BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **DAVID L. GREENE, M.D.** Holder of License No. **32747** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-07-0728A** **INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") on August 20, 2007. After reviewing relevant information and deliberating, the Board considered proceedings for a summary action against the license of David L. Greene, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearing or other Board action. A.R.S. § 32-1451(D).

INTERIM FINDINGS OF FACT

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

2. Respondent is the holder of License No. 32747 for the practice of allopathic medicine in the State of Arizona.

3. After conducting a formal interview at its August 8-9 meeting the Board issued Respondent a Decree of Censure and placed him on Probation, effective immediately, for multiple mishandled surgical complications and poor clinical judgment. During his opening statement at the formal interview Respondent testified that "over the last year and a half, [he had] not had any major technical complications." Later, in response to a question from a Member of the Board as to whether he had any complications at all in that same period of time Respondent testified he had patients secondary to anesthesia who have difficulty with voiding. The Board then asked whether

Respondent had surgical complications, such as vessel injuries, bowel injuries, nerve root injuries, paraplegia or quadriplegia. Respondent answered he has had no cases resulting in paraplegia, quadriplegia, and "no deaths secondary to technical complications." Respondent did inform the Board of a complication involving a cervical hematoma and one patient who developed increasing numbness and tingling and motor weakness post-surgery. Respondent testified he had no nerve root injuries resulting in foot drop after surgery and no other spine injuries (other than a three stage scoliosis procedure wherein the patient developed some dorsiflexion weakness, but she was only one week post-op). In response to a final question about whether he had any other surgical complications other than a urinary tract infection, Respondent testified he had not.

4. At the formal interview Respondent also reassured the Board that in his practice at the CORE Institute he was working with other experienced surgeons who would be mentoring him and he was working in an environment with a lot of structures in place for the Board to be assured he is practicing competently, appropriately and within the standard of care. One of these physicians spoke on Respondent's behalf at the Call to the Public.

5. Shortly after the Board meeting the Board was informed Respondent was no longer employed by the CORE Institute. CORE also gave the Board the names of two of Respondent's patients, ("DE") and ("DK") both of whom experienced complications during the time period Respondent had represented he had no complications.

Patient DE

6. DE, a seventy-two year-old female patient, died in the recovery room on May 15, 2007 after undergoing an extensive spine surgery performed by Respondent on this same date.

7. On May 10, 2007 Respondent performed an initial first stage surgical procedure on DE for a diagnosis of degenerative scoliosis, degenerative flat back syndrome, rotary lumbar listhesis and lumbar spinal stenosis. Respondent performed this surgery with a vascular surgeon in attendance. Specifically, Respondent performed an anterior lumbar release L2-S1 with anterior

lumbar interbody fusions and buttress plating. Respondent estimated DE's blood loss during the procedure at 800 ccs.

8. Post-surgery DE was monitored in the hospital, transfused and given epogen and her hemoglobin increased from 9.3 on May 12, 2007 to 11.2 on May 14, 2007. DE's coagulopathy studies were within normal limits with a PT of 12.0 and an INR of 1.0. DE's liver studies showed only mildly elevated AST. Respondent returned DE to surgery for the second stage of her procedure on May 15, 2007. Respondent's only assistant was a surgical assistant. Respondent performed a posterior instrumented fusion from T3-S1 with Smith-Peterson Osteotomies at L3-L4, L5-S1, T6-T7, and T10-T11. Respondent described DE as bleeding more than usual during the lumbar portion of the procedure after he had placed bilateral screws from the sacrum up to L2. Respondent placed some tamponade sponges and continued with procedure. Respondent did not investigate the source of bleeding. Respondent also noted that oozing became a problem during the thoracic portion of the procedure. During the procedure DE received seven liters of crystalloid, two units of fresh frozen plasma, 1700 ccs cell saver and eleven units of packed cells. Respondent expedited the normally eight hour procedure in five and one-half hours and emergently proceeded to the recovery room. Upon arrival in the recovery room staff documented that DE was mottled, had a bruised tense abdomen, and was pulseless.

9. Within one minute of arriving in the recovery room DE coded and was resuscitated with a return of pulse and electrical activity. DE received an additional four units of packed red blood cells and four units of fresh frozen plasma, but continued to bleed from multiple areas – nose, eyes, IV sites and wound. Coagulation studies were drawn and the results were drastically different demonstrating DE's clotting ability was severely compromised with a PT of 61, INR of 17, platelet of 21 and fibrinogen below 60. DE's abdomen was distended. Respondent consulted the vascular surgeon who did not think DE would survive an exploratory laparotomy. DE died less than one hour later. In his discharge summary of June 12, 2007 and on the death certificate

Respondent attributed DE's death to disseminated intravascular coagulopathy, liver failure, and scoliosis surgery with general anesthesia.

10. DE's lateral x-rays show an anterior protrusion of a screw though the anterior cortex of S-1.

11. The standard of care with a patient with degenerative scoliosis and back pain requires the physician conduct a thorough history and physical prior to proceeding with a complex two-stage extensive surgical intervention. The standard of care also requires the physician to describe the deformity and the plan for correction and any neurological deficits.

12. Respondent deviated from the standard of care by not conducting a pre-operative history or physical examination of the patient and by not describing the deformity and plan for correction or any neurological deficits.

13. The standard of care requires the surgical procedure be done in a manner to avoid injury to nerve or vascular structures and, if excessive bleeding is encountered, the procedure should be terminated and the source of the bleeding determined.

14. Respondent deviated from the standard of care when, in the face of excessive bleeding during the lumbar portion of the procedure, he continued with the procedure rather than terminating it.

15. DE died after the extensive spinal surgical procedure.

16. DE's complication is a significant complication and contradicts Respondent's testimony at his August 9, 2007 formal interview that he had no significant complications in the past sixteen months.

17. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for

another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent did not document a pathology necessitating the surgical intervention or any discussion of alternative treatments.

Patient DK

18. Respondent performed his initial surgery, a T10-S1 posterior instrumented fusion with Smith Peterson osteotomies at L3-L4, L4-L5 and L5-S1 with interbody fusions of L3-L4 and L5-S1, on DK, a seventy-two year-old female, on May 17, 2007. DK's estimated blood loss for the procedure was 1500ccs. Another physician evaluated DK in consultation and noted she was hypotensive post-surgery and transfused her with two units of packed cells and four liters of crystalloid. DK was stabilized and discharged on May 21, 2007.

19. Respondent's only office record for DK was on May 30, 2007, two weeks post-surgery, and he noted she was doing well. In an admission history and physical to the hospital on July 9, 2007 Respondent documented DK was having fever and chills for a couple of weeks and had been treated with antibiotics. Respondent noted DK's CBC, Sed Rate and CRR had gotten worse. Respondent also noted the wound had no drainage, but on x-ray an interbody cage was migrating into the spinal canal. Respondent's plan for DK was for a debridement, removal of the interbody cage and a PICC line for antibiotics.

20. An infectious disease specialist evaluated DK on July 10, 2007 and obtained a history that DK had a draining wound with erythema from about one week post surgery. This physician noted DK had been on Bactrim and Cipro. DK's SED Rate was 112 and her WBC was 20.7. This physician recommended Vancomycin. Respondent's operative report of this same day documented his debridement and irrigation of an infected lumbar spine wound, and removal of an interbody cage. Respondent also found pockets of purulence about the hardware and also had to repair an iatrogenic dural tear that occurred with removal of the hardware. A consult by another physician noted DK had a MRSA infection of the spine. On July 15, 2007 DK was discharged from

the hospital with a PICC line and home health arrangements for Vancomycin with minimal drainage form the wound.

21. DK's infection post surgery requiring a second surgery for debridement is a complication that Respondent managed appropriately. Respondent managed appropriately DK's technical problem of the interbody cage migrating into the spinal canal, though she did develop an iatrogenic tear. Respondent also managed the tear appropriately.

22. DK's complication is a significant complication and contradicts Respondent's testimony at his August 9, 2007 formal interview that he had no significant complications in the past sixteen months.

23. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). DK had a post-operative wound infection for two to five weeks and was receiving antibiotics. Respondent did not document those findings and the reason for the antibiotics.

24. The facts as presented demonstrate that the public health, safety or welfare imperatively requires emergency action.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent, holder of License No. 32747 for the practice of allopathic medicine in the State of Arizona.

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

patient;") A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;") A.R.S. § 32-1401(27)(jj) ("[k]nowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board;") and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence, or negligence resulting in harm to or the death of a patient.").

3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above, IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 32747, is summarily suspended pending a formal hearing before an Administrative Law Judge from the Office of Administrative Hearings.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

DATED this 20th day of August 2007

[SEAL]

ARIZONA MEDICAL BOARD

By _____
Timothy C. Miller, J.D.
Executive Director

ORIGINAL of the foregoing filed this 20th day of August 2007, with:

Arizona Medical Board
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Scottsdale, Arizona 85258

EXECUTED COPY of the foregoing mailed by US Mail this 20th day of August 2007 to:

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