	5
01/03/01	Lortab 7.5 mg.	4

- Dr. Little failed to complete and maintain medical records reflecting any examination, evaluation, diagnosis and/or purpose for which the controlled substances reflected in the above prescriptions, administrations and/or personal furnishings were utilized, and any additional information upon which any diagnosis was based.

(Tr. 7-13).

3. In addition, the parties stipulated to the following conclusions of law:

- The conduct of Dr. Little constitutes “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-08, Ohio Administrative Code, as in effect from November 11, 1998, through March 14, 2001, and since March 15, 2001.
- The conduct of Dr. Little constitutes “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(D), Ohio Administrative Code, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000.
- Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, the violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

(Tr. 14).

#### **Dr. Little’s Testimony Regarding Patient 1**

4. Dr. Little testified that Patient 1 is his wife of twenty-seven years. Dr. Little added that Patient 1 is a registered nurse, who had been employed in his office for many years. Dr. Little testified that Patient 1 had helped him establish his practice, and had functioned as an administrator of the practice. Patient 1’s office duties included ordering controlled substances for the office. (Tr. 29, 35-36, 110-112).

Dr. Little testified that, prior to 1997, Patient 1 had been a very active, physically fit, individual. However, in approximately 1997, Patient 1 had started getting severe headaches. After the headaches started, Dr. Little and Patient 1 consulted numerous physicians to diagnose and treat her discomfort. The consulted physicians included a neurologist, an ophthalmologist, a neuro-ophthalmologist, and Patient 1’s family physician. Patient 1 was diagnosed with static migraines, which, Dr. Little stated, are migraine headaches that do not end. (Tr. 36-38).

Dr. Little testified that Patient 1 had tried various traditional treatments for static migraine headaches, such as Imitrex, anti-seizure medicines, and antidepressants, and that all had been ineffective. In 1998, Patient 1 started to receive oral and injectable Demerol from her family physician, which had provided some relief from the pain. Nevertheless, Dr. Little testified that, after 1998, Patient 1 had been unable to work an eight-hour day. (Tr. 36-40).

Dr. Little stated that Patient 1 had started to visit the emergency room frequently for shots of Demerol to break the cycle of headaches. He further stated that Demerol injections had controlled her pain for a few days at a time and, in an attempt to help her, he had started giving her Demerol injections in the office. Dr. Little testified that, when he gave Demerol injections to Patient 1, he had been aware of the Board's rules prohibiting such conduct. Dr. Little testified that he had provided the injections with the thought that it was "emergency" intervention. He had wanted only to "make the pain go away." (Tr. 40-41, 46, 118).

Dr. Little testified that, for a short time, Patient 1 had appeared to be improving, despite the fact that her physicians had not initiated any new treatment. Dr. Little testified that he had thought it unusual, but was happy to see her doing well. Nevertheless, in late 1999, Patient 1's mood had started to change. Dr. Little testified that he had had a "sixth sense" that something was wrong, and that he and Patient 1 had had a number of confrontations about it. Dr. Little further testified that he had started to investigate possible reasons for Patient 1's mood changes. He stated that, eventually, he discovered that Patient 1 had been using Demerol, which she had diverted from his office. (Tr. 41, 47-48).

Dr. Little testified that he had been very confused. He stated that he had not had any experience with drug diversion, and that he had had "no clue" about drug dependency. He added that he had believed that a person could simply "stop" using the substance to which he or she was addicted. Dr. Little testified that, not knowing what to do, he had consulted a mental health professional who recommended that Patient 1 enter treatment for chemical dependency at Parkside Hospital. (Tr. 41-42, 48-49).

Patient 1 had entered Parkside Hospital in December 1999. She remained there for approximately three weeks for detoxification. After discharge, Patient 1 participated in the outpatient program for approximately ninety days. (Tr. 49-50).

Dr. Little testified that, during this time, Patient 1 had continued to be responsible for ordering controlled substances for the office. Dr. Little explained that he had not understood the nature of addiction at that time and, because Patient 1 had gone through detoxification, he had not been concerned regarding her access to controlled substances. (Tr. 124-129).

In July 2000, Patient 1 relapsed. She returned to Parkside Hospital for a second detoxification, and remained there for less than a week. She returned to her work and home duties. After discharge, Patient 1 relied on Imitrex to treat her headaches. Nevertheless, she also suffered several other health problems, and was "deteriorating physically." Dr. Little testified that Patient 1 had been unable to work or care for the family. She continued to see a number of physicians, and had been prescribed an antidepressant by her psychiatrist. (Tr. 50-53).

Dr. Little testified that, in mid-2001, he had discovered that Patient 1 was using Demerol again. He made the discovery after finding needle marks on her hip. Dr. Little further

testified that he later discovered that Patient 1 had hidden stashes of Demerol throughout their home. Nevertheless, Dr. Little stated that he had “made a big mistake” and had used “horrible judgment” after realizing that Patient 1 had relapsed. Dr. Little testified that, not understanding chemical dependency, and knowing that Patient 1 had been hospitalized twice without success, he had decided that he and Patient 1 should try to manage the problem themselves. (Tr. 53-55, 130, 134-135).

To reach this end, Dr. Little testified that he had initiated a procedure by which he would provide Demerol to Patient 1 in a very controlled manner. Dr. Little believed that Patient 1 was doing well under this treatment plan, but later discovered that Patient 1 had been supplementing what he gave her. He also learned that Patient 1 had been stockpiling her medications, and that Patient 1 had been using order forms from his office to purchase medications for her own use. (Tr. 54-58, 130-131-132, 135-138).

Dr. Little testified that Patient 1 had been able to do this under the procedure for ordering controlled substances which had been in effect in his office at that time. Dr. Little explained that, at that time, Patient 1 would advise him when controlled substances were needed in the office. Dr. Little would instruct Patient 1 to order the medication, and he signed blank forms by which Patient 1 could order the drugs. Patient 1 ordered more Demerol than the office required, and pilfered the additional Demerol as it came into the office. (Tr. 54-58, 130-131-132, 135-138).

Dr. Little testified that, in December 2001, Dr. Little and Patient 1 decided that Patient 1 should again attempt treatment for chemical dependency. Patient 1 entered Parkside Hospital, under the care of Edna Jones, M.D. Three days later, however, Patient 1 left the hospital against medical advice. (Tr. 60-62).

Dr. Little testified that he had had no idea what to do next. (Tr. 61).

5. Dr. Little testified that, a few weeks after Patient 1 had left the hospital against medical advice, Mr. McCafferty, an investigator from the Board, and Mr. Padgett, an investigator from the Pharmacy Board, had visited his office. Mr. McCafferty and Mr. Padgett asked to see Dr. Little’s records. They also interviewed Dr. Little and Patient 1 individually. Dr. Little testified that he had cooperated with the investigation and had turned over the records that they requested. Dr. Little further testified that the investigation had been very stressful, but had come as a relief. (Tr. 59, 62-64).

Dr. Little further testified that Mr. McCafferty and Mr. Padgett had instructed him in ways to keep his controlled substances more secure, and advised him to get help for Patient 1. Dr. Little testified that he then contacted Frederick Karaffa, M.D., at Shepherd Hill Hospital [Shepherd Hill]. Shortly thereafter, Dr. Little met with Dr. Karaffa and Dr. Whitney, and Patient 1 was admitted to Shepherd Hill later that day. Patient 1 remained at Shepherd Hill for ninety days. Upon discharge, she entered the Shepherd Hill outpatient program.

Dr. Little further testified that Patient 1 has maintained a successful recovery program since that time. (Tr. 64-66; Resp. Ex. H).

6. Dr. Little testified that he now realizes that he had been an “enabler,” acting in a codependent manner in Patient 1’s illness. He added that he had trusted Patient 1, and had never had any reason to distrust her. Dr. Little testified that he had believed that the medications were to be used only by patients. He admitted, however, that he had not reviewed any invoices or bills to assure that the drugs were being ordered properly. (Tr. 55-58, 130-131-132, 135-138).

Regarding his ignorance about chemical dependency, Dr. Little testified that,

I really didn’t have a feel for what was going on. I really didn’t have any education about it. I didn’t ever really meet the people that were involved with [Patient 1’s treatment] and they didn’t have a program to say what was – does the spouse do, what do I do to help keeping this from coming back. I mean, because I’m part of the problem here. I am thinking I’m hurting her, the person that I most love in my life, I am hurting as we go. Not so much physically, but emotionally, spiritually. I mean, it’s killing me, it’s killing her and we’re in this tango here. I’m hurting the person I most love in my life.

(Tr. 61).

7. Dr. Little testified that no matter how secure his office had been during the time Patient 1 was using, it would not have prevented his inappropriate conduct. Dr. Little explained that “nothing short of a brick wall” would have stopped him before he learned what he has learned about chemical dependency at Shepherd Hill. (Tr. 73-74).

Dr. Little testified that, while Patient 1 was at Shepherd Hill, he had attended family meetings to learn about drug dependency and family dynamics, enabling, co-dependency, and dealing with children. Dr. Little also participated in an eight-week program at Shepherd Hill for family counseling. Dr. Little testified that he learned a significant amount about chemical dependency through that eight-week program and, as a result, he realizes now what a destructive role he played in Patient 1’s illness. (Tr. 74-80; Resp. Exs. E, H).

In addition, Dr. Little stated that, in December 2002, he had attended a forty-hour course, entitled “Intensive Course in Controlled Substance Management,” at Case Western Reserve University. He stated that the course provided even more insight in to the disease of chemical dependency and the dangers imposed by his conduct. (Tr. 80-81; Resp. Ex. F).

Dr. Little testified that Patient 1 no longer works in his office, and will not do so in the foreseeable future. Dr. Little further testified that he no longer keeps Demerol in the office, and is changing his practice so that he no longer needs to use many controlled substances. Moreover, Dr. Little consulted with Dr. Karaffa, Dr. Whitney, and the Impairment Committee of the Licking Memorial Hospital for advice on proper medication prescribing, knowledge of

the disease of chemical dependence, and the rules concerning proper use of scheduled drugs. Dr. Little further testified that he has followed the advice of Mr. McCafferty and Mr. Padgett, and has instituted more secure practices regarding the controlled substances that are used in his office. (Tr. 66-70; Respondent's Exhibits [Resp. Exs.] A-C, H).

Dr. Little added that he now knows what to do should Patient 1 relapse again. He stated that his role would be that of a caring husband and nothing more. He stated that he would contact Shepherd Hill immediately, and support Patient 1 as she reentered treatment. Dr. Little testified that he also knows the signs of drug abuse, and that he would be better prepared to respond to them if necessary. Dr. Little testified that he has also learned to set boundaries with Patient 1. Finally, he has learned that he can not "fix" everything, and sometimes you have to just "let things crash." (Tr. 82-84).

#### **Dr. Little's Testimony Regarding Patients 2 through 6**

8. Dr. Little testified that Patient 2 was an employee in his office, and that she had worked as a medical assistant for several years until she left in 1998. Dr. Little further testified that Patient 3 is a registered nurse who has worked for him for fifteen years and who continues to work for him. Patient 4 is a medical assistant and aesthetician who worked for Dr. Little for approximately five years, but ceased employment one week prior to the hearing. Patient 5 is the son of Patient 4. Finally, Patient 6 is a licensed practical nurse who worked for Dr. Little for approximately eight years, but who ceased working for him two years ago. (Tr. 29, 101).
9. Dr. Little testified that, in the past, he had had an informal policy in his office whereby he would provide medical treatment to an employee if the employee had a problem that he was competent to treat. Dr. Little testified that, for the most part, the services he provided were related to dermatology. Dr. Little further testified that, when he provided medical treatment to an employee, he had not charged the employee. (Tr. 101, 141-142).

Dr. Little testified that he had maintained medical charts for employees to whom he provided medical treatment. Moreover, if he provided a controlled medication to an employee, he usually documented it in the controlled substances dispensing logs. (Tr. 103; St. Exs. 1-6, 9, 10).

Dr. Little acknowledged that some of the treatment he provided to his employees was not documented in their medical records, and the provision of some controlled substances were not included in the dispensing logs. Dr. Little testified that the same failure to document would not have occurred with his regular patients. He stated that the procedures for patients and employees receiving treatment were different. Dr. Little explained that, for patients, the medical records were readied for the visit prior to the time the patient arrived. For employees, however, the medical record was often collected after the treatment was provided. Dr. Little testified that this had led to the failure to document as noted in the stipulations. (Tr. 102-104).

10. Dr. Little testified that he had not kept a medical record for Patient 5, the son of Patient 4. Dr. Little further explained that he had written a prescription for Patient 5 when Patient 4 told him that Patient 5 had had a cough for a few days, and that he had been scheduled to see a pediatrician a few days later. Dr. Little testified that he had prescribed Phenergan with codeine, and had simply recorded it in the mother's chart. Dr. Little admitted that he had not seen Patient 5 prior to prescribing for him. Dr. Little acknowledged that he had been "too casual" about treating Patient 5. (Tr. 143-144).
11. Dr. Little testified that he no longer provides controlled substances or cosmetic surgery procedures to his employees. He testified that he now appreciates the dangers inherent in treating anyone other than in a formal physician-patient relationship. Dr. Little testified that the deficiencies revealed in his treatment of Patients 2 through 6 could not occur under his revised office policies. (Tr. 105-107; Resp. Exs. A-C).

### **Testimony of Patient 3**

12. Patient 3 testified at hearing on behalf of Dr. Little. Patient 3 testified that she is employed as a registered nurse in Dr. Little's office. Patient 3 testified that, during the course of her employment with Dr. Little, Dr. Little has, on occasion, provided medical treatment to her. She further testified that he had provided medications to her. (Tr. 86-87).

Patient 3 testified that Dr. Little had given her a Darvon tablet on one occasion in 1995, and on a second occasion in January 1997. She stated that she had received the doses of Darvon for shoulder and neck discomfort. Patient 3 testified that she had tried "Aspirin and other things" to treat the pain and had asked Dr. Little if she could try something stronger. Dr. Little suggested that she try Darvon, and Patient 3 accepted. (Tr. 87-89, 96, 98).

Patient 3 further testified that the provision of the Darvon tablet in January 1997 had not been recorded in her medical record. Patient 3 explained that, because there are so many charts on any given day, it was likely that no one had retrieved her chart to record the medication dispensation. Patient 3 distinguished this situation from the provision of medication to a patient in Dr. Little's office. Patient 3 stated that, when a patient is seen, the medical record is gathered prior to the patient coming to the office. When the patient is in the office, the treatment provider has the medical record at all times. She stated that the treatment provider tries to complete the chart as the patient is leaving the office or shortly thereafter. Patient 3 stated that, generally, Dr. Little is very meticulous about charting. (Tr. 89-92).

### **Letters of Support**

13. Dr. Little submitted numerous letters of support written by colleagues and patients. (Resp. Ex. G).

### FINDINGS OF FACT

1. Larry John Little, M.D., administered and/or personally furnished Demerol, a schedule II controlled substance, to Patient 1, a family member as defined by Rule 4731-11-08(C), Ohio Administrative Code, on at least sixty occasions between the years 1998 and 2002. Further, Dr. Little dispensed Darvocet and diazepam to Patient 1 on at least two occasions, on or about September 22, 1993, and on or about January 31, 1994. In addition, on at least six occasions, Dr. Little signed otherwise blank bulk purchase forms that Patient 1 subsequently completed and used to purchase Demerol for her own use.

Furthermore, Dr. Little failed to complete and maintain medical records reflecting any examination, evaluation, and/or treatment of Patient 1. Moreover, Dr. Little's medical records for Patient 1 fail to accurately reflect: the utilization of the above controlled substances in the treatment of Patient 1; any diagnosis and purpose for which the controlled substances reflected in the above administrations and/or personal furnishings were utilized; or any additional information upon which any diagnosis was based. Finally, Dr. Little failed to document any justification for administering and/or personally furnishing the above controlled substances to Patient 1 that would constitute an emergency.

2. During the period from in or about 1994 to in or about 2001, Dr. Little prescribed, administered and/or personally furnished and/or authorized another to administer and/or furnish schedule II, III, and IV controlled substances to Patients 2 through 6.

Of the medications Dr. Little prescribed, administered, personally furnished, or authorized another to administer or furnish to Patients 2 through 6, Dr. Little documented the following in a dispensing log, but not in a medical record for the patient:

Date	Drug	Patient Number
07/05/94	diazepam 5 mg.	2
07/05/94	Darvon 100	2
03/16/95	Darvon N-100	3
01/15/96	Demerol 50 mg.	6
05/23/96	diazepam 10 mg. #2	2
01/02/97	Darvon N	3
03/04/97	Darvon	4
03/05/97	Darvon	4
03/11/97	diazepam 2.5 mg.	2
05/27/97	Darvocet N-100	4
07/17/97	Darvon	4
01/19/99	diazepam 10 mg.	4
10/28/99	diazepam 10 mg.	6
12/30/99	Lortab 5/500	4

Moreover, of the medications Dr. Little prescribed, administered, personally furnished, or authorized another to administer or furnish to Patients 2 through 6, Dr. Little documented the diagnosis or purpose for prescribing the medication, but he did not document any examination or evaluation of the patient for the following controlled substances:

<b>Date</b>	<b>Drug</b>	<b>Patient Number</b>
05/18/97	Vicodin	6
12/22/97	Demerol 75 mg.	6
01/20/98	Darvocet N-100	6
08/10/98	Lortab 10/500	6
05/12/99	Dalmane 15 mg.	4
12/30/99	Lortab 10/500	4
12/30/99	Lortab 10/500	6
01/31/00	Dalmane 15 mg.	4
03/16/00	Darvocet N-100	6
09/12/00	diazepam 5 mg.	4
01/08/01	flurazepam 15 mg.	4
03/08/01	Xanax 5 mg.	4
08/24/01	Valium 5 mg.	6
12/20/01	Lortab 10/500	4

Furthermore, of the medications Dr. Little prescribed, administered, personally furnished, or authorized another to administer or furnish to Patients 2 through 6, Dr. Little did not adequately document in the patient chart the following prescriptions for controlled substances:

<b>Date</b>	<b>Drug</b>	<b>Patient Number</b>
01/20/00	Phenergan w/ codeine 4 oz.	5
01/03/01	Lortab 7.5 mg.	4

Finally, Dr. Little failed to complete and maintain medical records reflecting any examination, evaluation, diagnosis and/or purpose for which the controlled substances reflected in the above prescriptions, administrations and/or personal furnishings were utilized, and any additional information upon which any diagnosis was based.

3. The State did not present any evidence regarding the allegations made in the July 9, 2003, notice of opportunity for hearing that pertaining to the provision of propoxyphene and lorazepam to Patient 2 on October 2, 2001. Accordingly, the State did not prove those allegations.

### CONCLUSIONS OF LAW

1. The conduct of Larry John Little, M.D., as set forth in Findings of Fact 1, that occurred on or after November 11, 1998, constitutes “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-08, Ohio Administrative Code, as in effect from November 11, 1998, through March 14, 2001, and since March 15, 2001.
2. The conduct of Dr. Little, as set forth in Findings of Fact 1 and 2, constitutes “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(D), Ohio Administrative Code, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000.

Moreover, pursuant to Rule 4731-11-02(F), Ohio Administrative Code, the violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

3. The Board alleged that the conduct of Dr. Little, as set forth in Findings of Fact 1, constitutes “[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,” as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.03, Ohio Revised Code, Trafficking in drugs. Recent decisions by the Franklin County Court of Common Pleas suggest that, when a physician provides medication in the bona fide treatment of patients, more than a violation of rules and regulations must be shown to find a violation of trafficking in drugs. Instead, the evidence must demonstrate a criminal intent on the part of the physician. See *Warrick Barrett, M.D. v. Ohio State Medical Board* (May 23, 2002), Franklin C.P. No. 01CVF-08-8376; *Wallace Cobner Adamson, M.D. v. Ohio State Medical Board* (Aug. 11, 2003), Franklin C.P. No. 02CVF12-14459. See also *State v. McCarthy* (1992), 65 Ohio St.3d 589.

In the present case, Dr. Little admitted that he had provided Demerol to his wife knowing that to do so was in violation of the law. Accordingly, the evidence supports the conclusion that the conduct of Dr. Little constitutes “[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,” as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.03, Ohio Revised Code, Trafficking in drugs.

\* \* \* \* \*

The evidence presented at hearing overwhelmingly supported the State’s allegations that Dr. Little’s conduct violated statutes and rules governing the practice of medicine and surgery in

Ohio. Moreover, Dr. Little's loose management of controlled substances contributed significantly to Patient 1's escalating disease. Such conduct warrants severe sanction by the Board.

On the other hand, there is no evidence that Dr. Little was motivated by greed or self-interest when he engaged in this inappropriate conduct. Moreover, Dr. Little was cooperative and forthright during the investigation, and appeared to be genuinely remorseful at hearing. Finally, and most significantly, Dr. Little has made considerable effort to education himself and to improve procedures in his office. It appears that there is little chance that Dr. Little will repeat his transgressions at any time in the future.

### **PROPOSED ORDER**

It is hereby ORDERED that:

- A. **SUSPENSION:** The certificate of Larry John Little, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for an indefinite period of time, but not less than 180 days.
- B. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Little's certificate to practice medicine and surgery until all of the following conditions have been met:
  1. **Application for Reinstatement or Restoration:** Dr. Little shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
  2. **Additional Evidence of Fitness To Resume Practice:** In the event that Dr. Little has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.
- C. **PROBATION:** Upon reinstatement or restoration, Dr. Little's certificate shall be subject to the following **PROBATIONARY** terms, conditions, and limitations for a period of at least three years.
  1. **Obey the Law:** Dr. Little shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
  2. **Declarations of Compliance:** Dr. Little shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly

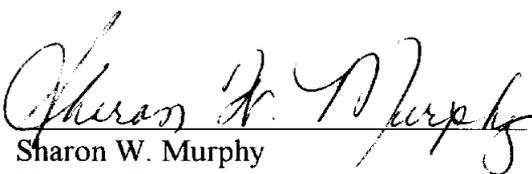
declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Little shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
  4. **Medical Records Course**: Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Little shall complete a course on maintaining adequate and appropriate medical records, such course to be approved in advance by the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which they are completed.
  5. **Tolling of Probationary Period While Out of State**: In the event that Dr. Little should leave Ohio for three consecutive months, or reside or practice outside the State, Dr. Little must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of this probationary period, unless otherwise determined by motion of the Board in instances where the Board can be assured that the purposes of the probationary monitoring are being fulfilled.
  6. **Noncompliance Will Not Reduce Probationary Period**: In the event Dr. Little is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.
  7. **Violation of Terms of Probation**: If Dr. Little violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
- D. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Little's certificate will be fully restored.
- E. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS**: Within thirty days of the effective date of this Order, Dr. Little shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Little shall provide a copy of this Order to all employers or entities with which

he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments.

- F. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, Dr. Little shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Little shall also provide a copy of this Order by certified mail, return receipt requested, at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Little shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.

  
Sharon W. Murphy  
Hearing Examiner



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

## EXCERPT FROM THE DRAFT MINUTES OF JANUARY 14, 2004

### REPORTS AND RECOMMENDATIONS

Ms. Sloan announced that the Board would now consider the findings and orders appearing on the Board's agenda. She asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and order, and any objections filed in the matters of: Mark L. Allen, M.D.; Glenda M. Dahlquist, M.D.; Joseph W. Fischkelta, P.A.; Timothy A. Gooden, M.D.; Richard W. Liss, M.D.; Larry John Little, M.D.; and Geoffrey D. Snyder, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

Ms. Sloan asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye

Dr. Steinbergh - aye  
Ms. Sloan - aye

Ms. Sloan noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Ms. Sloan stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....  
LARRY JOHN LITTLE, M.D.  
.....

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. MURPHY’S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF LARRY JOHN LITTLE, M.D. DR. KUMAR SECONDED THE MOTION.**  
.....

A vote was taken on Dr. Steinbergh’s motion to approve and confirm:

Vote: Mr. Albert - abstain  
Dr. Egner - nay  
Dr. Talmage - abstain  
Dr. Bhati - nay  
Dr. Buchan - nay  
Dr. Kumar - aye  
Mr. Browning - aye  
Dr. Davidson - aye  
Dr. Robbins - aye  
Dr. Garg - abstain  
Dr. Steinbergh - aye  
Ms. Sloan - aye

The motion carried.



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

July 9, 2003

Larry John Little, M.D.  
175 E Deshler Avenue  
Columbus, OH 43206

Dear Doctor Little:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- (1) You administered and/or personally furnished Demerol, a schedule II controlled substance, to Patient 1 (as identified on the attached Patient Key- Key confidential to be withheld from public disclosure), a family member as defined by Rule 4731-11-08(C), Ohio Administrative Code, on at least 60 occasions between the years 1998 and 2002.

Further, you dispensed Darvocet and diazepam to Patient 1 on at least two occasions, on or about September 22, 1993, and on or about January 31, 1994.

Further, on at least six occasions, you signed otherwise blank bulk purchase forms that Patient 1 subsequently completed and used to purchase Demerol for her own use.

Further, you failed to complete and maintain medical records reflecting any examination, evaluation, and/or treatment of Patient 1. Further, your medical records for Patient 1 fail to accurately reflect the utilization of the above controlled substances in the treatment of Patient 1 as well as any diagnosis and purpose for which the controlled substances reflected in the above administrations and/or personal furnishings were utilized, and any additional information upon which any diagnosis was based. Further, you failed to document any justification for administering and/or personally furnishing the above controlled substances to Patient 1 that would constitute an emergency.

- (2) During the period from in or about 1994 to in or about 2001, you prescribed, administered and/or personally furnished and/or authorized another to administer and/or furnish schedule II, III and IV controlled substances to Patients 2-6 (as identified on the attached Patient Key- Key confidential to be withheld from public disclosure), as follows:

Date	Drug	Patient Number
07/05/94	diazepam 5 mg.	2
07/05/94	Darvon 100	2
03/16/95	Darvon N-100	3

*Mailed 7/10/03  
7/11/03*

01/15/96	Demerol 50 mg.	6
05/23/96	diazepam 10 mg. #2	2
01/02/97	Darvon N	3
03/04/97	Darvon	4
03/05/97	Darvon	4
03/11/97	diazepam 2.5 mg.	2
05/18/97	Vicodin	6
05/27/97	Darvocet N-100	4
07/17/97	Darvon	4
12/22/97	Demerol 75 mg.	6
01/20/98	Darvocet N-100	6
08/10/98	Lortab 10/500	6
01/19/99	diazepam 10 mg.	4
05/12/99	Dalmane 15 mg.	4
10/28/99	diazepam 10 mg.	6
12/30/99	Lortab 5/500	4
12/30/99	Lortab 10/500	4
12/30/99	Lortab 10/500	6
01/20/00	Phenergan w/ codeine 4 oz.	5
01/31/00	Dalmane 15 mg.	4
03/16/00	Darvocet N-100	6
09/12/00	diazepam 5 mg.	4
01/03/01	Lortab 7.5 mg.	4
01/08/01	flurazepam 15 mg.	4
03/08/01	Xanax 5 mg.	4
08/24/01	Valium 5 mg.	6
10/02/01	propoxyphene 100 mg.	2
10/02/01	Lorazepam 1 mg.	2
12/20/01	Lortab 10/500	4

Nevertheless, you failed to complete and maintain medical records reflecting any examination, evaluation, diagnosis and/or purpose for which the controlled substances reflected in the above prescriptions, administrations and/or personal furnishings were utilized, and any additional information upon which any diagnosis was based.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above that occurred on or after November 11, 1998, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-08, Ohio Administrative Code, as in effect from November 11, 1998, through March 14, 2001, and since March 15, 2001.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section

Larry John Little, M.D.

Page 3

4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(D), Ohio Administrative Code, General Provisions, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.03, Ohio Revised Code, Trafficking in drugs.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

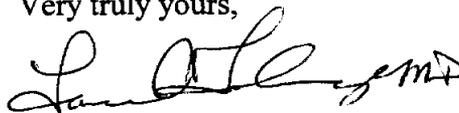
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.  
Secretary

LAT/blt

Larry John Little, M.D.

Page 4

Enclosures

CERTIFIED MAIL # 7000 0600 0024 5141 7249  
RETURN RECEIPT REQUESTED

cc: Eric Plinke, Esq.  
Porter, Wright, Morris & Arthur  
41 S. High St.  
Columbus, OH 43215-6194

CERTIFIED MAIL # 7000 0600 0024 5141 7256  
RETURN RECEIPT REQUESTED

cc: Mary Jane McFadden, Esq.  
McFadden Winner & Savage  
175 S. Third St., Suite 210  
Columbus, OH 43215-5134

CERTIFIED MAIL # 7000 0600 0024 5141 7263  
RETURN RECEIPT REQUESTED