

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

2011 AUG -5 AM 7:43

CLERK OF COURTS

MODESTO FONTANEZ, M.D. :

APPELLANT, :

vs. :

STATE MEDICAL BOARD
OF OHIO :

APPELLEE. :

CASE NO. 11CVF 03 1211

JUDGE RICHARD SHEWARD

FINAL APPEALABLE ORDER

TERMINATION NO. <u>10</u>
BY: <u>PG 8/4/11</u>

DECISION AND ENTRY

**AFFIRMING THE JANUARY 12, 2011 ORDER OF THE STATE MEDICAL BOARD
OF OHIO
AND DENYING LEAVE TO SUPPLEMENT THE RECORD**

Rendered this 4 day of August 2011
Sheward, J.

This matter is before this Court pursuant to the R.C. 119.12 appeal of Appellant Modesto Fontanez from a January 12, 2011 Order of the State Medical Board of Ohio ("Board"). In its January 12, 2011 Order, the Board permanently revoked the appellant's license to practice allopathic medicine and surgery in the state of Ohio. See R.C. 4731.22(B)(6).

The Board issued a Notice of Opportunity for Hearing to the appellant on November 12, 2008. See State's Exhibit 3. The November 12, 2008 Notice alleged that the appellant had practiced below the minimal standards of care with regard to the neurosurgical treatment of two patients.

The November 12, 2008 Notice alleged the following:

- (1) From in or about November 2005 to in or about January 2006, you undertook the care of Patients 1 and 2, as identified on the attached Patient Key (Patient Key confidential and to be withheld from public disclosure). In the regular course of your neurosurgical

treatment of Patients 1 and 2, you practiced below minimal standards of care, including, but not limited to, the following:

- (a) In the course of treating Patient 1 for an intraspinal, intradural tumor at the L1-L2 level, you failed to distinguish normal spinal cord tissue from abnormal tumor tissue, and inappropriately performed a bilateral laminectomy at T12, causing major neurological impairment as a result of biopsying tissue within a normal spinal cord.
- (b) After Patient 2 presented with a diagnosis of segmental and foraminal stenosis at L3-L4, L4-L5 and L5-S1, you performed a decompressive lumbar laminectomy that resulted in dural tear, and caused the patient to develop a spinal fluid leak. You failed to diagnose and/or document the diagnosis of and/or failed to appropriately treat said spinal fluid leak, despite the presence of headaches in the upright position following spinal surgery, necessitating a repeat surgery by another neurosurgeon.

See State's Exhibit 3.

Following the appellant's request, a hearing was held on November 18, 2009. The hearing examiner issued a Report and Recommendation to the Board on November 12, 2010. The hearing examiner concluded that the appellant "was not a trustworthy person," and that "[H]is written and testimonial statements were not only contradicted by reliable evidence such as objective clinical data, but his statements were internally inconsistent as well." See November 12, 2010 Report and Recommendation. The hearing examiner concluded that a permanent revocation of appellant's license was necessary to ensure public safety.

Thus, the hearing examiner recommended to the Board that the appellant's license to practice allopathic medicine and surgery in the state of Ohio be permanently revoked. See November 12, 2010 Report and Recommendation. The appellant filed objections to the hearing examiner's Report and Recommendation on December 15, 2010. Moreover, the appellant's request to personally appear before the Board and present his case was granted. See January 12, 2011 Board Minutes. The Board issued an Order on January 12, 2011 approving and confirming the hearing examiner's Report and Recommendation and thus, overruled the appellant's objections and permanently revoked the appellant's license to practice allopathic medicine and surgery in the state

of Ohio. The appellant filed this appeal on January 26, 2011. On May 3, 2011, the Appellant filed a Motion to Supplement the Record with a Partial Transcript from the January 12, 2011 State Med Board Adjudication. On July 1, 2011, the State filed a Memorandum in Opposition. On July 15, 2011, the Appellant filed a Reply.

FINDINGS OF FACT

In her November 12, 2010 Report and Recommendation, Hearing Examiner Patricia A. Davidson made the following findings of fact:

1. From in or about November 2005 to in or about January 2006, Modesto Fontanez, M.D., undertook the care of Patient 1, who is identified in a patient key that has been placed under seal to protect patient confidentiality.
 - (a) In the regular course of his neurosurgical treatment of Patient 1 for an intraspinal, intradural tumor at the L1-L2 level, Dr. Fontanez inappropriately performed a bilateral laminectomy at T12.
 - (b) In performing surgical procedures at T12, Dr. Fontanez failed to distinguish normal spinal cord tissue from abnormal tumor tissue. Dr. Fontanez excised tissue from a normal spinal cord.
 - (c) Dr. Fontanez's acts, conduct and/or omissions caused impairment to Patient 1.

There is sufficient evidence, however, to establish that "major" impairment resulted from the biopsy, as alleged. The urologist who examined Patient 1 opined that the post-operative neurological deficits were secondary to the tumor as well as the surgery. The medical record is clear that Patient 1 was already experiencing significant neurological impairment (weakness, difficulty walking, etc.) prior to the surgery. Although Dr. Poolos opined in his written report that Dr. Fontanez has caused "damage" to spinal tissues and that the patient had experienced "some neurological sequelae" following the surgery, including lack of bladder control. However, no medical records establish that the patient's bladder problems persisted beyond December 9, 2005, when he was discharged from the hospital a few days after surgery. In sum, the Hearing Examiner did not find sufficient evidence to characterize the amount of impairment caused by Dr. Fontanez as "major," with regard to impairment that is distinguishable from that caused by the tumor.

2. From in or about November 2005 to in or about January 2006, Dr. Fontanez undertook the care of Patient 2, who is identified in a patient key that has been placed under seal to protect patient confidentiality.

- (a) Patient 2's preoperative diagnosis was segmental and foraminal stenosis at L3-L4, L4-L5 and L5-S1. In the course of his neurological treatment of Patient 2, Dr. Fontanez performed decompressive lumbar laminectomies, resulting in a dural tear that caused the patient to develop a spinal fluid leak.
- (b) After Patient 2 developed a spinal fluid leak, Dr. Fontanez failed to diagnose and/or document the diagnosis of the spinal fluid leak, despite the presence of headaches, following spinal surgery, and/or Dr. Fontanez failed to treat the spinal fluid leak appropriately.
- (c) This failure to diagnose and/or document the diagnosis of spinal fluid leak and/or the failure to treat the spinal fluid leak appropriately necessitated a repeat surgery by another neurosurgeon. Although Dr. Fontanez testified that a surgical solution was not necessary, Dr. Maa was justifiably concerned about an active leak of spinal fluid, and the Hearing Examiner finds that it is more likely than not that the repeat surgery was necessitated by Dr. Fontanez's listed failures.

LAW AND ANALYSIS

The appellant has not set forth any assignments of error in his brief. However, the appellant did set forth the following "legal issue."

Dr. Fontanez has been sanctioned by the State Medical Board of Ohio because two surgical cases from almost five years ago when he, ever so briefly, lived and practiced in Ohio. Although the Ohio Medical Board has the authority to base an adverse licensing action upon proven standard of care deviations, RC 4731.22 (B)(24), that action must nevertheless be supported by reliable, probative, and substantial evidence as mandated by the Ohio Administrative Procedures Act (APA), RC Chapter 119. Moreover, under the APA, the agency action must also be in accordance with law, meaning that, in this case, due process must have been afforded the licensee.

See Appellant's Brief, p.1.

The appellant asserts that he was denied due process due to the Board's delay in bringing charges against him and his inability to cross-examine Dr. Susan Stephens, a member of the Medical Board. Due process is a flexible concept and involves procedural and substantive due process issues. The phrase "due process" expresses the requirement of "fundamental fairness." In defining the process necessary to ensure "fundamental fairness," the United States Supreme Court has recognized that the clause does not require that the procedures used to guard against an

erroneous deprivation be so comprehensive as to preclude any possibility of error, and in addition, the Supreme Court has emphasized that the marginal gains from affording an additional procedural safeguard may be outweighed by the societal cost of providing such a safeguard. Thus, an appellant must make a showing of “identifiable prejudice.” See *Ghassan Haj-Hamed v. State Medical Board*, 2007 Ohio App. LEXIS 2335.

The record demonstrates that once the appellant was placed on notice, he was given the opportunity to request a hearing. The record reflects that the appellant had an opportunity to be heard in the hearing that was held on November 18, 2009 and that he was represented by counsel and participated. Additionally, the appellant was granted the opportunity to address the entire Board regarding his case. Clearly, there is no issue regarding procedural due process since the appellant had notice and an opportunity to be heard. Additionally, even assuming that there was a delay, it is apparent that the appellant was not prejudiced in his ability to defend himself.

In essence, what the appellant actually is asserting is a laches argument, rather than a due process claim, by asserting that he was prejudice in some way as a result of the Board’s delay in initiating official agency action after the time when the incidents arose. Thus, the Court will review this issue under the appropriate analysis.

As a general rule, in the absence of a statute to the contrary, the doctrine of laches is not a defense when the government files a lawsuit or proceeds with some other quasi-judicial action to enforce the public right, or protect the public interest. See *Reed v. State Med. Bd.*, (2005), 162 Ohio App. 3d 429, 439, citing *Ohio Bd. Of Pharmacy v. Frantz, et al.*, 51 Ohio St. 3d 143, 146; see also *McCutcheon v. Ohio State Med. Bd.*, (1989), 65 Ohio App. 3d 49, 56. “The principle that laches is not imputable to the government is based upon the public policy in enforcement of the law and protection of the public interest.” *Frantz*, 51 Ohio St. 3d at 146. Thus, in order to successfully

invoke the equitable doctrine of laches, the appellant must show that he has been materially prejudiced by the delay. See *Smith v. Smith*, (1959), 168 Ohio St. 447. However, prejudice will not be inferred from the mere lapse of time. See *Sutton v. Ohio St. Bd. of Pharm.*, 2002 Ohio App. LEXIS 2051. The appellant has not demonstrated that he was in any way prejudiced in the underlying proceeding before the Medical Board.

As a preliminary matter, all the witnesses, whether they were testifying for the State or on behalf of the appellant, were placed in a position wherein they had to recall or address details and events throughout the time period from November 2005 through January 2006. The hearing examiner, as the trier of fact, had the opportunity to assess each witness's demeanor and when applicable, his/her ability to recall factual details. In her Report and Recommendation, the hearing examiner gave a detailed account of each of the witnesses' testimonies and a rationale for why she found their respective testimony to be credible or not credible.

In essence, the appellant was in the best position to recall and interpret what happened with respect to Patients 1 and 2 since he was the attending surgeon, performed the operations on Patients 1 and 2, and was responsible for the medical records surrounding both incidents. However, the hearing examiner, after weighing his credibility and finding many inconsistencies, found the appellant not to be credible and chose to believe the testimony of the appellee's expert, Dr. Poolos.

The common pleas court must give due deference to the administrative resolution of evidentiary conflicts and findings of fact. For example, the court must defer to the administrative body, as the fact-finder, since the hearing examiner is the person who actually had the opportunity to observe the demeanor of the witness and weigh his/her credibility. Where the court determines that legally significant reasons exist for discrediting certain evidence, it may reverse, modify or vacate the administrative order. Thus, where a witness's testimony is internally inconsistent, or

impeached by evidence of a prior inconsistent statement, the court may decide that the testimony should be given little or no weight. Most importantly, the appellant has not provided any legal basis to this Court demonstrating that there is a statutory basis that requires a certain timeframe or a limitation period in which the Board must initiate disciplinary actions.

Accordingly, the appellant has not demonstrated any identifiable prejudice or provided any legal authority demonstrating that the Board filed this action outside the scope of a mandated statutory time period. Accordingly, this Court concludes as a matter of law that there is reliable, probative and substantial evidence to support that the appellant was afforded procedural due process.

The appellant asserts that he was denied substantive due process and was denied his constitutional right of confrontation. Specifically, the appellant takes issue with comments that were made by one of the Board's member, Dr. Susan Stephens, during the course of the deliberations of the Board regarding his case at the January 12, 2011 Board meeting. Specifically, the appellant asserts that it was contrary to law for Dr. Stephens to interject her opinions into the case. To that end, counsel has provided a transcript of Dr. Stephens' dialogue as Exhibit A to his May 31, 2011 motion which the Court has reviewed.

Clearly, a review of the record demonstrates that Dr. Stephens, as a member of the Board and a practicing neurosurgeon, was deliberating the appellant's case and not acting as a witness. She did not testify before the Hearing Examiner on November 12, 2010 and none of her statements at the subsequent January 12, 2011 Board meeting were considered in the November 18, 2009 hearing before the hearing examiner, the testimony of which is the basis for the November 12, 2010 Report and Recommendation adopted by the Board. See R.C. 119.12. The Medical Board, unlike many other agencies, deliberates in open session at its public meetings, determines whether to

accept the recommendations of the hearing examiner, and then decides what sanctions to impose, if necessary.

Moreover, the Ohio Supreme Court has held that the Board “may rely on its own expertise to determine whether a physician failed to conform to minimum standards of care.” See *Arlen v. State Med. Bd. of Ohio* (1980), 61 Ohio St. 2d 168, 172. The Board has authority to rely on its own expertise on the standard of care and to interpret the technical requirements of the medical profession. The record demonstrates that the Board used its collective expertise, and voted unanimously¹ to adopt the Report and Recommendation of the hearing examiner which concluded that the appellant fell below the minimum standard of care in regard to Patients 1 and 2. Thus, the Court concludes as a matter of law that the appellant was afforded substantive due process.

Furthermore, the appellant challenges whether there is reliable, probative and substantial evidence to support the Board’s January 12, 2011 Order. In the case at bar, it was the state’s expert witness, Dr. Peter N. Poolos, Jr., M.D., who gave uncontroverted testimony that the appellant fell below the minimum standard of care by initiating and performing a laminectomy at the wrong vertebrae in Patient 1, and removing healthy spinal tissue instead of a tumor in Patient 2. Tr. 25-27, 35, 45-48, 53, 60-61; see also State’s Exhibit 5. After being presented with this reliable, probative and substantial evidence, the Board concluded that the appellant’s conduct in his treatment of Patients 1 and 2 was a departure from, or was 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 appellant did not present any expert opinion testimony (other than his own self-serving testimony) which would have supported his assertion regarding the appropriate standard of care.

¹ Two of the Board members, Mr. Albert and Dr. Talmage, abstained from casting their votes on Dr. Fontanez’s case.

Moreover, the Board's primary focus is the safety of the general public. It is the duty of the Board to protect the public. By permitting the appellant to continue to practice medicine in Ohio, the Board would have been sanctioning conduct which allowed a risk to the public that was simply too great.

DECISION

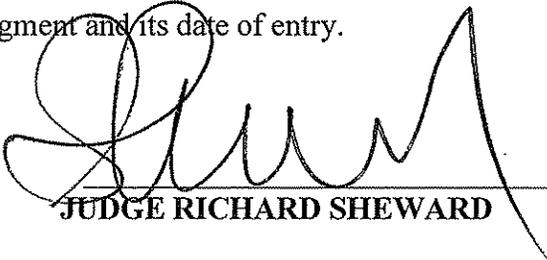
The Board's Order permanently revoking the appellant's license to practice allopathic medicine in the state of Ohio is supported by reliable, probative and substantial evidence and is in accordance with law. Accordingly, this Court hereby **AFFIRMS** the Board's January 12, 2011 Order. Further, the Court **DENIES** the Motion to Supplement with audio recordings; the transcript provided by counsel with his certification sufficed.

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. Pursuant to Civil Rule 58, the Clerk of Court shall serve upon all parties notice of this judgment and its date of entry.

It is so ordered.



JUDGE RICHARD SHEWARD

Copies to:

Kevin P. Byers, Esq.
529 East Town Street, Suite 200
Columbus, Ohio 43215
Counsel for Appellant

Michael DeWine, Esq.
Katherine Bockbrader, Esq.
Office of the Attorney General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215
Counsel for Appellee

FILED
COMMON PLEAS COURT
FRANKLIN CO. OHIO
2011 APR 23 12:25
CLERK OF COURTS

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

MODESTO FONTANEZ, M.D.

Plaintiff,

v.

Case No. 11CVF-1211 (Sheward, J.)

STATE MEDICAL BOARD OF OHIO,

Defendants.

DECISION AND ENTRY GRANTING
APPELLANT'S MOTION FOR SUSPENSION OF AGENCY ORDER, FILED
FEBRUARY 24, 2011

Rendered this 22 day of April 2011

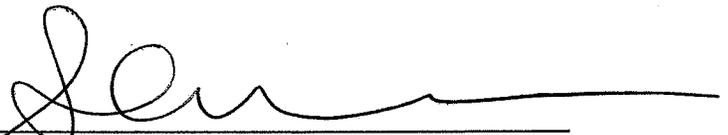
This matter is before the Court upon the Motion of Appellant to stay the decision of the Ohio Medical Board pending his appeal to this Court. The State Med Board opposed his motion in a memorandum filed March 4, 2011. The doctor filed a Reply on March 21, 2011.

Previously, in an order mailed January 13, 2011 the Board permanently revoked Dr. Fontanez's license to practice medicine and surgery in the State of Ohio. In a 7-0 decision, the Board found Dr. Fontanez's practice on two surgical patients was below the standard of care in violation of R.C. 4731.22(B)(6). Moreover, the hearing examiner noted he was not a trustworthy witness. Notwithstanding the order, Dr. Fontanez asks this Court to stay the revocation. Since the incidents underlying the Board's action, Dr. Fontanez has worked in New York and asserts that he has no intention of returning to Ohio to practice. (He is licensed in New York, New Jersey, as well as Vermont.) He asserts that immediate implementation of the revocation would be a death sentence. In legal terms, he argues, it would impose "unusual hardship," more than the usual

financial trouble. It would also implicate insurance and third-party payers to the extent that he would be uninsurable. However, staying the Board's decision would not threaten the public health, safety and welfare because he practices non-surgical medicine (and the complaints involved surgeries.) Moreover, there is plenty of information available to the public regarding his Ohio Board status.

The State submits Dr. Fontanez's practice was especially egregious as evidenced by the most harsh sanction upon finding that he covered up his errors and then lied about his awareness at the hearing. As for the legal requirements, the State submits the hardship Dr. Fontanez may suffer is nothing the legislature did not foresee. And, the public is at risk. Dr. Fontanez has demonstrated poor judgment and lack of trustworthiness.

The Court recognizes the Medical Board found Dr. Fontanez's conduct warranted the most harsh sanction: permanent revocation. Yet, the State has agreed to extend the briefing schedule in this matter before the Court determined whether the revocation would be stayed. This indicates Dr. Fontanez's continued practice is not a serious threat to the public. But, more importantly, Dr. Fontanez is not practicing surgery any more. He limits his practice to pain management. While it could be said that his general inattentiveness that led to a surgery at the wrong site is a common thread that may transfer into his pain management practice, the record only shows shortcomings related to surgeries. Thus, the Court agrees to stay the revocation of his license for the short time that remains until the matter is fully briefed and a decision entered. The threat to the public has not been established. Should the decision by the Court on the merits not be issued before **July 15, 2011**, the State may seek reconsideration.



RICHARD S. SHEWARD, JUDGE

Copies to:

Katherine Bockbrader
Assistant Attorney General
Health & Human Services
30 E. Broad St. 26th Floor
Columbus, OH 43215-3400
Counsel for Appellee

Kevin P. Byers
529 E. Town St. Suite 200
Columbus, OH 43215
Counsel for Appellant

STATE OF OHIO
COURT OF APPEALS
MILWAUKEE COUNTY

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

Modesto Fontanez, MD,
c/o Kevin P. Byers Co., LPA
529 East Town St., Suite 200
Columbus, Ohio 43215

Appellant,

v.

State Medical Board of Ohio,
30 East Broad Street, 3d Floor
Columbus, Ohio 43215
Appellee.

11 CVF 01 - 1211

CASE NO. _____

2011 FEB 23 AM 11:34
STATE MEDICAL BOARD

APPELLANT'S NOTICE OF APPEAL

Pursuant to RC 119.12, Appellant Modesto Fontanez, MD, hereby appeals the State Medical Board "Entry of Order," Case No. 08-CRF-132, dated January 12, 2011, and mailed January 13, 2011, Exhibit A, attached. The Board Order is not supported by reliable, probative, and substantial evidence nor is it in accordance with law.

Respectfully submitted,



Kevin P. Byers 0040253
KEVIN P. BYERS CO., LPA
529 East Town Street, Suite 200
Columbus, Ohio 43215
614.228.6283
614.228.6425 Facsimile
Kevin@KPByersLaw.com

Certificate of Service

I hereby certify that on this 25th day of January, 2011, the original of this Notice was deposited in prepaid overnight United States Postal Service custody, addressed to:

FILED
COMMON PLEAS COURT
FRANKLIN COUNTY, OHIO

2011 JAN 26 PM 3:51

CLERK OF COURTS

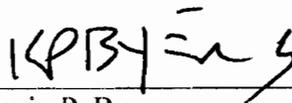
Clerk, Franklin County Court of Common Pleas-Civil Division
369 South High Street, 3d Floor
Columbus, Ohio 43215;

With a copy deposited in prepaid overnight United States Postal Service custody, addressed to:

State Medical Board of Ohio-Case Control
30 East Broad Street, 3d Floor
Columbus, Ohio 43215;

With a second copy deposited in prepaid first class United States Postal Service custody,
addressed to:

Office of the Ohio Attorney General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215.



Kevin P. Byers

2011 FEB 23 AM 11:34
STATE MEDICAL BOARD OF OHIO

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

January 12, 2011

Modesto Fontanez, M.D.
1838 Second Avenue, #184
New York, NY 10128

RE: Case No. 08-CRF-132

Dear Doctor Fontanez:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Patricia A. Davidson, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on January 12, 2011, 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 must be commenced by the filing of a Notice of Appeal with the State Medical Board and the Franklin County Court of Common Pleas. The Notice of Appeal must set forth the Order appealed from and state that the State Medical Board's Order is not supported by reliable, probative, and substantive evidence and is not in accordance with law. The Notice of Appeal may, but is not required to, set forth the specific grounds of the appeal. 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. 91 7108 2133 3936 3071 7435
RETURN RECEIPT REQUESTED

Cc: Kevin P. Byers, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3071 7442
RETURN RECEIPT REQUESTED

2011 FEB 13 AM 11:34
STATE MEDICAL BOARD OF OHIO

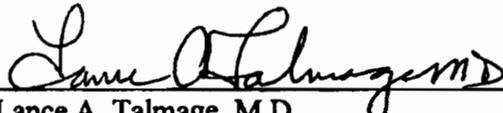
A

Mailed 1-13-11

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Patricia A. Davidson, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on January 12, 2011, 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 Modesto Fontanez, M.D., Case No. 08-CRF-132, 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 12, 2011
Date

2011 FEB 13 AM 11:34
STATE MEDICAL BOARD

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

CASE NO. 08-CRF-132

*

MODESTO FONTANEZ, M.D.

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on January 12, 2011.

Upon the Report and Recommendation of Patricia A. Davidson, 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:

The certificate of Modesto Fontanez, M.D., to practice allopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.



Lance A. Talmage, M.D.
Secretary

(SEAL)

2011 FEB 13 AM 11:34
STATE MEDICAL BOARD

January 12, 2011

Date

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

January 12, 2011

Modesto Fontanez, M.D.
1838 Second Avenue, #184
New York, NY 10128

RE: Case No. 08-CRF-132

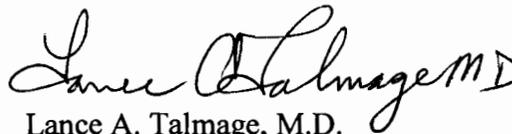
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THE STATE MEDICAL BOARD OF OHIO



Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3936 3071 7435
RETURN RECEIPT REQUESTED

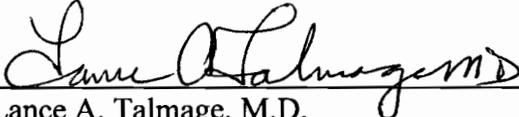
Cc: Kevin P. Byers, Esq.
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mailed 1-13-11

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Lance A. Talmage, M.D.
Secretary

(SEAL)

January 12, 2011
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

CASE NO. 08-CRF-132

MODESTO FONTANEZ, M.D.

*

ENTRY OF ORDER

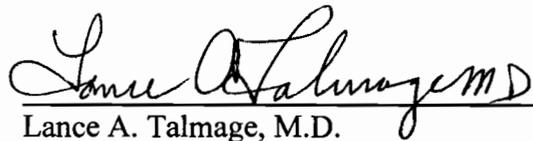
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Lance A. Talmage, M.D.
Secretary

(SEAL)

January 12, 2011
Date

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BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of

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Case No. 08-CRF-132

Modesto Fontanez, M.D.,

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Hearing Examiner Davidson

Respondent.

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REPORT AND RECOMMENDATION

Basis for Hearing

In a notice of opportunity for hearing dated November 12, 2008, the State Medical Board of Ohio notified Modesto Fontanez, M.D., that it intended to determine whether to take disciplinary action against his certificate to practice allopathic medicine and surgery in Ohio. The Board alleged that Dr. Fontanez had practiced below the minimal standards of care with regard to his neurosurgical treatment of two patients. The Board charged that Dr. Fontanez's acts, conduct, and/or omissions 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," pursuant to Ohio Revised Code Section [R.C.] 4731.22(B)(6). (St. Ex. 3)

On December 12, 2009, Dr. Fontanez submitted a hearing request. By agreement of the parties, a schedule was established for the exchange of documents including expert reports, and a July 2009 hearing was scheduled. However, in June 2009, Dr. Fontanez filed a motion to continue the hearing. On July 7, 2009, he signed an agreement to refrain from practicing medicine and surgery in Ohio until a final order was issued regarding the allegations in the notice of opportunity for hearing. The hearing was then continued to November 2009. (St. Ex. 3; Entry filed July 7, 2010; Ohio eLicense Center at <<https://license.ohio.gov/lookup/default.asp?division=78>>, accessed 10/26/10)

Hearing Date: November 18, 2009

Appearances

Richard Cordray, Attorney General, by Barbara Pfeiffer, Melinda Snyder, and Karen Unver, Assistant Attorneys General, on behalf of the State of Ohio. Kevin P. Byers, Esq., for the Respondent.

SUMMARY OF THE EVIDENCE

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

Background

1. Modesto Fontanez, M.D., received his medical degree in 1972 from the University of Puerto Rico in San Juan, Puerto Rico. Dr. Fontanez stated that he then completed more than six years of training in surgery and neurosurgery at the University of Puerto Rico Medical Center. (Resp. Ex. A)

2. In his curriculum vitae, Dr. Fontanez set forth the following work history:

Dec. 89 – June 93	Mt. Sinai Medical Services in Elmhurst, NY Asst. Professor of Neurosurgery
Aug. 93 – Apr. 94	Brooklyn Neurosurgical Associates (no location stated)
May 94 – July 94	Mobile Medical Project (no location stated)
Aug. 94 – June 95	Private practice in Plattsburg, NY
July 95 – Feb. 98	St. Luke Hospital in Saginaw, MI
Mar. 98 – Feb. 99	Liberty Surgical Associates in Jersey City, NJ
Mar. 99 – Oct. 99	University Medical Group in Brooklyn, NY
Nov. 99 – Aug. 00	Sall/Myers Medical Associates in Paterson, NJ
Sept. 00 – May 01	Neurological & Neurosurgical Associates in Poughkeepsie, NY
June 01 – Nov. 02	Sall/Myers Medical Associates in Paterson, NJ
Nov. 02 – Aug. 03	University Medical Group in Brooklyn, NY
Aug. 03 – Dec. 03	New York Neurosurgery & Neuroscience Associates in Rockville Centre, NY
Feb. 04 – June 05	Medical College of Ohio Physicians, LLC, in Toledo, OH Asst. Professor of Neurosurgery, Medical College of Ohio
Aug. 05 - Mar. 06	Neurosurgical Assoc. of Northwest Ohio, LLC, in Findlay, Ohio, with privileges at Blanchard Valley Regional Health Center
Aug. 06 – Aug. 07	Elmhurst Hospital Center in Elmhurst, NY

(Resp. Ex. A; Tr. at 96)

3. Dr. Fontanez testified that, after August 2007, he joined Central Medical Services of Westrock. In 2008, he joined “NY Rehab, Pain Management and Medical Services” in Long Island City, New York, where he said he still works. Dr. Fontanez stated that he no longer practices neurosurgery and works primarily in pain management. He stated that the reason for this is that outpatient work does not involve taking calls and working weekends, and he wants to pursue his interest in being an opera singer. (Tr. at 75-76, 98-99, 135-136; Ohio eLicense Center, *supra*)
4. In 2004, Dr. Fontanez was granted a license to practice allopathic medicine and surgery in Ohio under certificate number 35.083857. According to his curriculum vitae, Dr. Fontanez is also licensed in New York, New Jersey, Michigan, Vermont, North Dakota, and Puerto Rico. (Resp. Ex. A; Tr. at 75; Ohio eLicense Center, *supra*)
5. Dr. Fontanez stated that he was board certified in spinal surgery by the American Academy of Neurological and Orthopedic Surgery in 1986. He further stated that he is a diplomate of the American Board of Neurological Surgery, the American Board of Pain Medicine, and the American Board of Forensic Medicine. (Resp. Ex. A; Tr. at 76-77)

Patient 1 - Medical Records

6. Patient 1, a male in his fifties, was experiencing pain of his lumbar spine and shuffling gait in September 2005. His primary-care physician noted weakness of the lower extremities and ordered a diagnostic work-up including an MRI of the lumbar spine on November 17, 2005. Patient 1 was placed on steroids, and his lower extremity symptoms improved dramatically. (St. Ex. 1 at 5, 45, 143) The MRI showed:

Lumbar spinal canal: There is presence of enhancing intraspinal tumor at L1-L2 level which is slightly hypointense on T2-weighted and isointense on T1-weighted sequence. The tumor measures 3.6 cm in length and 1.6 x 1.5 cm in transverse dimension. The lesion most likely represent[s] myxopapillary ependymoma. The differential diagnosis would include astrocytoma.¹

(St. Ex. 1 at 5) The final impression set forth by the radiologist included:

Enhancing spinal cord tumor of the conus,² measuring 3.6 x 1.6 x 1.5 cm. The lesion most likely represent[s] myxopapillary ependymoma. The differential diagnosis would include astrocytoma.

(St. Ex. 1 at 5) (Observations regarding levels L3 to S1, not at issue in this action, are omitted.)

7. Patient 1 was referred to Dr. Fontanez, who noted the risks of surgery and obtained the patient's consent on November 29, 2005. (St. Ex. 1 at 23-25, 47) In a history and physical examination dictated on December 1, 2005, Dr. Fontanez noted that the patient's gait was currently normal and that "strength is 5/5 in the lower extremities at this point." Dr. Fontanez reviewed the MRI and symptoms with Patient 1, and discussed the desirability of removing the lesion due to the potential for further growth and further compression on the conus and cauda equina. He noted that the compression was already causing symptoms and felt it was "imperative that an attempt is made for this not to progress." (St. Ex. 1 at 45-49)
8. On December 5, 2005, Dr. Fontanez performed surgery on Patient 1 at Blanchard Valley Regional Health Center [Blanchard Valley RHC] in Findlay, Ohio. In his operative report, Dr. Fontanez

¹"Hypointensity" refers to the darkness of an area in contrast to surrounding areas. *E.g.*, "Magnetic resonance imaging and extrapyramidal movement disorders," Nat'l Center for Biotechnol. Information, Nat'l Library of Medicine, PubMed, at <www.ncbi.nlm.nih.gov/pubmed/2714306>, accessed 11/3/10). Thus, "hypointense" means "darker" than surrounding areas. *E.g.*, "T2-weighted MRI in Parkinson's disease," Bioline Int'l at <www.bioline.org.br/request?ni04110>, accessed 11/3/10. "Isointense" refers to having the same intensity as another object, in images such as MRIs. *Cancer Medical Dictionary* at <<http://cancer.medical-dictionaries.org/isointense>>, accessed 11/3/10.

² The **conus** is at the end of the spinal cord, which ends at L1, as described by Pete Poolos, M.D., the State's expert witness. Dr. Poolos testified that the spinal cord comes down to a point, around which is a "cascade of nerves." Dr. Poolos explained that the conus is the tapered end of the spinal cord, and that these nerve roots emerge from the conus. Dr. Poolos stated that the nerve roots look like spaghetti noodles. (Tr. at 14, 33) Dr. Fontanez commented that the nerve roots emerging from the spinal cord are called the **cauda equina** because they resemble a horse's tail. (Tr. at 102) Other sources confirmed this information. *E.g.*, R. O'Rahilly et al., *Basic Human Anatomy*, Ch. 41, reprinted at <www.dartmouth.edu/~humananatomy/>; Merriam-Webster Medical Dictionary at <<http://dictionary.reference.com/browse/cauda+equina>>, accessed 10/26/10).

noted the pre-operative diagnosis of “intraspinal, intradural tumor at L1-L2 conus region.” He reported that he had performed a “decompressive laminectomy T12 through L2 with intramedullary decompression of tumor.” (St. Ex. 1 at 143, emphasis added)

In his operative report, Dr. Fontanez described his procedures, including the following:

* * * [A] spinal needle was placed at the level of L1-L2 interspace, and the level was verified by intraoperative cross-fire x-ray. * * * A mid-line incision was made over the spinous processes of T12, L1 and L2 * * *. * * * [S]ubperiosteal detachment of the paraspinal muscles from the spinous processes and the lamina and facets of T12, L1-L2 was performed bilaterally. After this was done the McCullough retractor system was placed in situ. A Kocher³ was placed at the T12-L1 interspace and again interspace level was verified by intraoperative cross-fire x-ray.⁴

With the router of the Stryker [power drill] the intraspinal ligaments were entered and the spinous tips of T12, L1 and L2 were removed and these were further removed with the bone cutter and double action rongeur. With the ultrasonic aspirator, soft tissues were removed from the lamina and spinous process base of the aforementioned levels, and then with the high-speed 5-mm drill of the Stryker, the base of the spinous processes and lamina were singed down and a decompressive laminectomy was carried with Kerrison punch rongeurs #2 and #3. This was done at T12, L1 and L2 respectively.⁵

After the decompressive laminectomy was done a bulging dura was encountered at the L1-L2 region and with the 11 blade, dura was opened in the midline and stay sutures with a 4-0 nylon sutures were taken. The pia [membrane attached to the spinal cord, enveloped by the arachnoid layer and then the dura] was coagulated and then the microscope was brought into the operative field and the venous plexus in the posterior part of the conus was gradually detached and mobilized, and with the bipolar coagulator a midline myelotomy⁶ was done and samples of tissues were taken with a micropituitary forceps and sent for frozen section.

³ A Kocher forceps/clamp has teeth that can grab tissue or compress bleeding tissue. *E.g.*, Medical Dictionary at <<http://medical.dictionary.thefreedictionary.com/Kocher+forceps>>, accessed 11/8/10. According to Dr. Poolos, this instrument “shows up very well on an x-ray, and it’s another way of localizing or saying where you are.” (Tr. at 31)

⁴ The medical records include no films of x-rays taken during the surgery, but there are two radiology reports for cross-table x-rays on December 5, 2005. However, in these reports, there are no descriptions of what was shown. The radiologist stated only that the films had been “provided” for intraoperative support. (St. Ex. 1 at 119-121)

⁵ A post-surgery MRI showed no change to the bony structures at L1 or L2. The only vertebral change shown in the postoperative MRI was bilateral laminectomy at T12. (St. Ex. 1 at 11)

⁶ A **myelotomy** is the surgical severing of fibers of the spinal cord. *E.g.*, *The American Heritage Medical Dictionary* (Houghton Mifflin Harcourt 2010); *Merriam-Webster Medical Dictionary* at <www.merriam-webster.com/medical/myelotomy>, accessed 11/3/10). Dr. Poolos described the pia and thermal-coagulation methods in detail. (Tr. at 34)

Frozen section was preliminarily reported as myxopapillary ependymoma. Then further tissue was removed using suction trap and with the ultrasonic aspirator. A cavity was finally obtained where the tumor was present. It was interlaced and intertwined and intermeshed with the white matter. There was no clear cut plane of cleavage and no cystic component was encountered.

Further dissection and probing was stopped given the fact that the motor wave patterns on the right lower extremity were diminished as well as of the somato-sensory evoked potentials. Copious saline irrigation was performed. 160 mg of DepoMedrol [an anti-inflammatory medication] were instilled intramedullary and the dura was then closed water tight with running 4-0 nylon sutures. After the dura was closed Tisseel [surgical glue] was laid over the dura, followed by a layer of DuraGen [surgical fabric], followed by Tisseel, followed by another layer of DuraGen and followed by Tisseel.

(St. Ex. 1 at 143-145)

9. After describing his closing of the muscles and skin, Dr. Fontanez stated that “there were no intraoperative complications other than the diminished wave patterns.” He also stated that his postoperative diagnosis was “Intraspinal, intramedullary, intradural tumor at the conus level at L1-L2, myxopapillary ependymoma by frozen section.” (St. Ex. 1 at 143-145)
10. In a handwritten progress note on December 5, 2005, Dr. Fontanez stated that he had performed “laminectomy” at “T12–L2” and had biopsied the tumor. He stated his postoperative diagnosis as “Spinal, intradural, intramedullary tumor at conus region L1/L2 – Myxopapillary Ependymoma by Frozen.” (St. Ex. 1 at 83) In addition, Dr. Fontanez wrote in the patient’s chart on that he had resected the tumor. (St. Ex. 1 at 199)
11. With respect to services provided on December 5, 2005, the pathology department stated a Gross Description of the tissue samples as follows:
 - Part I, frozen section labeled “spinal cord tumor, L1-L2”; gross description and preliminary diagnosis of “abnormal neural tissue, deferred for permanent.”
 - Part II, frozen section labeled “spinal cord tumor, L1-L2”; gross description and preliminary diagnosis of “neural tissue, deferred for permanent.”
 - Part III, in formalin, labeled “spinal tumor, L1-L2”; gross description of “frothy tissue.”
 - Part IV, in formalin, labeled “bone and tissue, T12-L2”; gross description of “bone and soft tissue.” (St. Ex. 1 at 147, with size measurements omitted)

The Microscopic Description by the pathologist on December 5, 2005, was as follows:

- Part I: “* * * neural tissue consisting neuropil, nerve fibres and scattered neurons. The focal degenerative changes of the neuropil which were seen on the frozen section are not noted on the permanent sections. There is no evidence of malignancy.”

- Part II: “* * * neural tissue. There is no evidence of malignancy.”
- Part III: “* * * skeletal muscle, fibrous tissue and rare fragments of neural tissue. There is no evidence of malignancy.”
- Part IV: “* * * fibroelastic cartilage, bone and soft tissue. No neural tissue is noted. There is no evidence of malignancy.” (St. Ex. 1 at 147-149)

The report further states that the case was “being sent to the Mayo Clinic, Rochester MN, for consultation.” (St. Ex. 1 at 149)

12. On December 7, 2005, it was noted that Patient 1 lacked bladder control, which had required reinsertion of the catheter. On December 8, 2005, a urologist examined Patient 1 and found “postoperative urinary retention, most likely neurogenic in nature.” The urologist also found “some compromise mobility and sensation in the lower extremities,” which he deemed to be secondary to the baseline pathology of the tumor “as well as expected symptom secondary to the surgery that he just underwent.” On December 9, 2009, Patient 1 was still using a catheter due to urinary incontinence. (St. Ex. 1 at 33, 87, 105)

13. Patient 1 was discharged from the hospital on December 9, 2005. In his discharge summary, Dr. Fontanez reviewed that the lesion was located at the conus region of L1-L2. He reported that the patient had been “admitted for decompressional biopsy of the lesion *and this was done via a T12 to L2 laminectomy and a myelotomy.*” (St. Ex. 1 at 97, emphasis added)

Dr. Fontanez also reported in his discharge summary that Patient 1 was experiencing a neurogenic bladder and weakness in the right lower extremity, but that sensation had improved. Dr. Fontanez stated that the biopsy was “suggestive of a myxopapillary ependymoma,” but that “not enough tissue has been available for a definitive diagnosis thus far,” and that tissue would be sent to the Mayo Clinic. Dr. Fontanez also stated that Patient 1 would have a follow-up MRI “in approximately six weeks.” (St. Ex. 1 at 97)

14. On December 14, 2005, the Mayo Clinic transmitted the following pathology report to Blanchard Valley RHC regarding the tissues taken from Patient 1 on December 5:

Benign spinal cord tissue, bone, bone marrow, ligamentous tissue, and disc material. No neoplasm is identified.⁷

(St. Ex. 79-81)

15. On December 14, 2005, the pathologist at Blanchard Valley RHC noted the content of the consultation report, set forth the Final Diagnosis as made by the Mayo Clinic, and reported that she had reviewed the consultation report and found no major discrepancies. (St. Ex. 1 at 149-150)

⁷A **neoplasm** is “a new growth of tissue serving no physiological function: TUMOR.” *Merriam-Webster Medical Dictionary* at <<http://dictionary.reference.com/browse/neoplasm>>, accessed 10/26/10. In addition, “neoplasm” is defined as follows: “A tumor. An abnormal growth of tissue. * * * A neoplasm may be benign or malignant.” *Medical Dictionary, Medicine.Net.com*, at <www.medterms.com/script/main/art.asp?articlekey=4526>, accessed 10/26/10.

16. On December 19, 2005, ten days after his discharge, Patient 1 had another MRI of his lumbar spine. In the MRI report, the radiologist reported that there had been bilateral laminectomy at T12 since the previous MRI study. No changes were noted with regard to bony structures at L1 or at L2. (St. Ex. 1 at 11) In addition, the radiologist reported that the tumor was still present at L1-L2:

* * * The patient [had] interval bilateral laminectomies of T12 since previous study. There were postoperative changes and soft tissue enhancement at T11-T12 through T12-L1 posteriorly, representing granulation tissue. There is a small fluid collection in the subcutaneous plane, extending from T11 through L1, measuring 9 cm in length and 1 x 1 cm in transverse dimension. There is persistent visualization of enhancing intraspinal intradural tumor of the conus at L1 level. The tumor extends extensively related to L1-L2 level. * * *

Impression:

1. Stable size, imaging characteristics and enhancement pattern of intraspinal intradural tumor of the conus, measuring 3.9 x 1.5 x 1.5 cm. The lesion most likely represent[s] a myxopapillary ependymoma.
2. Interval bilateral laminectomies of T12 with recent postoperative changes as described above. A small subcutaneous fluid collection at T11 through L1, measuring 9 cm in length and 1 x 1 cm in transverse dimension.

(St. Ex. 1 at 11)

The State's Expert Witness – Dr. Poolos

17. Pete N. Poolos, Jr., M.D., testified as an expert witness on behalf of the State. His medical education, training, and experience are set forth in detail in his curriculum vitae and testimony at the hearing. Among other professional activities, Dr. Poolos serves as an assistant clinical professor of neurosurgery at Case Western Reserve University in Cleveland and is chief of neurosurgery at Fairview General Hospital, a Cleveland Clinic hospital. Dr. Poolos testified that he has been board certified in neurosurgery since 1967 and remains active in performing spinal surgery. (St. Exs. 4, 5; Tr. at 9-12, 65)

General information regarding the spine and spinal surgery

18. Dr. Poolos discussed the cervical vertebrae (in the neck area), the thoracic vertebrae (in the chest area), the lumbar vertebrae (above and below the waist), and the sacrum (near the bottom of the spine). Among other things, he described the parts of an individual vertebra including the lamina, and how the opening in each stacked vertebra create a channel or tube for the nerve structures of the spinal cord. Dr. Poolos also described the spinal cord and its coverings, including the arachnoid layer and the dura that encase the spinal fluid and spinal cord. In

addition, he described the pia, a membrane that is attached to the spinal cord and enveloped by the arachnoid layer and then the dura. Dr. Poolos agreed that the arachnoid and dura create a waterproof environment, but he stated that it is the tough dura that maintains the integrity of the spinal canal and spinal-fluid content. (Tr. at 12-19, 34; St. Exs. 8-9)

19. Dr. Poolos further explained that the vertebra at T12 (twelfth thoracic vertebra) looks basically the same as the vertebra directly beneath it at L1 (the first lumbar vertebra). That is, the lamina and the spinous process (bony structures) look the same, and the surgeon cannot determine the spinal level by looking at the vertebrae themselves. Rather, the surgeon must know the surrounding anatomy, and, if there is any doubt, must use x-rays to pinpoint the location accurately. (Tr. at 25-30)
20. Dr. Poolos explained that a laminectomy involves cutting through the skin, peeling the muscle away from the bone, and then removing the lamina of a vertebra. "The lamina is an arch, and you remove it to gain access to the contents of the spine." Each vertebra has two lamina, one on the left side and one on the right. "So you can take one side off, unilateral. You can take a little window out. But if it's a bilateral, you take out both sides. If you're looking for good access to see all the elements of the spine, you usually take both sides out so you can really see all the anatomy of that spine." (Tr. at 12-15)

Dr. Poolos explained that if the surgeon is looking for a herniated disc, that can be done through a small opening, but "if you're looking for something bigger, a tumor, you've got to take out a lot more bone so that you can have good visibility." He further stated: "If you need to actually see the spinal cord or the individual nerves inside the spine, then you can also proceed from that, opening up the dura." (Tr. at 13-14)

21. With regard to the use of DuraGen and Tisseel in spinal surgery, Dr. Poolos testified:

When a surgeon has to open the dura to explore inside the dura, it can be sewn up and it can be watertight. Sometimes a very tiny hole can develop in the dura. It's not big enough to sew, it's not big enough to put a suture, so this material has been developed to help seal off the hole. And there's several things you do. You first of all dry up the blood because the blood does seep there. You put the glue, which is a double-barrel epoxy type material, squirt that in on top of the dura. Then you cut a piece of this DuraGen and place it on top of that to make a seal. Then you close up, close the muscles, have them as tight as you can.

* * * If you've got a dural leak, you have to seal it. You check it first, before they wake up. You have anesthesia do something called Valsalva. It's a strain motion. They pump the bag. It distends the veins, it distends the spinal fluid, and you can see if it's leaking or not, because if it's still leaking, you've got to go back and do something else.

Then after surgery, you try to lessen the pressure on that part of the spine. Spinal fluid is just a column of water. When you're erect, vertical, down at the bottom of the spine it's higher pressure than it is at the top. So you keep them in bed * * * [with] the head lower than the tail, [and] so you lessen the pressure. * * * You keep them in bed for 48 hours. Then you let them get up gradually. You sit up a little bit at a 40-degree angle, then you go to 60-degree, then you go to 90-degree to see if they're leaking because you can't send them home with a leak. If a leak is there, you can get infected; you can get meningitis; they can die. * * * You have to attend to it * * *.

(Tr. at 54-56)

Dr. Poolos' Written Report – Treatment of Patient 1 by Dr. Fontanez

22. In his written report, Dr. Poolos summarized the content of Patient 1's medical records, noting among other things that Patient 1 had been admitted for surgery due to neurological complaints and diagnostic studies that "demonstrated a tumor at the lumbar 1-2 level." He reviewed the operative report in which Dr. Fontanez stated that he had performed laminectomies from T12 to L1 and had reportedly confirmed the location with x-rays. However, Dr. Poolos stated that there was "no x-ray report available to this reviewer to confirm the operative report descriptions of x-rays confirming localization of the operative procedure." (St. Ex. 5)

Dr. Poolos further noted that Dr. Fontanez had biopsied tissue and that, although the intraoperative frozen section was reported as "abnormal neural tissue, permanent deferred," the permanent report had revealed "no evidence of malignancy." Dr. Poolos further reviewed the Mayo Clinic's pathology report finding "benign spinal cord tissue" in which "no neoplasm" was identified. (St. Ex. 5)

In addition, Dr. Poolos observed that the postoperative MRI had revealed that there had been a bilateral laminectomy "at T12" and that there was "persistent visualization" of the tumor of the conus related to the L1-L2 level. (St. Ex. 5)

23. Dr. Poolos also set forth several opinions. He concluded that Dr. Fontanez had explored the "wrong level of the spine" and that his "neurosurgical care of this patient falls below the standard of care expected." Dr. Poolos further stated that the "postoperative course revealed major neurological impairment as a result of biopsying tissue within a normal spinal cord." (St. Ex. 5)

Dr. Poolos explained that Dr. Fontanez should have been alerted to being at the wrong level of the spine by the absence of lumbar nerve roots. He observed that the MRI had identified the tumor as "being at L1-L2, at which point nerve roots would have been encountered," because "it is normal for the spinal cord to end at L1." Dr. Poolos also stated that Dr. Fontanez should have recognized that there was no abnormal tumor tissue in the area where he was performing the surgery. Further, Dr. Poolos noted that the patient record "does

not provide written confirmation of the plain x-rays that the surgeon describes in his operative report.” (St. Ex. 5)

Dr. Poolos’ Testimony Regarding Patient 1

24. Dr. Poolos testified that the initial MRI report not only identified the location of the tumor at L1-L2 but also described the tumor’s size and its defined shape as distinguished from normal tissue. Dr. Poolos explained that, because the pre-operative MRI report stated that the tumor was located at the L1-L2 level, the surgeon would know that the tumor is “at and below the end of the spinal cord, and it’s extending over two segments of the spine.” (Tr. at 22-25)

Dr. Poolos further opined that, with a tumor located at L1-L2, the patient’s spine should have been opened up at L1-L2, that the laminectomy should have been done first at L1-L2. Then, depending on what is observed, the surgeon could do a further laminectomy at the next higher level, T12, and remove bone at that level to see intraspinal tissues, or he could go lower to L3 if necessary. However, Dr. Poolos was unequivocal that, in order to locate a tumor at L1-L2, the surgeon should start with laminectomy at L1-L2. (Tr. at 30; 59-60)

Dr. Poolos testified that the tumor would have been visible during the surgery. The surgeon would see a “lump of tissue that’s not normal and shouldn’t be there.” Dr. Poolos described the appearance of various kinds of tumors, and he testified that tumors are “distinguishable from the spinal cord itself, normal spinal cord.” (Tr. at 24)

25. With regard to Dr. Fontanez’s description of a “bulging dura” during the surgery, Dr. Poolos commented that, “when you open up a portion of the spine and you expose the dura, it’s always bulging because these patients are all done face down, lying on their stomach, asleep. So the intraspinal pressure is increased when you’re asleep under anesthesia, so it looks like the dura bulges, but that wouldn’t indicate anything to me as far as what I’m expecting to find if I open it up.” (Tr. at 32)
26. Dr. Poolos testified that, although Patient 1’s tumor was clearly located at L1-L2, Dr. Fontanez had performed the surgery at T12. Dr. Poolos noted that a comparison of the MRIs before and after the surgery demonstrate that Dr. Fontanez had performed a laminectomy only at T12. Further, Dr. Poolos relied on pathology reports stating that the tissues removed at the surgical site included no neoplasm/tumor, which demonstrated that the samples were not taken at the level of L1-L2 where the tumor was located. Dr. Poolos explained that, if Dr. Fontanez had been exploring at L1-L2, he would have seen the tumor, which was “delineated and sizeable.” In addition, Dr. Poolos testified that, if Dr. Fontanez had been exploring at L1-L2, he would also have seen the nerve roots, whereas, at T12, the spinal cord would still be present. Dr. Poolos stated that, at T12, the surgeon would not see the nerve roots and should know that he was not exploring tissue at L1-L2. (Tr. at 25-26, 38-42, 60-62)

In Dr. Poolos’ opinion, when the surgeon did not see the tumor or the nerve roots, the surgeon should have known he was at the wrong level and stopped the surgery. Instead, Dr. Fontanez continued to explore in the T12 area and went into normal spinal cord. (Tr. at 25-26, 60-61)

27. With regard to whether Dr. Fontanez failed to meet the minimal standard of care with regard to Patient 1, the following testimony was given:

Q. Dr. Poolos, do you have an opinion to a reasonable degree of medical certainty as to whether Dr. Fontanez's treatment of Patient 1 for the intraspinal, intradural tumor at the L1-L2 level constituted a departure from or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances?

A. Yes.

Q. And what is that opinion?

A. He fell below the standard.

Q. * * * Can you indicate your reasoning for why Dr. Fontanez has fallen below the standard of care in his treatment of Patient 1?

A. He operated at the wrong level. He operated on a normal spinal cord, and he should have known that he was not at the right level by just looking at the anatomy of the spine at T12.

(Tr. at 25-26)

28. Dr. Poolos opined that Dr. Fontanez's exploration into Patient 1's spinal cord and the excision of healthy spinal tissue had caused harm to Patient 1. (Tr. at 26-27) He noted that Patient 1 had experienced "neurological sequelae immediately after this procedure," consisting of incontinence of urine and leg weakness.

Q. And would those particular weaknesses be indicative of taking tissue from that T12 location?

A. Yes. Well, may I qualify that?

Q. Certainly.

A. Not only just taking the tissue, the exploration causes distortion. I mean, the spinal cord is not all that big. * * * So going into it – and he used an ultrasonic instrument that cavitates and, you know, sucks and cavitates [creates a cavity] at the same time, so it causes tissue destruction, damage.⁸

(Tr. at 26-27, 35)

⁸ Dr. Poolos' description is consistent with what Dr. Fontanez stated in his operative report, which was that he had cut into the spinal cord (performed a myelotomy) and had then taken tissue samples with forceps, and that he had subsequently removed "further tissue" and "finally obtained" a "cavity" using a suction trap and ultrasonic aspirator. (St. Ex. 1 at 143-145)

29. Dr. Poolos opined that, even when force must be used to remove bony structures of a vertebra, it can be done without damaging the spinal cord if the surgeon is careful in removing the bone. (Tr. at 63)

Written Statement by Dr. Fontanez Regarding Patient 1

30. In his statement prepared for the hearing, Dr. Fontanez acknowledged that the MRI had shown that Patient 1's tumor was located at L1-L2, and he described the surgery as follows:

The primary neurosurgeon in this case [Dr. Fontanez] began his bony opening *at the T12 level in order to approach the lesion from the cranial dome of the same and in an effort to delineate any possible plane of cleavage between conus medullaris/cauda equine and lesion.* Ergo, it is not a scenario of operating at a wrong level, it was part of an operative strategy. The planned approach was one of cephalo-caudad debulking after appropriate delineation between cord parenchyma, lumbar nerve roots and lesion. [Emphasis in original]

Upon completing the T12-L1 laminectomy the neurosurgeon was confronted with an exceedingly tight thecal sac and a tightly fungating cord through the bony opening. Given these immediate findings, of a tightly fungating cord through the initial bony opening, and given the possible differential diagnosis [ependymoma versus astrocytoma] he felt obligated to open the dura and explore the situation. Also, the take off of the cauda equina nerve roots was also visible indicative of the conus region. *A grossly abnormal spinal cord was encountered*, fungating out of the dural opening. Again, given the different diagnosis, he felt compelled to biopsy the abnormal looking tissue matter. One of the fragments sent for frozen section was in fact reported as "*abnormal tissue.*" During the sampling of grossly abnormal appearing tissue there was a drop in the motor evoked and sensory evoked potentials corresponding to the right lower extremity. After, waiting a reasonable period of time and with the lack of restoration of wave patterns to acceptable amplitudes the neurosurgeon made a judgment call not to proceed any further with bony work and further exploration and contemplate a re-exploration at a later date. It was also felt at that time, that given the abnormal appearance of the tissue, that some portion of the lesion might have been decompressed. [Emphasis in original]

Post operative MRI was done and the strategy was to allow the patient to recuperate, see what the point of maximum improvement was going to be, monitor the size of the lesion, and unless there was any neurological deterioration, the patient would then be re-explored under optimum conditions.

Clearly the goals of this initial surgery were not attained but given the neurophysiological occurrence during the procedure a judgment call was warranted and the decision not to continue was made. * * *

(Resp. Ex. B)

Testimony of Dr. Fontanez Regarding Patient 1

31. In his testimony at the hearing, Dr. Fontanez averred that he had knowingly started with a bilateral laminectomy at T12 because he had intended to approach the tumor from above. He stated that approaching from above was an appropriate strategy based on several considerations: the differential diagnosis of ependymoma versus astrocytoma; the expected swelling of the spinal cord, particularly in the conus area; that the tumor could be inside or outside the spinal cord; and that he thought it better to approach the tumor from the top because then he could “encounter a plane of cleavage if there would be between lesion and matter of the conus [*sic*].” He testified that entering the spine above the tumor’s level “is an option,” a “surgical nuance,” and it was his preference to look for the plane of cleavage from above and look for the interface between the spinal cord and the lesion. (Tr. at 77-78, 100-101, 119-121)
32. Dr. Fontanez testified that he had in fact inserted the spinal needle at the L1-L2 space, and that he had done so despite the fact that his plan was to start with a laminectomy at T12. Dr. Fontanez testified that, after opening Patient 1 and getting into subcutaneous tissues, he had also placed a Kocher at T12-L1 and had then done another x-ray, again for the purpose of determining the spinal level. (Tr. at 84-85, 118-119)
33. Dr. Fontanez stated that he does not know why there are no x-rays in the hospital records for Patient 1. He stated that, during his surgeries, the x-ray film was sent into the operating room where he read it. He testified that the x-ray film “is then read also by the radiologist.” Dr. Fontanez stated that, if the surgeon has any question that the needle has been placed at the right level, then he contacts the radiologist through the intercom. (Tr. at 83-84)
34. Dr. Fontanez testified that, after he removed the laminae of the T12 vertebra, he saw a very “tense” dura with a “fungating dural sac that was tightly coming out through that initial opening.” He explained that fungating means “attempting to herniate or come out due to pressure.” He stated that he “shaved a little bit of the upper margin” of the L1 vertebra, and then decided to open up the dura due to the differential diagnosis and the tenseness of the dura. Dr. Fontanez testified that he opened up the dura “to start inspecting and working my way through the area.” (Tr. at 78-79)
35. Dr. Fontanez testified that the conus had been “extremely bloated,” and so he had “felt obligated to start sampling to determine if [the patient] had an intraconus substance lesion or a portion of an ependymoma that could be occupying the area,” and so he accordingly took samples, “sending for frozen section.” Dr. Fontanez acknowledged that the tumor shown in the MRI was “quite a large tumor.” (Tr. at 79, 120)
36. Dr. Fontanez testified further regarding his exploration of the tissues at T12: “I had to try to decompress the swollen tissue before I could continue doing further bony work to reach the L1-L2 epicenter.” Dr. Fontanez said that he had planned to proceed to L1-L2 but that, as he “was manipulating to try to get further to where I wanted to get,” there was a drop in motor evoked responses, causing Dr. Fontanez to stop the procedure. Dr. Fontanez testified that,

when the evoked responses did not improve, he “decided to abort the procedure and not continue with more bony work to get to the epicenter of the lesion.” (Tr. at 79-81)

Dr. Fontanez asserted that, at the time he stopped the procedure, he felt he “may have gotten some small fragment of the periphery [of the tumor] at most” but that he knew that the goal of the surgery “certainly was not met.” (Tr. at 81)

37. Dr. Fontanez was asked to explain the statement in his operative report that “detachment” of the “*lamina facets of T12, L1 and L2 was performed bilaterally.*” He responded: “Okay. Basically, I laminectomized T12 and part of L1. *I did not go into the lamina of L2.*” (Tr. at 103, emphasis added)

Dr. Fontanez acknowledged that, although his operative report states that he performed bilateral laminectomy at T12, L1, and L2, he had in fact removed only the laminae at T12. (Tr. at 109-110) Dr. Fontanez’s explanation for the discrepancy between his testimony and his operative report is that the operative report “is inaccurate.” (Tr. at 109-110)

38. Dr. Fontanez asserted, however, that he had also removed “part of” a lamina at L1. He said he had removed a “portion of the upper rim of L1.” However, when asked to explain why the MRIs showed that the only change to bony structures was the removal of both laminae at T12, Dr. Fontanez commented that MRIs are not as sensitive to bone tissue as CT scans. (Tr. at 103, 109-110)

39. Dr. Fontanez was also questioned regarding his statement in the operative report that, “the spinous tips of T12, L1 and L2 were removed and these were further removed with the bone cutter and double action rongeur.” When asked to explain what this statement meant, Dr. Fontanez stated that he had been referring to the “tip of the spinous process.” When asked whether he had removed the spinous tip at L2, Dr. Fontanez answered, “No. No. Just the ligament, the ligament covering of it.” (Tr. at 103-104)

Next, when asked to explain why his operative report states that he *did* remove the spinous tip of L2 and why the report does not explain that he removed only the ligamentous covering, Dr. Fontanez answered: “It should have said it.” (Tr. at 104)

40. When asked what he meant in his operative report when he stated that “the base of the spinous processes and lamina were singed down” Dr. Fontanez stated that the word “singed” is wrong and “must be a typo.” He stated that the correct word is “dissected” or “exposed.” He said he had detached soft tissue and ligament from the base of the spinous process with a drill in order to expose the bone. (Tr. at 106-108)
41. Dr. Fontanez acknowledged that his operative report states: “After the decompressive laminectomy was done a bulging dura was encountered at the L1-L2 region.” However, Dr. Fontanez testified that this sentence in his report is incorrect and that his report “should” instead state “the T12-L1 region.” (Tr. at 113, emphasis added)

42. In addition, Dr. Fontanez admitted that, in his operative report, he had made no mention of the “grossly abnormal spinal cord” that he emphasized in his written statement for the hearing. Dr. Fontanez’s explanation was that he had not elaborated in his operative report as he “should have.” (Tr. at 117-118)
43. Dr. Fontanez agreed that, during the surgery, tissue samples were labeled as having been excised from “spinal cord tumor L1 to L2.” However, Dr. Fontanez testified that the technician had mislabeled the samples, which had actually been excised from T12 to L1. He asserted that the reason for this mislabeling was that operating-room staff tend to paraphrase the pre-operative diagnosis. Dr. Fontanez later acknowledged, however, that he directs the biopsy process during his surgeries and that the staff would get its information from him. “Yes, I would be telling them I’m taking from here or from there, yes.” (Tr. at 115-117)
44. With respect to the final pathology report, Dr. Fontanez commented that he cannot be sure that all the tissue he provided to the hospital pathologist were sent to the Mayo Clinic for review. He testified that he does not know whether the pathologist sent all the permanent slides along with the frozen section. (Tr. at 81, 119)
45. With regard to his statement in the operative report that “Frozen section was preliminarily reported myxopapillary ependymoma,” Dr. Fontanez acknowledged that the documents from the pathology department include no mention of myxopapillary ependymoma. However, he asserted that the operative report “reflects what I was verbally told, that there were some abnormal cells and some abnormal myxoid cells, but it would be subject to the permanent staining slides.” (Tr. at 79, 115) He further stated: “In one of the communications between the pathologist and me in the operating room, the pathologist indicated that there were some myxoid cells in one of the fragments, which led me to believe that this – that I was confronting an ependymoma, a myxoid ependymoma.” (Tr. at 79)
46. Dr. Fontanez acknowledged that he had dictated the operative report at 1530 hours (3:30 p.m.) on the day of the surgery, December 5, 2005. (Tr. at 104-105) When asked whether he had ever amended or corrected his report, Dr. Fontanez answered: “I don’t recall if I did.” (Tr. at 113)
47. Dr. Fontanez was also asked whether it was standard in December 2005 for him to direct the anesthesiologist to do a Valsalva maneuver on every spinal patient, prior to closure. He answered: “It was a pretty routine procedure that was generally done after decompressions.” Dr. Fontanez asserted, however, that Patient 1 was *not* “a decompression patient.” (Tr. at 84-85)
48. Dr. Fontanez outlined the postoperative strategy that he would have pursued, but stated that he was not able to carry out his plan because his “work relationship with the hospital ended.” (Tr. at 82-83)

Patient 2 – Medical Records

49. In November 2005, Patient 2 was described as a 47-year-old man with a history of back pain extending to the right lower extremity. Dr. Fontanez evaluated the patient on November 9, 2005,

noting among other things an antalgic gait, limited range of motion, weakness of the right lower extremity, and hypoesthesia of the right lower extremity. He ordered further diagnostic studies. During a follow-up visit on November 29, 2005, Dr. Fontanez discussed his findings of right S1 radiculopathy and segmental stenosis at L4-L5 and L5-S1, and he also discussed decompressive lumbar surgery, to which Patient 2 agreed. (St. Ex. 2 at 47, 51-53, 127-139, 545, 611)

50. On December 14, 2005, Patient 2 was admitted to Blanchard Valley RHC. The records include a history and physical examination by Dr. Fontanez on that date. His pre-operative diagnosis was "Segmental and foraminal stenosis, L3-L4, L4-L5, and L5-S1."⁹ (St. Ex. 2 at 329, 333-335)
51. The surgery proceeded on December 14, 2005. (St. Ex. 2 at 329-331) In his operative report, Dr. Fontanez set forth his operative procedures as follows:

* * * A midline incision running from the L3 segment down to the S1 segment was made and carried down to the subcutaneous tissues and further deepened with the Bovie coagulator and cutting. With the periosteal elevators and the osteotomes and the cutting of the Bovie, a subperiosteal dissection of the paraspinal muscles was carried through from L3 to S1 bilaterally from the corresponding lamina and facets.¹⁰ The McCullough and Collis retractors were then placed in situ. A Kocher was placed over L3 spinous process and the level was verified by intraoperative crossfire x-ray.

The soft tissues were dissected free from the spinous processes, lamina, and facets with the ultrasonic aspirator, and once this was done with the cutting of the Bovie the interspinous ligaments were entered and with the dual-action rongeurs and bone cutters the spinous processes of L3, L4, and L5 were shaved down to the base. Once this was done with the 5 mm cutting Stryker high-speed drill, the base of the spinous processes and lamina were shaved down. The ultrasonic aspirator was used to reduce and thin down the yellow ligament as well as epidural fat, and with the combination of 1 mm, 2 mm, and 3 mm Kerrison punch rongeurs, the laminectomies from L3 through S1 were completed. Once this was done with the 3 mm bit of the high-speed Stryker drill

⁹ An intervertebral **foramen** is a passageway between two vertebrae where nerve roots exit the spine. Between every pair of vertebrae, on both the right and left sides, are openings (foramen) through which spinal nerves exit the spinal canal and travel to the rest of the body. **Foraminal stenosis** is a narrowing of a foramen, which can put pressure on the nerves, causing pain, weakness, and numbness. In contrast, the term "spinal stenosis" is typically used to describe a narrowing of the spinal canal. The term "segmental spinal stenosis" may be used to describe a narrowing of the spinal canal in a particular area or segment. Univ. of Maryland Medical Center, Spine Program, "Patient's Guide," at <www.umm.edu/spinecenter/education/low_back_pain_overview.htm>, accessed 11/8/10; MedLinePlus at <www.merriam-webster.com/medlineplus/foramen>, accessed 11/8/10; SpinalStenosis.org, at <www.spinalstenosis.org/foraminal-stenosis.php>; Nervous System Diseases, at <www.nervous-system-diseases.com/foraminal-stenosis.htm>, accessed 11/8/10.

¹⁰ The **facets** are knobs of bone on the vertebrae that form joints linking the vertebrae. There are two facets per vertebra, on the left and right sides. See, e.g., The Cleveland Clinic, Health Information, "Facet Joint Syndrome," at <http://my.clevelandclinic.org/disorders/facet_joint_syndrome/hic_facet_joint_syndrome.aspx>, accessed 11/8/10; Medical Dictionary, MedlinePlus, at <www.merriam-webster.com/medlineplus/facetotomy>, accessed 11/8/10.

system, the lateral gutters were shaved down and hemifacetectomies at L4-L5 were done and foraminotomies at L4-L5-S1 bilaterally were done.¹¹

There was extensive soft tissue and overlay at the L5-S1 segment encountered and this was reduced and removed with a combination of the ultrasonic aspirator and a #2 Kerrison punch rongeur. At the end of the decompression, the thecal sac expanded.¹² Copious saline irrigation was performed and 120 mg of Depo-Medrol were instilled epidurally followed by a layer of Tisseel followed by a layer of DuraGen followed by another layer of Tisseel and another layer of DuraGen and another layer of Tisseel.

Also, a FloSeal was placed over the facets and lateral gutters and then the paraspinal muscles were reapproximated with inverted interrupted 2-0 Vicryl sutures in layers and subcutaneous tissues with inverted interrupted 3-0 Vicryl sutures in layers. The skin was closed with 3-0 nylon mattress interlocking sutures. No drainages were left. There was a total of about 300 cc blood loss. There were no intraoperative complications and the wave patterns were stable throughout the procedure.

(St. Ex. 2 at 329-331)

52. On December 16, 2010, Patient 2 was discharged. (St. Ex. 2 at 327) In his discharge summary, Dr. Fontanez stated in part:

* * * [Patient 2] was admitted for elective decompressive laminectomies which were carried through uneventfully from L3-S1 with bilateral L4 and L5 hemifacetectomies and bilateral L4-L5 and L5-S1 foraminotomies under continuous SSEP monitoring. Surgery went on uneventfully. The patient has had a stable and very good postoperative course with resolution of his preoperative radicular and paresthetic pain. There is residual peri-incisional and lumbar discomfort. He is using a lumbar corset for ambulation. He is able to ambulate fairly well, has better strength on the toes of his right lower extremity, and has had no sphincter complaints. At this point we are discharging him and will be following him up in the office in two weeks for suture removal.

(St. Ex. 2 at 327)

¹¹ **Foraminotomy** is surgery that widens the opening where nerve roots exit the spinal column. By shaving or cutting some bone away to widen the nerve opening (foramen), a foraminotomy takes pressure off of nerves in the passageway from the spinal column. Nat'l Library of Medicine, Nat'l Institutes of Health, MedLine Plus, at <www.nlm.nih.gov/medlineplus/ency/article/007390.htm>, accessed 11/8/10.

¹² The term **thecal sac** is used to describe all three layers that cover the spinal cord, consisting of the dura, the arachnoid, and the pia. The thecal sac surrounds the spinal cord and contains the spinal fluid, also called cerebrospinal fluid. As noted above, in the lumbar spine there is no spinal cord below L1; instead the nerve roots hang like a horse's tail in the fluid-filled thecal sac. E.g., Vaccaro, *Spine: Core Knowledge in Orthopedics* (Elsevier Mosby 2005) at p. 12, reprinted in <<http://books.google.com/books>>, 11/9/10; Cohen, "The anatomy of the cauda equina on CT scans and MRI," at <<http://web.jbjs.org.uk/cgi/reprint/73-B/3/381.pdf>>, accessed 11/9/10.

53. Patient 2 reported that he had been having headaches but that he awakened on December 24, 2005, with a “terrible” headache and fluid leaking out of the wound in his back. The headache was so severe that they attempted to contact Dr. Fontanez, but were told to visit the emergency department. Patient 2 reported that, at the ED, he was given pain medication. However, he continued to have headaches, back pain, and fluid leaking from his wound. (St. Ex. 2 at 65, 205)

54. On December 27, 2005, Patient 2 visited Dr. Fontanez, who noted as follows in the chart:

Wound healing fairly well but there has been some drainage. Several episodes of mild headache. Sutures left in and elastoplast placed over wound.

(St. Ex. 2 at 45) Dr. Fontanez prescribed Imitrex, Percocet, and Robaxin. Further, he instructed the patient to return in one week. (St. Ex. 2 at 45, 65, 169-171)

55. On January 3, 2006, Patient 2 returned as instructed. He was seen by Dr. Fontanez’s associate, Shane Maa, M.D., who observed a collection of spinal fluid under the wound. Dr. Maa was concerned and tried to reach Dr. Fontanez, but “could not reach Dr. Fontanez through repeated phone calls.” Dr. Maa thought there was active leakage of spinal fluid, and he scheduled surgery for the next day to repair the leak and check for infection. Dr. Maa cautioned Patient 2 in writing that the leakage of spinal fluid might not be stoppable if the dura was too fragile. (St. Ex. 2 at 45, 65, 183, 205, 283, 309)

56. Dr. Maa’s preoperative notes include:

There is a healed lumbar laminectomy incision. However, underneath this incision there was fluid. After pressure on the fluid pocket, *clear fluid* started to leak through the suture holes. The fluid collection pocket was measured about 3 x 2 inches.

(St. Ex. at 283, emphasis added)

57. Dr. Maa also noted in his preoperative report:

The patient was examined about a week ago by Dr. Fontanez. The cerebrospinal fluid collection was noticed at the lower part of the incisional area. The sutures were not removed. The patient was brought back today. The collection of the fluid was even more prominent, especially in the lower end. It was measured about 3 inches and 2 inches wide. It is clear to me that the cerebrospinal fluid leakage is prominent [and] that immediate attention has to be taken place.

(St. Ex. at 283)

58. On January 4, 2006, Dr. Maa performed surgery on Patient 2. (St. Ex. 2 at 281) In his operative report, he stated in part:

FINAL POSTOPERATIVE DIAGNOSES:

1. Cerebrospinal fluid leakage from large dural laceration, extending from L4 to S1 level, about a one-inch gap.
2. Status post three-level decompressive lumbar laminectomies on December 14 of 2005.

PROCEDURE:

1. Primary repair of the dural laceration with muscle fascia.
2. Secondary closure of the muscles and fascia.

(St. Ex. 2 at 281) Dr. Maa reported that, upon opening up the superficial layer of tissue, he had encountered a “large amount of cerebrospinal fluid.” He stated that he found an opening in the dura that “measured about one inch in length, about 1/20th inch in width.” (St. Ex. 2 at 281)

59. In a subsequent report of the patient’s history and physical examination in May 2006, Dr. Maa provided further details regarding the January 2006 surgery he performed. He stated that, after locating the inch-long gap in the dura, he had not been able to anchor a repairing suture because the dura had become so attenuated that it was as thin as “tissue paper.” Dr. Maa stated that he had used a muscle fascia to cover the dura hole and had anchored the fascia on the surrounding muscles along the edge of the laminectomy site. In addition, Dr. Maa noted that he had removed “a large amount of cerebrospinal fluid, yellowish mixture of glue and DuraGen.” Dr. Maa opined that glue and DuraGen would never be adequate to prevent leakage from such a large hole in the dura. Dr. Maa noted that he had explained to the patient that the dura was so attenuated that a primary repair had been impossible and that he may have to go back again to repair the torn area after more scar tissue develops around the edge of the laminectomy site, allowing him to anchor a piece of muscle fascia. (St. Ex. at 205)
60. On January 17, 2006, Dr. Maa removed the drain he had inserted. (St. Ex. 2 at 263-265) During 2006, Dr. Maa continued to treat Patient 2, and the medical records include office notes and copies of prescriptions. (St. Ex. 2 at 19-45, 159-191)

Dr. Maa’s office notes describe a series of contacts with Patient 2. For example, on March 30, 2006, the patient called, reporting that his headaches had been quite severe the last two days and that he was having a hard time with all the pain and felt shaky. The patient reported that he “can’t do much of anything” and is “just miserable, not having any good days.” (St. Ex. 2 at 25) On March 31, 2006, Dr. Maa ordered a CT scan and noted that he would like to schedule surgery in May to repair the dura laceration and pseudomeningocele.¹³ A subsequent note indicates that approval was requested for an MRI. (St. Ex. 2 at 25-27)

¹³A meningocele is an abnormal collection of fluid surrounded and confined by the dura, but, with a **pseudomeningocele**, the abnormal collection of fluid has no surrounding membrane but simply lies in a cavity within the soft tissues. See, e.g., testimony by Dr. Poolos (Tr. at 51); Paolini, “Intraspinal postlaminectomy pseudomeningocele,” at SpringerLink, <www.springer-link.com/content/431ljfa2brqpv2wyb>, accessed 11/9/10; Couture, “Spinal pseudomeningoceles and cerebrospinal fluid fistulas: pathophysiological features,” reprinted at Medscape Today, <www.medscape.com/viewarticle/466999_2>, accessed 11/9/10.

61. On April 4, 2006, Patient 2 had a CT scan of the lumbar spine. The radiologist, after listing postoperative changes to specific vertebrae, reported that the “postoperative bed” was remarkable for a large, homogeneous, hypodense, fluid collection. The radiologist commented that the fluid appeared to be “simple fluid,” and that it extended from L3 through L5, measuring 4.4 x 4.7 x 10.8 cm. (St. Ex. 2 at 117)
62. In a pre-operative report on May 1, 2006, Dr. Maa reviewed Patient 2’s history and explained the rationale for further surgery. Among other things, Dr. Maa noted that the recent CT scan had shown a large amount of cerebrospinal fluid leakage at L4 to S1. Dr. Maa also noted the patient’s current complaints including headaches upon standing and limited ability to stand or sit up. Dr. Maa reported that pressure on the patient’s incision area resulted in extreme headache pain. In addition, Dr. Maa considered that there was no indication of infection and that, with the passage of time, more scar tissue had formed. (St. Ex. 2 at 205-207)
63. Dr. Maa performed the surgery on May 1, 2006. In his operative report, he described his efforts to repair the damage but reported that he had found the tissues so fragile that he could not obtain a fully watertight closure. Further, Dr. Maa opined that the dural tear had occurred during Dr. Fontanez’s surgery. (Tr. at 201-203) In his discharge summary on May 4, 2006, Dr. Maa reported that the dura was still as thin as tissue paper and almost irreparable, although he believed that his May 2006 surgery had resulted in an improvement regarding the patient’s headaches. Dr. Maa also opined that Dr. Fontanez had caused extensive and severe injury to Patient 2’s dura. (St. Ex. 2 at 199)
64. The medical records include additional items such as the pathology report from the May 2006 surgery, a July 2006 MRI report, an October 2006 MRI report, an April 2007 MRI report, a September 2007 MRI report, and a lengthy report of a history and physical examination in August 2008 by Jason Schroeder, M.D., noting the ongoing neurological deficits and limited physical abilities, and discussing the potential benefit from further surgery. (St. Ex. 2 at 65-69, 105, 107, 111-113, 115, 209) [A page is missing from the Schroeder report.]

Patient 2 – Dr. Poolos’ Opinion

65. Dr. Poolos reviewed the medical records, noting that Patient 2 had originally been hospitalized on December 14, 2005, with a diagnosis of “segmental and foraminal stenosis L3-4, L4-5 and L5-S1.” He noted that the patient had undergone “surgical decompression on 12/14/05 from L3 to S1 with bilateral L4-5 and bilateral L4-L5 and S1 foraminotomies.” Dr. Poolos explained that the medical records for Patient 2 indicated that Dr. Fontanez had performed a laminectomy, removal of bone and ligamentous structures. He explained that this meant that Dr. Fontanez had taken off the spinous processes, then taken off the lamina, and then opened up the holes through which the individual nerve roots go, thus performing a foraminotomy. (St. Ex. 5, Tr. at 45)
66. Dr. Poolos stated his opinion that, to a reasonable degree of medical certainty, Dr. Fontanez’s treatment of Patient 2 fell below the standard of care for similar practitioners. Specifically, he concluded that Dr. Fontanez’s failure to diagnosis and/or document the diagnosis of spinal fluid

leak and/or his failure to treat the leak appropriately constituted a departure from the applicable standard of care. (Tr. at 45-46)

67. Dr. Poolos explained that the complaints by Patient 2 to Dr. Fontanez following the surgery in December 2005, as documented in the patient's chart, should have alerted Dr. Fontanez to the fact that there was spinal fluid leakage. He stated that headache following spinal surgery is a typical indicator of spinal fluid leak. (Tr. at 46-49; St. Ex. 5)
68. Dr. Poolos stated that, if a patient reported headaches, he would have wanted more information about the headaches, including whether the patient had experienced such headaches before the surgery. Dr. Fontanez testified that the significance of the fluid coming out of the wound would depend on the characteristics of the fluid, which are not set forth in the patient's chart for December 27, 2005. "I'd want to know why they're having these symptoms, the drainage and the headaches, before I let them out of the office." (Tr. at 49)
69. Dr. Poolos stated that such symptoms would prompt him to order an MRI to find out whether there is spinal fluid "collecting outside of where it's supposed to be." If the fluid were serosanguineous [containing blood], then the fluid would look different on an MRI, he stated. (Tr. at 50)
70. Further, Dr. Poolos pointed to the report of Dr. Maa in which he stated that Patient 2 had complained to Dr. Fontanez, two weeks after the surgery, that it was "clear fluid" leaking from his incision area. Dr. Poolos also pointed to the fact that, three weeks after Dr. Fontanez's surgery, Dr. Maa had reported seeing a large collection of spinal fluid and a one-inch tear in the dura. (Tr. at 52)
71. In addition, Dr. Poolos focused on the fact that Dr. Fontanez has applied layers of Tisseel and DuraGen before closing Patient 2's wound, which indicated to him that Dr. Fontanez had been trying to seal a dural leak during the surgery. (Tr. at 46)
72. Dr. Poolos testified that a neurosurgeon would not use Tisseel and DuraGen unless there was a hole or slice in the dura. Dr. Poolos stated that these products are used in neurosurgery to patch over an opening in the dura, sealing a leak until the dura grows back. He stated that he had "never heard of it being used except to seal an opening in the dura or to make up a gap in the dura." He reiterated that there is "no other purpose" that he has "ever heard of."¹⁴ (Tr. at 56)
73. Dr. Poolos noted that Dr. Maa had encountered cerebrospinal fluid and a "yellowish mixture of glue and DuraGen" when he opened the patient's lumbar spinal area during his January 2006 surgery. Dr. Poolos concluded from the presence of these things at Dr. Fontanez's surgical site

¹⁴ Dr. Poolos' testimony regarding the use of DuraGen is supported by the manufacturer's information and instructions, which state that DuraGen is for "repair of dural defects" and is intended for use as a dural substitute to repair the dura. (St. Ex. 6)

that Dr. Fontanez had made “attempts to stop the spinal fluid leak at the surgery.”¹⁵ Dr. Poolos further noted that Dr. Fontanez’s attempt to seal the leak with Tisseel and DuraGen “didn’t stop the leak, for sure.” (Tr. at 53-54)

74. Dr. Poolos also noted that Dr. Fontanez, in his operative report, made no reference to the large laceration of the dura, which Dr. Maa later identified as being a one-inch opening. Dr. Poolos testified that even a tiny hole made in the dura and arachnoid by a spinal needle can cause problems with leakage of spinal fluid, whereas Patient 2 had a one-inch gap, which “is a big gap.” (St. Ex. 2 at 47, 51-53)
75. Dr. Poolos commented that Dr. Fontanez did state in his operative report that he saw the dura “filled out,” in that Dr. Fontanez stated that he observed the thecal sac “expanded.” Dr. Poolos explained that an observation that the thecal sac “expanded” is essentially a statement that the thecal sac looked normal, because, when thecal sacs are watertight and sealed, “you see them expand.” (Tr. at 57)
76. Dr. Poolos testified that the opening or tear in Patient 2’s dura, which Dr. Fontanez had tried to seal, constituted a surgical “complication.” He stated that, even “if you make a needle hole, you indicate that in the report.” Further, Dr. Poolos stated that, when a tear or slice is made in the dura, the patient should have close monitoring post-operatively. Dr. Poolos testified that, even when a dural repair is successfully achieved and no leakage is seen, and the surgeon has subjected the repair to all the tests, the surgeon should still keep a close watch on the patient. (Tr. at 57)
77. Dr. Poolos opined that the “delay in diagnosing and the necessity of a second surgeon diagnosing and treating this condition” constituted a departure from the applicable standard of care. Dr. Poolos pointed to the patient’s complaint of headache, which should have alerted Dr. Fontanez that there was spinal fluid leakage. In addition, Dr. Poolos stated that certain aspects of the operative report indicated that Dr. Fontanez had been aware of the leak and had tried to repair it. Further, Dr. Poolos testified that Dr. Fontanez had failed to conform to the standard of care in neurosurgical practice by failing to be available to address Patient 2’s postoperative problems.¹⁶ While acknowledging that a surgeon “can’t be around 24 hours a day,” Dr. Poolos stated that the surgeon should be “available” to take care of problems or should make sure that someone equally qualified is available to take care of the patient. (St. Ex. 5, Tr. at 45-48, 53)

¹⁵ In his operative report, Dr. Fontanez did not state the purpose for placing the layers of Tisseel and DuraGen nor identify the location where he placed them. (St. Ex. 2 at 329-331)

¹⁶ Dr. Poolos was apparently referring to the situation on December 24 when Patient 2 was suffering from a severe headache, and he and his wife attempted to contact Dr. Fontanez but were told to visit the emergency department, which apparently did little more than provide pain medication, not recognizing the potential significance of this individual’s headache. Further, Dr. Fontanez admitted that he had been “on call” during all of the holiday season. (Tr. at 95; St. Ex. 2 at 65, 205.)

Although Dr. Poolos agreed that it would have been beneficial to the patient if the leakage problem had been attended to soon after the surgery (Tr. at 53), his written conclusion was that the “delay in diagnosing the spinal fluid leak” did not cause harm to Patient 2.¹⁷ (St. Ex. 5)

Patient 2 – Testimony and Written Statement of Dr. Fontanez

78. In support of his testimony at hearing, Dr. Fontanez submitted a statement setting forth his views and opinions regarding his treatment of Patient 2, as follows (emphasis in original):

Initially evaluated on 11/04/05 for persistent and progressive lumbalgia with radicular extension to the right lower extremity and which did not improve with extensive conservative treatment. Pre-operative neuro-imaging workup revealed segmental lumbar stenosis L3-S1 and neurophysiological study revealed right S1 radiculopathy. Pre-operative dynamic lumbar films failed to reveal any evidence of instability.

In view of the above, mechanism of pain, natural history and treatment options were extensively discussed with the patient. Goals, limitations and risks of surgery were also extensively discussed. Surgical risks were delineated as being hemorrhage, infection, *cerebrospinal fluid leakage*, *lumbar nerve root sheath tear*, lumbar nerve root damage, cardiopulmonary complications, pulmonary embolism, phlebitis and *unforeseen events*. The patient agreed to proceed with surgery.

To that effect, the patient was admitted to Blanchard Valley Regional Health Center on 12/14/05, after appropriate pre-operative medical clearance evaluation and was submitted to decompressive lumbar laminectomies from L3 through S1 with bilateral hemifacetomies L4, L5 and bilateral L4, L5 and S1 foraminotomies under SSEP monitoring.

This was a straightforward, uneventful and uncomplicated procedure devoid of any untoward events. It was a tight stenosis with bloated facets and there was also extensive soft tissue thickening and overlay due to chronic, ongoing inflammation and degenerative changes.

The ultrasonic aspirator was used to assist in removal of soft tissues attached to the bone that otherwise would have to be pulled off with cutting rongeurs and in order to thus, minimize blood loss. It was also used to reduce the thickness of the yellow ligament which was ultimately detached from the dural surface with blunt dissectors and Kerrison punch rongeurs in the standard fashion. The ultrasonic aspirator *did not come in any direct physical contact* with the dura; apart from the fact that this device has been designed to be used around nerves and blood vessels.

¹⁷The State did not allege in its notice of opportunity for hearing that Dr. Fontanez caused harm to Patient 2 (in contrast to the specific allegation of harm to Patient 1). Thus, no issue of patient harm is before the Hearing Examiner with respect to Patient 2.

At the end of the procedure the dural/theal sac had expanded and although thin and friable due to *long standing severe tight compression* it was *totally intact and there were no wrents or tears visible under loop magnification. No CSF exudation was encountered under valsalva maneuver. The entire operative field was dry of blood, debris or any evidence of CSF.*

Part of [my] *regular operative technical routine and nuance* in large *decompressive spinal surgeries and in instrumented surgeries as well, was the routine application of Tisseal and Duragen to create a protective barrier for the thecal sac, particularly in the gutters where there can be a potential rubbing effect with the sharp lateral borders of the bony canal. This was the reason why this was done in this case and NOT because a dural tear had been encountered which would have been repaired primarily by suture and would have been documented as well and other measures would have been taken also had that been the case; which it wasn't.*

The patient had an uneventful post operative course and was discharged on 12/16/05. He was seen by [me] outpatient on 12/27/05 and on that visit back pain and spasm was encountered. There was some serosanguinolent discharge, reason for which the sutures were not removed. No abnormal bulge in the peri-operative area was encountered no evidence of infection. A follow up appointment was set within a week. That was the last time that [I] had the opportunity to see the patient.

(Resp. Ex. C) (Emphasis in original)

79. Dr. Fontanez testified that Patient 2 had a very narrow spinal canal in three adjacent segments of the lumbar spine. He stated that, during the surgery, he not only opened up the inner part of the lumbar joints but had opened up the side tunnels where the nerve roots exit from the segments. Dr. Fontanez further testified that, at the end of the procedure, the thecal sac containing the nerve roots expanded due to “the increase in diameter of the canal.” He explained that compressions can narrow the thecal sac, so that when the area is decompressed, the thecal sac expands back to its normal size. Dr. Fontanez asserted that his report of the thecal sac’s being expanded was accurate, and he commented that Dr. Poolos had agreed that an expanded thecal sac indicates that the sac is watertight. Further, Dr. Fontanez testified that “there was no visible rent in the dura, in the operative field.” Dr. Fontanez asserted that, if there had been a tear, the dura would have collapsed.¹⁸ He subsequently clarified that the flaps of the dura “can” collapse on each other. In addition, he testified that, when there is a leak, spinal fluid may pulse into the operative field, but he insisted that his operative field was dry. (Tr. at 85-86, 94, 140)

¹⁸ Dr. Fontanez’s assertion that a tear in the dura would have caused a visible collapse of the dura, before the muscles were closed, does not appear to take into account the prone/horizontal position of the patient at the time, which is significant according to the testimony of Dr. Poolos. Dr. Poolos stated that a dural opening is more likely to leak when the individual stands and is active. (Tr. at 52) He also testified that when a person is “erect, vertical,” there is higher pressure at the bottom of the spine, and that lying flat reduces the chance of leakage from a dural tear. (Tr. at 55)

80. Dr. Fontanez testified that, if he had seen a dural tear, he would have repaired it at that time with sutures, Tisseel, and DuraGen. (Tr. at 95)
81. Dr. Fontanez reiterated that he routinely applies Tisseal and DuraGen to strengthen the dura and to create a buffer between the dura and the bone margins following removal of the yellow ligament that would otherwise serve as a buffer. He stated that using these materials also helps to control bleeding. Further, he stated that Patient 2's dura was thin. He would not describe it as paper thin, but he said it was not as thick as one would normally see. (Tr. at 86-90, 128-129)
82. In addition, Dr. Fontanez stated that he would not release a spinal-surgery patient from the hospital if there had been complaints of headache. He would have kept the patient in the hospital for monitoring and assessment with appropriate neuro-imaging. He also stated that, with a small leak, it can sometimes heal itself. If he had noted a collection of spinal fluid on January 3, 2006, he would not have immediately resorted to surgery but would have tried a "blood patch" under fluoroscopic control, together with a drain. (Tr. at 87-92)
83. With regard to his office note on December 27, 2005, Dr. Fontanez acknowledged that the handwriting is his own. He stated that, only two weeks after the surgery, he had documented the existence of headaches and had noted the drainage. Further, Dr. Fontanez insisted that the drainage had been serosanguinolent even though he did not document that in the chart note. He explained that serosanguinolent drainage is a bloody drainage from capillaries in tissues such as muscles. It is pinkish, as opposed to spinal fluid, which is clear or yellowish. Dr. Fontanez stated that he is sure about what he saw on December 27, 2005, despite the lack of a chart notation, because he has a personal recollection. (Tr. at 88-89, 124-125)
84. Dr. Fontanez said he was not concerned about the drainage in combination with reported headaches on December 27, and that he thought it was sufficient to have the patient come back in a week and see how the patient was evolving at that time. (Tr. at 125)
85. When asked whether he would agree that a headache following spinal surgery would be "a classic symptom of a spinal leak," Dr. Fontanez answered that patients "can have spinal leaks without having headaches as well." He further stated that "headache" is a "very nonspecific symptom," and that "unless they are accompanied by other features that you can distinguish between different categories, but, otherwise, they're very nonspecific." (Tr. at 132-133)
86. With regard to the patient's report of headaches during the December 27 visit, Dr. Fontanez testified that, "If the patient describes it, I write it down." He stated that he had asked about the headaches, whether were accompanied by neck pain or visual symptoms, but the patient had indicated none of that was present. Dr. Fontanez acknowledged, however, that none of these answers about the headaches are in the chart notes. He explained that, "what the patient was complaining to me more of was back pain." However, Dr. Fontanez also acknowledged that there is no mention in his December 27 office note regarding a complaint of back pain. However, Dr. Fontanez testified that he knows there was a complaint of back pain because he prescribed a muscle relaxant. (Tr. at 126)

87. When asked what is the “absolute longest you should keep sutures in after surgery, a laminectomy,” Dr. Fontanez answered that it was “maximum 14 days.” When asked why he had not removed Patient 2’s sutures on December 27 following the surgery on December 14, Dr. Fontanez stated that the wound was not completely healed and that he decided to “have him come back in a week to reevaluate.” However, Dr. Fontanez acknowledged that, as of the time of seeing Patient 2 on December 27, he had already known that he would be on vacation when the patient returned in a week. When asked whether he had charted any instructions regarding the sutures, Dr. Fontanez stated that he could not remember whether he charted the instructions, but he knew he had told the office manager, who was a nurse. (Tr. at 134)
88. With respect to whether the fluid leak could have been detected earlier if he had ordered a CT scan or MRI on December 27, 2005, Dr. Fontanez answered, “Maybe.” He explained that an active spinal fluid leak may not show on an imaging study due to postoperative changes such as swelling, and that bloody fluid usually collects at a surgical site. (Tr. at 132)
89. With respect to Dr. Maa’s observation of a one-inch tear, Dr. Fontanez testified that, just because Dr. Maa observed the tear, that does necessarily mean that the tear existed before Dr. Maa opened the patient. For example, there could have been an adhesion, and, when Dr. Maa opened the muscles, the dura could have torn. Similarly, there could have been a very small tear, which was made bigger by the retraction of the muscles during the second surgery. (Tr. at 92-93, 130-131) In addition, Patient 2 had reported to a subsequent physician that Dr. Fontanez had told him to do “nothing” and that he had felt that being “up with nurses or therapy walking” had been, in his mind, against Dr. Fontanez’s wishes. However, Dr. Fontanez stated that he usually does want patients to be up and walking, although not climbing stairs. (Tr. at 137-138)
90. With regard to not providing care to Patient 2 after the visit on December 27, 2005, Dr. Fontanez stated that he “took time off” and “took a vacation” for the first two weeks of January 2006. He said that he had made arrangements with his colleague, Dr. Maa, to cover for him while he was gone. Dr. Fontanez stated that, when he returned, the patient was seeing Dr. Maa, and then he left his position at Blanchard Valley RHC in February 2006. (Tr. at 95, 123, 126-128)

FINDINGS OF FACT

1. From in or about November 2005 to in or about January 2006, Modesto Fontanez, M.D., undertook the care of Patient 1, who is identified in a patient key that has been placed under seal to protect patient confidentiality.
 - (a) In the regular course of his neurosurgical treatment of Patient 1 for an intraspinal, intradural tumor at the L1–L2 level, Dr. Fontanez inappropriately performed a bilateral laminectomy at T12.

- (b) In performing surgical procedures at T12, Dr. Fontanez failed to distinguish normal spinal cord tissue from abnormal tumor tissue. Dr. Fontanez excised tissue from a normal spinal cord.
- (c) Dr. Fontanez's acts, conduct and/or omissions caused impairment to Patient 1.

There is insufficient evidence, however, to establish that "major" impairment resulted from the biopsy, as alleged. The urologist who examined Patient 1 opined that the post-operative neurological deficits were secondary to the tumor as well as the surgery. The medical record is clear that Patient 1 was already experiencing significant neurological impairment (weakness, difficulty walking, etc.) prior to the surgery. Although Dr. Poolos opined in his written report that Dr. Fontanez had caused "major" neurological impairment, Dr. Poolos stated at the hearing that Dr. Fontanez had caused "damage" to spinal tissues and that the patient had experienced "some neurological sequelae" following the surgery, including lack of bladder control. However, no medical records establish that the patient's bladder problems persisted beyond December 9, 2005, when he was discharged from the hospital a few days after the surgery. In sum, the Hearing Examiner did not find sufficient evidence to characterize the amount of impairment caused by Dr. Fontanez as "major," with regard to impairment that is distinguishable from that caused by the tumor.

2. From in or about November 2005 to in or about January 2006, Dr. Fontanez undertook the care of Patient 2, who is identified in a patient key that has been placed under seal to protect patient confidentiality.
 - (a) Patient 2's preoperative diagnosis was segmental and foraminal stenosis at L3-L4, L4-L5 and L5-S1. In the course of his neurosurgical treatment of Patient 2, Dr. Fontanez performed decompressive lumbar laminectomies, resulting in a dural tear that caused the patient to develop a spinal fluid leak.
 - (b) After Patient 2 developed a spinal fluid leak, Dr. Fontanez failed to diagnose and/or document the diagnosis of the spinal fluid leak, despite the presence of headaches following spinal surgery, and/or Dr. Fontanez failed to treat the spinal fluid leak appropriately.
 - (c) This failure to diagnose and/or document the diagnosis of spinal fluid leak and/or the failure to treat the spinal fluid leak appropriately necessitated a repeat surgery by another neurosurgeon. Although Dr. Fontanez testified that a surgical solution was not necessary, Dr. Maa was justifiably concerned about an active leak of spinal fluid, and the Hearing Examiner finds that it is more likely than not that the repeat surgery was necessitated by Dr. Fontanez's listed failures.

CONCLUSION OF LAW

The acts, conduct, and/or omissions of Modesto Fontanez, M.D., as set forth above in Findings of Fact 1, 1(a), 1(b), 1(c), 2, 2(a), 2(b), and/or 2(c), 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 language is used in R.C. 4731.22(B)(6).

DISCUSSION

In this matter, the statements made by Dr. Fontanez were riddled with inconsistencies. His written and testimonial statements were not only contradicted by reliable evidence such as objective clinical data, but his statements were internally inconsistent as well. His explanations regarding the inconsistencies were not convincing. Indeed, his tone and demeanor during the hearing, together with the content of the evidence, convinced the Hearing Examiner that he was not a trustworthy witness.

The evidence regarding Patient 1 was especially compelling. The medical records present an alarming picture of serious errors and omissions. Nonetheless, if Dr. Fontanez would have come to the hearing with a realization and acceptance that his treatment of one or both of these patients was below the minimal standard of care, and if he had convincingly avowed a dedication to make sure that such errors and omissions never happened again, the Hearing Examiner could have found a potential for training, rehabilitation, monitoring, and future medical practice without undue risk to the public. Similarly, if Dr. Fontanez had offered an explanation that, for example, he knew he had made serious mistakes and errors in judgment but that he had been in a period of unusual circumstances that affected his work, then the Hearing Examiner might have been able to conclude he could practice in the future without undue risk to the public.

In this matter, however, Dr. Fontanez’s presentation indicated that he is lacking in fundamental awareness and/or integrity. Under the circumstances, a limitation to non-surgical practice would not provide sufficient protection to the public. Accordingly, the Hearing Examiner concludes that a permanent revocation of the certificate is necessary to ensure public safety.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Modesto Fontanez, M.D., to practice allopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.


Patricia A. Davidson
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 JANUARY 12, 2011

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Suppan announced that the Board would now consider the Reports and Recommendations, and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Suppan asked whether each member of the Board had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law, Proposed Orders, and any objections filed in the matters of: Anthony Joseph DiCello, M.T.; Bruce T. Faure, M.D.; Modesto Fontanez, M.D.; Kenneth James Fox, P.A., Josh Utah Hill, P.A.; Sridhar K. Iyer, M.D.; Parag Patel, M.D.; Stephen Nels Rhinehart, M.D.; and Jose Vargas, M.D. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Ramprasad	- aye

Dr. Suppan 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:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Ramprasad	- aye

Dr. Suppan noted that, in accordance with the provision in section 4731.22(F)(2), Ohio 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. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member. Dr. Suppan stated that all Board

members may vote on the matters of Kenneth James Fox, P.A., and Jose Vargas, M.D., as those cases are not disciplinary in nature and only involves the respondents' qualifications for licensure.

Dr. Suppan reminded all parties that no oral motions may be made during these proceedings.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....
MODESTO FONTANEZ, M.D., Case No. 08-CRF-132
.....

Dr. Steinbergh moved to approve and confirm Ms. Davidson's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Modesto Fontanez, M.D. Mr. Hairston seconded the motion.

.....
A vote was taken on Dr. Steinbergh's motion to approve and confirm:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Mr. Albert	- abstain
	Dr. Talmage	- abstain
	Dr. Ramprasad	- aye

The motion carried.

STATE MEDICAL BOARD
OF OHIO
2009 JUL -7 PM 12:09

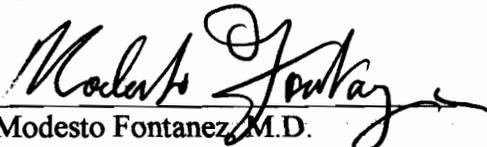
**INTERIM AGREEMENT
BETWEEN
MODESTO FONTANEZ, M.D.
AND
THE STATE MEDICAL BOARD OF OHIO
08 CRF-132**

Modesto Fontanez, M.D., [Dr. Fontanez] hereby agrees that he will not practice medicine and surgery in the State of Ohio until the allegations contained in the November 12, 2008, Notice of Opportunity for Hearing [2008 Notice] issued by the State Medical Board of Ohio [Board] have been heard by the Board through its administrative hearing process and the Board has issued a Final Order. Dr. Fontanez further agrees that any violation of the above-referenced limitation shall subject him to further disciplinary action pursuant to Section 4731.22, Ohio Revised Code. Dr. Fontanez states that he is requesting a continuance of the Board's proceedings for the reasons set forth in "Respondent's First Motion for Continuance" filed with the Board on or about June 10, 2009. Respondent asserts that he currently resides outside of Ohio.

The Board, by its acceptance of this Interim Agreement, hereby agrees not to object, through its counsel, to a continuance of the July 28-29, 2009 hearing date for the 2008 Notice.

This Interim Agreement shall not be construed as an admission by Dr. Fontanez to the allegations contained in the 2008 Notice. Nothing in this Interim Agreement shall be construed to limit Dr. Fontanez's right to a full hearing on the allegations contained in the Board's 2008 Notice.

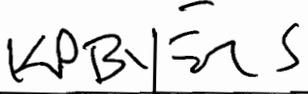
This Interim Agreement shall become effective immediately upon the last date of signature below.

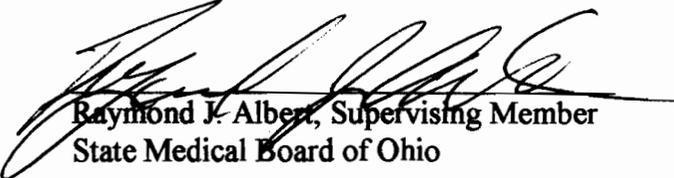

Modesto Fontanez, M.D.


Lance Talmage, M.D., Secretary
State Medical Board of Ohio

6/22/09
Date

7-7-09
Date


Kevin P. Byers
Attorney for Modesto Fontanez, M.D.


Raymond J. Albert, Supervising Member
State Medical Board of Ohio

6/29/09
Date

7/6/09
Date

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

November 12, 2008

Case number: 08-CRF- 132

Modesto Fontanez, M.D.
1838 2nd Avenue, 95th Street
Box #184
New York, NY 10128

Dear Doctor Fontanez:

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) From in or about November 2005 to in or about January 2006, you undertook the care of Patients 1 and 2, as identified on the attached Patient Key (Patient Key confidential and to be withheld from public disclosure). In the regular course of your neurosurgical treatment of Patients 1 and 2, you practiced below minimal standards of care, including, but not limited to, the following:
 - (a) In the course of treating Patient 1 for an intraspinal, intradural tumor at the L1 – L2 level, you failed to distinguish normal spinal cord tissue from abnormal tumor tissue, and inappropriately performed a bilateral laminectomy at T12, causing major neurological impairment as a result of biopsying tissue within a normal spinal cord.
 - (b) After Patient 2 presented with a diagnosis of segmental and foraminal stenosis at L3 – L4, L4 – L5 and L5 – S1, you performed a decompressive lumbar laminectomy that resulted in dural tear, and caused the patient to develop a spinal fluid leak. You failed to diagnose and/or document the diagnosis of and/or failed to appropriately treat said spinal fluid leak, despite the presence of headaches in the upright position following spinal surgery, necessitating a repeat surgery by another neurosurgeon.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute “[a] departure from, or the failure to conform to, minimal

Mailed 11/13/08

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.

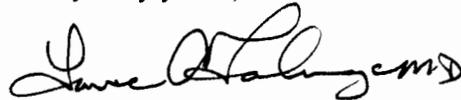
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at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



Lance A. Talmage, M.D.
Secretary

LAT/DSZ/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3934 3683 8068
RETURN RECEIPT REQUESTED