**BEFORE THE ARIZONA MEDICAL BOARD**

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| In the Matter of<br><br>**DAVID L. GREENE, M.D.,**<br><br>Holder of License No. **32747**<br>For the Practice of Allopathic Medicine<br>In the State of Arizona. | Board Case No. MD-07A-070728-MDX<br><br>**FINDINGS OF FACT,<br>CONCLUSIONS OF LAW AND ORDER**<br><br>(License Revocation) |

On August 6, 2008, this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge (ALJ) Diane Mihalsky's proposed Findings of Fact and Conclusions of Law and Recommended Order. David Greene M.D., ("Respondent") appeared before the Board with legal counsel Paul Giancola, Assistant Attorney General Dean E. Brekke represented the State. Chris Munns, Assistant Attorney General with the Solicitor General's Section of the attorney General's Office, was present and available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

**FINDINGS OF FACT**

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

2. Respondent David L. Greene, M.D. graduated from the University of Virginia School of Medicine in 1997. Between 1997 and 1998, Dr. Greene completed a general surgery internship at Maricopa Medical Center and, between 1998 and 2000, he started an orthopaedic surgery residency at Maricopa Medical Center in Phoenix. After the residency program at Maricopa Medical Center was placed on probation, between 2000 and 2003,

Dr. Greene completed an orthopaedic surgery residency in the Brown University Orthopaedic Residency Program in Providence, Rhode Island.

3. In 2003 and 2004, Dr. Greene completed a fellowship in orthopaedic spine surgery at Beth Israel Spine Institute in New York City, New York.[1]

4. The Board issued License No. 32747 for the practice of allopathic medicine to Dr. Greene.

5. Between the time when Dr. Greene completed his spine fellowship in 2004 and February 2006, he worked at Sonoran Spine Center ("Sonoran") in Phoenix, Arizona. Between April 2006 and August 2007, Dr. Greene worked at the Center for Orthopaedic Research and Education ("CORE") in Sun City, Arizona. He primarily performed orthopaedic spinal surgeries at both jobs. According to Dr. Greene, he "has performed approximately 563 surgical spine cases."[2]

6. The Board received a complaint regarding Dr. Greene's care and treatment of LO. LO's daughter, who was a nurse, filed a complaint and also informed the Board that she was aware of other poor patient outcomes. The Board opened an investigation and assigned Case No. MD-06-1043A to the initial complaint and five other cases.

7. The Board referred the six cases in Case No. MD-06-1043A to Internal Medical Consultant Gerald C. Moczynski, M.D. for review. Dr. Moczynski prepared and submitted a report to the Board.

8. On August 9, 2007, the Board conducted a formal interview of Dr. Greene under A.R.S. § 32-1451(H). During the interview, in response to Board members' direct question, Dr. Greene represented to the Board that, during the preceding year and a half, he had not

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[1] *See* Ex. 7 (Dr. Greene's curriculum vitae).

[2] Dr. Greene's closing statement at 1.

had any other major technical complications in his surgeries, such as vessel injuries, bowel injuries, nerve root injuries, paraplegia, or quadriplegia.[3]

9. The Board subsequently unanimously voted to find that, in Dr. Greene's care of five of the six patients that comprised Case No. MD-06-1043A, Dr. Greene had committed "unprofessional conduct . . . for failure to appropriately deal with surgical complications, for displaying poor clinical judgment in selection of patients for surgery, and for overly aggressive surgical treatment resulting in significant neurologic and vascular injuries."[4]

10. Based on Dr. Greene's representation that he had not experienced any other major technical complications in the preceding year and a half, the Board voted to issue a decree of censure against Dr. Greene and to place him on probation for two years, with close monitoring.[5]

11. On August 16, 2007, based on the Board's vote at the August 7, 2007 meeting, the Board's Executive Director on behalf of the Board issued Findings of Fact, Conclusions of Law, and Order in Case No. MD-06-1043A, issuing a decree of censure against Dr. Greene and placing his license on probation for two years.

12. In the Findings of Fact, Conclusions of Law, and Order in Case No. MD-06-1043A, the Board concluded that Dr. Greene had committed unprofessional conduct in five of the six patient files reviewed, in relevant part as follows:

12.1 On January 29, 2005, Dr. Greene had performed T12-L1 and L2-L3 laminectomy/discectomy with a posterior spinal fusion T10 to L1 with pedicle screw fixation on PH. Dr. Greene's operative report noted no complications and that PH's blood pressure remained stable. PH died on January 31, 2005. A February 2, 2005 pathology report

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[3] *See* Ex. UU (transcript of formal interview proceedings) at 10, ll. 22-23; 64-66, ll. 13-4.
[4] Ex. UU at 105-06, ll. 20-1 (motion); 108, ll. 8-14 (vote).
[5] Ex. UU at 110-11, ll. 22-3 (Dr. Goldfarb); 112, ll. 15-19 (Dr. Petelin).

noted a laceration of PH's abdominal aorta and retroperitoneal hematoma. The Board concluded that Dr. Greene had deviated from the standard of care by failing to diagnose and manage the iatrogenic laceration of PH's aorta, which eventually caused her death, despite PH's continued need for transfusions and a large retroperitoneal bleed.

12.2 On February 2, 2005, Dr. Greene performed transforaminal lumbar interbody fusion of L5-S1 with posterior pedicle screw fixation on RD, a 51-year-old male patient who had been referred by another physician for a second opinion on treatment of back pain. After Dr. Greene's surgery, RD had developed severe right leg pain with foot drop. The Board concluded that Dr. Greene had deviated from the standard of care by failing to use intraoperative fluoroscopy to document the position of the right S-1 pedicle screw to prevent nerve or dural injury.

12.3 Between April and June 2005, Dr. Greene evaluated JD, a 35-year-old male, who presented with a history of mid-back pain following a motor vehicle accident several years earlier. X-rays and an MRI demonstrated an old compression fracture of T-8. On July 25, 2005, Dr. Greene performed a Percutaneous Kyphoplasty at T-8 and T-9 with allograft and fluoroscopy control. Dr. Greene reported that placement of his dilator and working cannula at T-8 was difficult and required three attempts. On awakening, JD had no sensation below T-9. The Board concluded that Dr. Greene had departed from the standard of care, which required a physician to perform a kyphoplasty for osteoporotic compression fractures or traumatic compression fractures with relatively recent history, by performing surgery on a 35-year-old patient who had neither. As a result of the spinal injury that occurred during Dr. Greene's surgery, JD had been rendered a paraplegic.

12.4 LO was a 77-year-old female patient who complained of back and lower extremity pain. On January 6, 2006, Dr. Greene placed pedicle screws from T11-S1, performed a laminectomy at L3-L4 and an interbody cage at L3-L4. After more than four

hours of surgery, after Dr. Greene encountered significant bleeding, he removed the pedicle screws, then obtained a vascular surgery consult. The vascular surgeon found a retroperitoneal hemorrhage from an inferior vena cava injury. Although resuscitative attempts were made, LO died. The autopsy report on LO noted an abdominal aorta laceration at L2-L3, the area where Dr. Greene had performed surgery. The Board opined that the standards of care required Dr. Greene (1) to identify excessive bleeding intra-operatively with a decreased blood pressure as a possible vascular injury and to terminate the procedure and obtain a vascular surgery consult and (2) to consider a patient's age, evaluation, prior treatment failures, co-morbidities, and the extent of planned surgery before proceeding with an extensive elective surgery. The Board concluded that Dr. Greene had deviated from these standards (1) by removing the pedicle screws prior to closure and turning LO for abdominal exploration and (2) by showing poor surgical judgment in deciding to proceed with LO's aggressive elective surgery knowing that LO was 77 years old and had a documented history of cardiac disease and pre-operative anemia.

12.5 GG was a 73-year-old male who had a history of chronic back pain who reported relief with a spinal cord stimulator, which had quit working. On June 13, 2006, Dr. Greene removed old hardware and implanted a new spinal cord stimulator and created a new battery pocket. After GG had problems with delayed healing, on June 26, 2006, Dr. Greene performed surgery to create a new battery pocket in GG's buttock, cultured the wound, washed the battery and leads with Betadine and re-implanted them. Over the next four months, Dr. Greene documented continued drainage from the battery pocket, noted that the battery had failed to charge, and prescribed Cipro. On November 10, 2006, another physician removed the stimulator and debrided the upper and lower back wounds.

The Board concluded that Dr. Greene had deviated from the standard of care, which required that hardware not be re-implanted after it was been removed due to infection.

13. Dr. Greene did not appeal the Board's Findings of Fact, Conclusions of Law, and Order in Case No. MD-06-1043A to superior court and they became final.

14. After the Board entered its order in Case No. MD-06-1043A, it received complaints involving care that Dr. Greene had rendered to patients DE and patient DK in May 2007. DE had died after an extensive procedure that Dr. Greene had performed. DK had had an interbody cage migrate into the spinal canal.

15. The Board felt that both DE's and DK's cases involved technical complications that Dr. Greene should have reported to the Board.

16. The Board contacted Dr. Greene's former employers Sonoran and CORE to request that they identify Dr. Greene's patients who had experienced surgical complications. Sonoran or CORE identified four of Dr. Greene's patients who had experienced serious surgical complications, which cases the Board added to Case No. MD-07-0728A.

17. As a result of the new complaints, on August 20, 2007, on Case No. MD-07-0728A, the Board summarily suspended Dr. Greene's license to practice allopathic medicine in Arizona and referred the complaints to the Office of Administrative Hearings for hearing. The summary suspension was reported in the media.

18. On August 31, 2007, the Board issued an initial complaint in Case No. MD-07-0728A, involving the care that Dr. Greene rendered to patients DE and DK. The Board referred the complaints involving DE and DK to Dr. Moczynski for investigation.

19. The Board received seven additional complaints made by Dr. Greene's former patients or their families, which the Board designated with new case numbers.

20. The Board referred the new complaints to Dr. Moczynski for investigation.

21. On March 11, 2008, the Board issued a second amended complaint, which charged that Dr. Greene had committed unprofessional conduct in his care of patients DE, DK, MB, MC, WR, and TB (Case No. MD-07-0728A), DC (Case No. MD-07-0738A), RW (Case No. MD-07-0762A), AZ (Case No. MD-07-0763A), RJ (Case No. MD-07-0768A), DC (a second patient having the same initials, designated Case No. MD-07-0885A), CD (Case No. MD-07-0857A), and SN (Case No. MD-07-0936A).

22. An administrative hearing was held on April 9, 10, 11, 16, and 17, 2008 and June 11, 2008. The record was held open until June 23, 2008 to allow both parties to file closing memoranda.

23. At the hearing, the Board presented the testimony of Dr. Moczynski and had admitted into evidence 52 exhibits. Dr. Greene testified on his own behalf, presented the testimony of Paul Saiz, M.D., and William A. Norcross, M.D. and had admitted into evidence 145 exhibits.

## EXPERT WITNESS QUALIFICATIONS

### Dr. Moczynski

24. Dr. Moczynski maintains a private practice and has spent on average 20 hours per week consulting for the Board for the past two years. In 1969, he graduated from medical school at the University of Illinois and, in 1974, completed a four-year orthopaedic residency. For the next two years, he was the chief of orthopaedic surgery at the U.S. Naval Hospital at Guantanamo Bay in Cuba. He began practicing in Arizona in 1976. He is board-certified in orthopaedic surgery. There is no separate certification for orthopaedic spinal surgery. At the time he completed his orthopaedic training, there were no fellowships in spinal surgery.

25. Dr. Moczynski testified that one of his mentors during his residency was Ron DeWald, one of the fathers of orthopaedic spinal surgery. He performed multiple spinal

surgeries during his residency. Over the years, he has seen many patients who required spine surgery. Although recently he has not been actively involved in a surgical practice, he has assisted on the cases he has referred to other surgeons. He has worked with doctors at Barrows, including Volker Sonntag, Tim Harrington, and Bill White.

26. Dr. Moczynski has not recently personally performed orthopaedic spinal surgery on which he was the primary surgeon.

27. Because the Board was concerned about Dr. Greene's safety to practice, it asked Dr. Moczynski to perform an expedited review of the 13 new cases it assigned to him.

**Dr. Saiz**

28. Dr. Saiz graduated from the Baylor College of Medicine in 1995. He completed his residency in Orthopaedic Surgery at the Phoenix Orthopaedic Residency Program in 2000. He completed a fellowship in spine surgery at the Sonoran Spine Center in 2001 followed by a fellowship in Musculoskeletal Oncology and Reconstruction at Rush Presbyterian-St. Luke's in 2002.

29. Dr. Saiz presently performs elective spinal surgery in Las Cruces, New Mexico. He is board-certified in orthopaedic surgery, a member of the North American Spine Society, has published and presented on spine surgery, and is the Spine Team physician for New Mexico State University.

30. Dr. Saiz was Dr. Greene's partner at Sonoran. Dr. Saiz left Sonoran in February 2007 to move to New Mexico. He was therefore implicated in the cases that Dr. Greene performed while he worked for Sonoran.

31. In 2006, the Board issued a letter of reprimand to Dr. Saiz.

**Dr. Norcross**

32. William Arthur Norcross, M.D. graduated from Duke University School of Medicine in 1974. Between June 1974 and June 1977, he completed a residency in family medicine at the University of California at San Diego ("UCSD"). He has been licensed as a medical doctor since September 1975.[6]

33. Since 1977, Dr. Norcross has been an instructor or professor of family medicine at various institutions.

34. Since 2007, Dr. Norcross has been a clinical professor of family medicine at the UCSD School of Medicine.

35. Since 1996, Dr. Norcross has been the Director of the UCSD Physician Assessment and Clinical Education ("PACE") program. Dr. Norcross testified that the California Medical Board and Arizona Medical Board have referred many physicians to the PACE program for evaluation of their knowledge and skills.

**Requirements for Expert Testimony**

36. Dr. Greene had admitted into evidence the Standards of Professionalism for Orthopaedic Expert Witness Testimony from the American Association of Orthopaedic Surgeons.[7] Dr. Greene attacked Dr. Moczynski as failing to meet the mandatory standard that "[a]n orthopaedic expert witness shall provide evidence or testify only in matters in which he or she has relevant clinical experience and knowledge in the areas of medicine that are the subject of the proceeding."

37. The mandatory standards also required an expert to review "all pertinent medical records pertaining to a particular patient prior to rendering an opinion on the medical or surgical management of the patient" and to "provide opinions and/or factual testimony in a fair and impartial manner."

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[6] Dr. Norcross' curriculum vitae is Greene Ex. 143.
[7] Greene Ex. 128.

38. Dr. Saiz admitted that he had not reviewed all patient records. Dr. Saiz was also Dr. Greene's former partner and had cared for some of the patients for whom Dr. Greene's care was at issue in these complaints. Dr. Moczynski argued that Dr. Saiz therefore did not meet the Standards of Professionalism for Orthopaedic Expert Witness Testimony.

**EVIDENCE REGARDING DR. GREENE'S CARE OF THE 13 PATIENTS**

**Case No. MD-07-0728A**

**DE**

39. DE was a 72-year-old female patient who had been diagnosed with Hepatitis C. Dr. Greene diagnosed her with degenerative scoliosis, degenerative flat back syndrome, rotary lumbar listhesis, and lumbar spinal stenosis. Dr. Greene testified that he had discussed the high risk of surgery, including death, with DE, but that she had elected to proceed with the surgery because she had no quality of life due to her spinal condition and was suicidal.

40. On May 10, 2007, Dr. Greene performed the anterior surgery on DE with a vascular surgeon in attendance, performing an anterior lumbar release L2-S1 with anterior lumbar interbody fusions and buttress plating. Dr. Greene estimated DE's blood loss during the May 10, 2007 anterior procedure to have been 800 cc.

41. Post-surgery, DE was monitored in the hospital, transfused and given epogen. 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.

42. On May 15, 2007, Dr. Greene returned DE to surgery for the second stage of her procedure. His only assistant was a surgical assistant. Dr. Greene's operative report

noted that he performed a posterior instrumented fusion from T3-S1 with Smith-Peterson Osteotomies at L3-L4, L5-S1, T6-T7, and T10-T11.

43. In his operative report for May 15, 2007, Dr. Greene described DE as bleeding more than usual during the lumbar portion of the procedure, which he characterized as "oozing," after he had placed bilateral screws from the sacrum up to L2. Dr. Greene placed some tamponade sponges and continued with the procedure.

44. During the procedure, DE received seven liters of crystalloid, two units of fresh frozen plasma, 1700 cc's of cell saver, and eleven units of packed cells. Dr. Moczynski testified that DE was given a total of almost 13,000 cc's of fluid, which is more than twice her total blood volume.[8] Dr. Moczynski testified that the documented fluid replacement suggests a more serious condition than the "oozing" that Dr. Greene's operative report described.

45. Dr. Greene expedited the normally 8-hour procedure to 5½ 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.

46. 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 from those drawn before DE's surgery, which demonstrated that DE's clotting ability was severely compromised, with a PT of 61, INR of 17, platelets of 21, and fibrinogen below 60. DE's abdomen was distended. Dr. Greene

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[8] T. 37 at ll. 4-5.

consulted a vascular surgeon, who did not think DE would survive an exploratory laparotomy.

47. DE died less than an hour after she arrived in the recovery room. In his discharge summary of June 12, 2007 and on the death certificate, Dr. Greene attributed DE's death to disseminated intravascular coagulopathy ("DIC"), liver failure, and scoliosis surgery with general anesthesia. No post-operative CT scan or autopsy was performed to determine the actual cause of death.

48. DE's lateral x-rays show an anterior protrusion of a screw through the anterior cortex of S-1. Dr. Moczynski opined that either the screw or the instruments that Dr. Greene had used to insert the screw into the sacrum had caused a vascular injury. The end of the screw was near the vena cava. Dr. Moczynski testified that the intra-operative fluid replacement showed that DE had suffered a huge blood loss.

49. Dr. Greene suggested that such a vascular injury would have been catastrophic and would have been noticed immediately.

50. Dr. Moczynski pointed out that DE was face-down on the operating table for the posterior portion of the procedure, with her belly hanging free. This position would have allowed blood to accumulate in the abdomen, causing the "bruised tense abdomen" noted in the recovery room. From his prior experience with patient PH, for whom an autopsy had confirmed a vascular injury, Dr. Greene would have known that not all vascular injuries result in catastrophic bleeding.

51. Dr. Greene and Dr. Saiz suggested that DE's coagulopathy was caused by liver failure from her chronic Hepatitis C.

52. Dr. Moczynski noted that Hepatitis C is a slowly progressing disease and that DE had been cleared for surgery.

**DK**

53. DK was a 72-year-old female in whom Dr. Greene had performed 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 May 17, 2007.

54. On July 9, 2007, Dr. Greene readmitted DK to the hospital for infection. An x-ray showed that an interbody cage was migrating into the spinal canal. On July 10, 2007, Dr. Greene subsequently performed surgery on DK for a debridement, removal of the interbody cage, and administration of IV antibiotics.

55. Although Dr. Moczynski had initially faulted Dr. Greene for failing to provide adequate medical records for DK, after additional records were produced, Dr. Moczynski withdrew this criticism.

56. A post-surgery infected lumbar spine wound and interbody migration are surgical complications that in DK's case required further surgical intervention. Dr. Moczynski opined that Dr. Greene managed both complications appropriately, as well as an iatrogenic tear that occurred during the second surgery.

57. Dr. Moczynski testified that Dr. Greene should have reported the surgical complications that occurred in DK's case on July 10, 2007 in response to the Board's question less than a month later, at the meeting on August 9, 2007.

**MB**

58. MB was a 15-year-old female with a congenital scoliotic curve.

59. On March 24, 2005, Dr. Greene performed a posterior instrumented fusion from T10-S1 for spinal stenosis. Dr. Greene's operative report documented his posterior fusion and correction of MB's scoliosis from T3 to L2 using C-Arm fluoroscopy.

60. Dr. Greene reported in a progress note on April 14, 2005 that his screw placement was excellent with no migration of screws.

61. Dr. Greene ordered a CT scan of MB, which was taken on November 17, 2005. His report noted that the T-10 screw was not in the pedicle and the T-11 screw went through the costovertebral joint. On December 7, 2005, Dr. Greene noted the malpositioned screws, but called them "acceptable."

62. Dr. Greene testified and had admitted into evidence at the hearing medical literature that stated that screw placement in the costovertebral joint is suboptimal but acceptable.[9]

63. When Dr. Greene's partner at Sonoran, Dennis Crandall, M.D., assumed MB's care and ordered another CT scan in March 2006, he noted the malpositioned screws and took MB to surgery on April 19, 2006 for removal of spinal instrumentation and repair of a pseudoarthrosis with posterior fusion T12-L2.[10] Dr. Crandall noted preoperatively that he was concerned about the danger posed by Dr. Greene's placement of the screws:

> I reviewed all of the images on the CT scan with the family present. There are two screws of concern. The first is on the right at T6. This is lateral to the pedicle indenting the soft tissues of the lung. The second is on the left at T11 in the costovertebral junction and extending up to and underneath the aorta.[11]

Dr. Crandall had also reported to the Board MB's case as a surgical complication of Dr. Greene's.

64. When Dr. Saiz was shown Dr. Crandall's records and an image of MB's screws, he admitted on cross-examination that "[t]hat screw is not within the bone and it is

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[9] Greene Ex. 23-20; T. 818-820; 825; 827, ln. 10-20; 829-830; Ex. 15C; T. 608-610.
[10] Greene Ex. 54, 55.
[11] Board's Ex. L, Tab 19.

lateral. That to me would be a cause of concern. . . . Clearly [the screw] is indenting the pleural sac."[12]

65. Dr. Greene agreed that, in retrospect, he should have informed MB's family of "the acceptable but suboptimal screw placement he was aware of at T11."[13] But he insisted that MB was not harmed by screw placement near her lung and aorta and that there was only a theoretical risk of harm to adjacent structures.[14] He insisted that the primary reason for Dr. Crandall's surgery was the pseudoarthrosis.

**MC**

66. MC was a 70-year-old female who had been diagnosed with back pain secondary to degenerative scoliosis, lumbar spinal stenosis and lumbar spondylosis.

67. On June 30, 2005, MC had a two-stage surgical procedure of the spine in which a vascular surgeon performed the anterior approach and Dr. Greene performed the posterior approach. The anterior approach was accomplished in approximately 4.5 hours, without incident.

68. At 1300 hours, or 1:00 p.m., the anesthesiologist notified Dr. Greene that MC was developing acidosis.[15]

69. At 1309 hours, or 1:09 p.m., Dr. Greene started the posterior portion of the 2-stage surgery on MC.[16] Dr. Greene noted that MC had a dural tear and metabolic acidosis.[17]

70. Although the anesthesiologist reported persistent blood pressure problems at approximately 3:30 p.m., the surgery continued for three more hours.[18]

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[12] T. 715, ll. 10-14.
[13] T. 827-828, 868.
[14] T. 828-30, 613.
[15] Greene Ex. 57, 59.
[16] Greene Ex. 59.
[17] Greene Ex. 56.

71. The pH in MC's arterial blood gases were measured at 7.43 at 10:59 a.m., 7.33 at 12:16 p.m., 7.32 at 3:13 p.m., and 7.17 at 5:19 p.m.[19] Dr. Greene testified that the normal range was 7.35 to 7.45.[20]

72. Dr. Greene testified that, initially, the anesthesiologist told him that MC's acidosis was resolving and that he could continue with the posterior surgery.[21] After the anesthesiologist informed him that the acidosis had returned, Dr. Greene testified that the anesthesiologist did not tell him to terminate the procedure but, instead, advised him to expedite it.[22] Dr. Greene then called in his partner, Dr. Crandall, to expedite the surgery.

73. Dr. Moczynski testified that the surgeon, not the anesthesiologist, is responsible for making the decision whether to proceed with or terminate a surgery.

74. Dr. Greene and Dr. Saiz both testified that the decision to continue MC's posterior surgery was a "judgment call" that was up to the surgeon and, in light of the alleged advice from the anesthesiologist, defensible.

75. Dr. Moczynski testified that anesthesia records documented fluid replacement at 17,500 cc's.[23] He testified that blood loss with volume replacement reduces a patient's ability to clot and causes acidosis.

76. MC was taken post-surgery for an emergency heart catherization and was given a dose of Heparin. Her hemoglobin dropped from 15.3 (normal) at 1845 hours to 4.4 at 2215 hours.[24] The physician who performed the catherization reported that it

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[18] Greene Ex. 57.
[19] Greene Ex. 58.
[20] T. at 9845, l. 21.
[21] T. 533-534, ll. 1-15, 537 ll. 1-7.
[22] T. 539, ll. 19-25; 537, ll. 1-23.
[23] *See* Greene Ex. 57.
[24] T. 540, 542, 546-47; Greene Ex. 132).

demonstrated no coronary occlusion and attributed MC's myocardial injury to hypotension. He also noted that MC had lactic acidosis.

77. Dr. Saiz admitted that a CT scan of MC taken one day post-surgery demonstrated a sacral screw protruding anteriorly.[25] However, Dr. Saiz opined that bi-cortical purchase at S1 was an acceptable screw placement that likely would not have caused any vascular damage because there are fewer vascular structures at that level than at the thoracic levels.[26]

78. Dr. Greene testified that the administration of Heparin caused MC to bleed generally with blood accumulating intraperitoneal and retroperitoneal.[27]

79. MC's condition continued to deteriorate and, on July 22, 2005, she died. Dr. Greene's discharge summary did not report that MC had developed acidosis before he started the anterior portion of her surgery.[28]

80. Dr. Greene testified that, since MC's surgery, he no longer attempts to do the anterior and posterior stages of multi-level adult deformity surgery on the same day, but instead performs the two stages at least two days apart.[29]

**WR**

81. WR was a 65-year-old male whom Dr. Greene initially evaluated in the hospital on August 5, 2005 and diagnosed with a vertebral osteomyelitis and psoas abscess.

82. WR returned to the hospital on August 29, 2005, complaining of difficulty walking.

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[25] T. 717, l. 25.
[26] T. 718, l. 8-17.
[27] T. 547, ll. 4-20; 551-552).
[28] Greene Ex. 61.
[29] T. 984, ll. 5-21.

83. On September 1, 2005, Dr. Greene performed an anterior surgical debridement and reconstruction on WR, with the assistance of a vascular surgeon to localize the blood vessels.[30]

84. During the dissection, Dr. Greene lacerated WR's vena cava, which was repaired by the vascular surgeon. WR required a blood transfusion.

85. Dr. Greene presented medical literature, which indicated that there is a greater than 15% vascular complication rate for the type of surgery that he performed on WR. This is why he had a vascular surgeon present and participating in the surgery.

86. Dr. Saiz called the type of surgery that Dr. Greene performed in WR "a minefield" and testified that "[i]t's only a matter of time before you have a vessel injury. So having a vessel injury in this scenario is completely within an expected complication and his treatment was within the standard of care."[31]

**TB**

87. TB was a 63-year-old male with a history of numerous prior spine surgeries. Dr. Greene evaluated TB for complaints of chronic back pain in March 2005.

88. TB also had a history of a coronary bypass in 1995 and cardiac catheterization in 2002 and was under the care of Tri-City Cardiology Consultants.[32]

89. Dr. Greene requested cardiac clearance for TB. Tri-City Cardiology Consultants administered a stress test to TB on March 9, 2005 and, after discussing the "small to moderate risk of surgery from cardiac standpoint," issued a note clearing TB for spinal surgery.[33]

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[30] Greene Ex. 71B.
[31] T. 423-427; Greene Ex. 129, 34, 35; T. 619-620.
[32] Greene Ex. 63.
[33] Greene Ex 64, 65.

90. On March 22, 2005, Dr. Greene performed a L2-S1 posterior fusion on TB for lumbar stenosis and degenerative disease.[34]

91. TB suffered a dural tear, which Dr. Greene did not recognize during the surgery. The day after the first surgery, TB showed classic symptoms of a dural tear and Dr. Greene performed a second surgery to repair it.

92. Dr. Greene and Dr. Saiz testified that the risk of dural tears increases in revision surgeries, from 5% in initial surgeries to 18% in revision surgeries, due to the presence of scar tissue from the prior procedures.[35] Dural tears are notorious for not been seen initially and for being difficult to repair.[36]

93. Although Dr. Greene interpreted a CT scan report to demonstrate excellent position of the screws, post-surgery, TB had a foot drop on the right, which is a permanent injury that requires TB to wear a foot brace.

94. Dr. Greene testified that the risk of a foot deficit from this type of surgery is approximately 3 to 7%. Dr. Saiz testified that, when the patient exhibits a nerve injury post-operatively, an error by the surgeon cannot by inferred:

> The three factors that come to mind are, number one, scar tissue, mobilization of the nerves as well as straightening out the general scoliosis in all predispose nerves to change post-op.
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> . . . .
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> This was a technically difficult case and there was nothing in [Dr. Greene's] technique that caused the patient's change aside from the main purpose of the surgery which was deformity correction.

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[34] Greene Ex. 66.
[35] T. 771-772; 624-625.
[36] T. 625, 775.

95. Dr. Moczynski had testified that nerve injury is a complication of the surgical procedure that can happen "usually either due to manipulation or traction on a nerve or in cases of hardware being utilized, either a mal-positioned screw or some piece if hardware."[37] But Dr. Moczynski admitted on cross-examination that TB's foot drop, or increased neurologic deficit, was "not due to any identifiable deviation from the standard of care by Dr. Greene."[38]

**DC (Case No. MD-07-0738A)**

96. DC was a 67-year-old female who had had a Kyphoplasty[39] for a compression fracture of the spine at L1 performed by a surgeon in the State of Washington on August 8, 2005. She had returned to Arizona.

97. On September 15, 2005, Dr. Greene evaluated DC. He documented that she had low back pain and right lower extremity numbness and weakness. DC ambulated with the aid of a walker and had right leg weakness or iliopsoas, L4 nerve root strength at 3/4 and L5 and S1 at 4/5. DC had numbness at L2-L3-L4 and intact sensation at L5-S1. Dr. Greene noted that imaging studies demonstrated cement in the spinal canal. Dr. Greene recommended a laminectomy and cement removal due to DC's motor weakness.

98. DC's pre-operative EMG was reported as normal.

99. On September 22, 2005, Dr. Greene performed a laminectomy of T12-L2, medial facetectomy on the right T12-L2, and removal of intradural and extradural cement with mass effect and repair. His operative report states that "I noticed that there were some significant rootlets that had been probably severed during the procedure, but had not suffered any damage from my removal."[40]

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[37] T. 85, ll. 4-9.
[38] T. 241-42, ll. 23-1.
[39] Kyphoplasty is a minimally invasive procedure that utilizes liquid bone glue within the vertebrae.
[40] Greene Ex. 100.

100. A September 23, 2005 post-surgical progress note documented an unchanged sensory examination but decreased motor strength of the right lower extremity. A September 24, 2005 post-surgical progress note documented an unchanged right lower extremity.

101. A right foot drop was noted on September 25 and 26, 2005. DC's post-surgical progress showed a continuing right foot drop that was not present prior to Dr. Greene's surgery.

102. Dr. Moczynski questioned Dr. Greene's decision to operate on DC, despite a normal EMG.

103. Dr. Moczynski also testified that a neurologist assisting at the surgery may have benefited the DC's outcome.

104. Dr. Greene testified that, before he operated on DC, he presented her case to his partners. All of his partners agreed that surgery should be performed and that he, as an orthopaedic spinal surgeon, was competent to perform the surgery. There is significant overlap between the areas of expertise of spinal surgeons and neurologists.

**RW (Case No. MD-07-0762A)**

105. RW was a 47-year-old male who had a history of chronic back pain. After a back surgery in 1997, he was prescribed large doses of Vicodin, Oxycontin, and Morphine. When he was referred to Sonoran, he provided a note stating that he had "an incredible tolerance for narcotics."[41] Dr. Greene's October 4, 2005 report of his initial examination of RW notes that "[h]e has tried all narcotics, but says he is basically immune to them all."

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[41] Greene Ex. 77.

106. Dr. Greene performed surgery on RW on December 15, 2005, with an initial anterior approach and fusion of L4-L5 and L5-S1 with anterior buttress plates and BMP, and then a posterior fusion of L4-L5 and L5-S1 with screw and rod fixation.

107. A progress note dated December 17, 2005 documented that RW was intact to motor and sensory examination and his abdomen was soft and distended. The plan was for pain control.

108. Dr. Greene's partner, Dr. Saiz, saw RW on December 18, 2005. Dr. Saiz noted that RW appeared comfortable and was started on oral medications.

109. Nursing notes dated December 19, 2005 documented that RW was using IV Dilaudid for pain relief.

110. RW was discharged from the hospital on December 19, 2005. Dr. Greene's discharge note documents that RW was doing better with pain control, had intact N/V, and was voiding well. RW's diet was advanced, IV Dilaudid discontinued, and RW was discharged. Dr. Greene prescribed MS Contin 30 mg BID and oral Dilaudid 4 to 8 mg every 3 hours to RW.

111. The only medication instructions that are documented as having been given to RW are the hospital's standard "general information of medication use."[42] These instructions cautioned patients not to take more or less of prescribed medications.

112. RW was readmitted to the hospital on December 20, 2005, with abdominal pain and distention. An x-ray demonstrated a high grade partial ileus. The initial consulting physician noted that, after Dr. Greene's surgery, RW had been placed on a liquid diet but had passed no flatus post surgery prior to discharge when his diet was advanced. He recommended an NG tube and IV fluids.

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[42] Greene Ex. 85.

113. Dr. Greene testified that he did not own a stethoscope. He did not remember whether he had borrowed a stethoscope to listen for RW's bowel sounds. Instead he relied on nurses' notes, which documented bowel sounds and flatus on December 16, 17, 18, and 19, 2005 and a bowel movement on December 17, 2005.[43]

114. Dr. Greene testified that he routinely asked patients whether they are passing gas, have had a bowel movement, or are experiencing nausea or vomiting before discharging them.[44]

115. Dr. Moczynski testified that a physician should personally listen for bowel sounds before discharging a patient, especially after a surgery such as Dr. Greene had performed on RW and administration of Dilaudid. Dr. Greene's reliance on nurses and statement that he did not own a stethoscope was "arrogant."

116. Dr. Saiz agreed that RW probably had an ileus when Dr. Greene discharged him.

117. Another physician discharged RW on December 24, 2005, after he was tolerating oral intake and passing gas. The discharging physician prescribed Percocet-5 every six hours.

118. On December 29, 2005, RW died from a drug overdose. The autopsy report showed that RW had taken between 5 and 8 times the dosage of MS Contin that Dr. Greene had prescribed, in addition to much lower doses of prescription drugs that he had not prescribed.

119. Dr. Moczynski testified that MS Contin was a time-release pain medication that was indicated for chronic pain control. It was not recommended for acute post-surgical pain control. The danger of prescribing a time-release medication for acute pain was that

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[43] T. 492-497, 502; Greene Ex. 79, 80, and tabbed nurse's notes for 12/18/05 and 12/19/05 in the Board's Ex. U.

the patient would not experience expected relief and would take more of the medication. Patients need to be advised that they should not take MS Contin with other sedative medications.

120. Dr. Greene testified a time-release medication like MS Contin is a more humane alternative to immediate relief medications because it provides a more consistent and steady relief.

**AZ (Case No. MD-07-0763A)**

121. AZ was a 24-year-old male with a three-year history of low back pain and numbness in his right leg and foot from a motor vehicle accident in 2001.

122. On September 23, 2005, Dr. Greene performed surgery. His report documents transforaminal lumbar interbody fusion of L4-L5, interbody cage placement at L4-L5 and posterior instrumentation and fusion with pedicle screw fixation.

123. According to Dr. Moczynski's report,[45] on September 24, 2005, a Dr. Singh evaluated AZ in the hospital for a complaint of headache. Dr. Singh's note of the consultation indicates "migraine HA."[46]

124. AZ was discharged from the hospital on September 26, 2005.

125. In a progress note dated October 18, 2005, Dr. Greene documented that AZ had increasing pain in his lower back and serous drainage.[47] There was some redness around the incision. AZ reported that he had taken a neighbor's Cipro for a few days. Dr. Greene continued AZ on Cipro because "[a]ny time you have significant drainage it can increase the risk of infection. . . ."

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[44] T. 498.
[45] Board Ex. X.
[46] Greene Ex. 113.
[47] Greene Ex. 115.

126. In a progress note dated November 8, 2005, Dr. Greene documented that AZ had increasing back pain, fever at night, nausea and vomiting.[48] Dr. Greene recommended surgical drainage.

127. Dr. Greene performed surgery on AZ on November 10, 2005. He documented irrigation and debridement of the lumbar spine wound with closure over a drain.[49] Dr. Greene noted no purulence but did note an intense amount of drainage from the "seroma." AZ was discharged on November 12, 2005.

128. AZ was continued on antibiotics and continued to experience pain in his lumbar spine, which Dr. Greene continued to attribute to the seroma rather than infection. In a progress note dated November 22, 2005, Dr. Greene noted that AZ was "going to try to go back to work fairly soon."[50]

129. In the next progress note, dated December 20, 2005, Dr. Greene noted that AZ probably had a cerebral spinal fluid ("CSF") leak.[51] Dr. Greene stated that "I did not have a CSF leak during my surgery but the patient did have only preoperatively after his IDET procedure. He had a successful blood patch because of this by Dr. Wolff and I think maybe he has a recurrence of this dural leak. Why it would happen at this time frame I have no idea but it looks like it is."

130. AZ had undergone surgery on March 11, 2005 by Michael Wolff, M.D., for an interlaminar epidural injection and blood patch to repair a CSF at L4-L5.[52]

131. On December 22, 2005, Dr. Greene performed surgery on AZ for blood patches and dural repair. Dr. Greene's operative report documented his lumbar

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[48] *Id.*
[49] Greene Ex. 116.
[50] Greene Ex. 115.
[51] *Id.*
[52] Greene Ex. 111.

laminectomy for a dural leak at L4-L5 with scar revision and dural repair.[53] He noted that he could not localize an anterior dural tear but placed Duragen and fibrin glue around the dura.

132. On December 28, 2005, another physician evaluated AZ for headaches and noted that AZ had post-surgical meningitis improving with antibiotics and recommended transfer to a neurologist.

133. On December 30, 2005, neurologist Arnold B. Calica, M.D. evaluated AZ and noted that his lumbar puncture showed evidence of bacterial meningitis.[54] Dr. Calica reviewed a December 29, 2005 myelogram and noted a left paramedian CSF leak or pseudomeningocoele. A CT scan from the same day reported that there was left posterior paramedian thecal sac dehiscence. Dr. Calica noted a screw tract medial to the screw site used on the left and recommended neurosurgical exploration.

134. AZ was returned to surgery for dural repair on January 18, 2006 by Dr. Theodore. Dr. Theodore's operative report documents his laminectomy at L4-L5 with a porcine collagen patch repair of a large posterior dural defect and placement of a drain. He noted that after a complete laminectomy there was ligamentum flava adherent to the dura and, after removal, he found a large posterior dural defect.

135. Subsequent medical records indicate that, through 2007, AZ required continued pain management with fentanyl patches and Percocet. A recent MRI in 2007 showed post-operative changes of laminectomy and fusion and interpedicular screws at L4-L5, clumping of the roots from L3 through L5 and extensive scarring at L4-L5.

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[53] Greene Ex. 118.
[54] Greene Ex. 117.

136. Dr. Greene testified at hearing that the incidence of a dural tear during spinal surgery is between 6 and 8%. His incidence was around 9%, despite doing a lot of revision surgery.[55]

137. Dr. Saiz testified that, after Dr. Greene's first surgery, AZ's symptoms were consistent with an infection and that AZ did not have signs and symptoms of a dural tear through Dr. Greene's second surgery.[56] Dr. Saiz testified that the December 2, 2005 MRI[57] showed no fluid collection, which would have been expected if AZ had an undiagnosed dural tear.[58] Dr. Saiz testified that, when AZ did not improve, a second surgery was performed by two spinal surgeons, Dr. Greene and his partner Dr. Appel, and that they appropriately treated the suspected leak even though they could not find it.[59]

**RJ (Case No. MD-07-0768A)**

138. RJ was a 45-year-old male who was referred to Dr. Greene for complaints of chronic cervical pain. He had undergone spinal surgery in 2005.[60]

139. Dr. Greene first saw RJ on July 24, 2006.[61] Dr. Greene noted that RJ complained of left and right upper extremity pain. Dr. Greene's examination noted weakness of RJ's left arm with no upper motor neuron signs. Dr. Greene did not think that RJ was a candidate for surgery and recommended a spinal cord stimulator.

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[55] T. 765.
[56] T. 647-655.
[57] Greene Ex. 133.

[58] T. 656.
[59] T. 659.
[60] Greene Ex. 102.
[61] Greene Ex. 103.

140. On August 16, 2006, Dr. Greene performed surgery to place a spinal cord stimulator.[62] He documented a laminectomy at C3-C4 with placement of a spinal cord stimulator.

141. In a progress note dated August 28, 2005, Dr. Greene noted that RJ was "getting excellent left arm pain relief right now, but states that his right arm is absolutely 'killing him.'"[63] Dr. Greene noted than an x-ray showed that the spinal cord stimulator lead was a "little bit off to the right in the upper cervical spine." Because "lead placement should be excellent," Dr. Greene had arranged to meet with the stimulator's manufacturer. Dr. Greene noted that RJ's neurological examination was the same.

142. On September 1, 2006, Dr. Greene performed a second surgery for revision of the spinal cord stimulator.[64] He noted that he attempted to position the lead on the stimulator at least 30 times and that subsequently the paddle lead broke. Dr. Greene attributed his difficulty in placing the stimulator to a defect in the paddle.

143. Dr. Saiz testified that 30 attempts to position the lead on the stimulator was excessive.[65] But he testified that it was quite common for a surgeon to experience difficulty in placing the paddle and possible for a surgeon to make 30 attempts.[66] Dr. Greene noted that RJ was neurologically intact upon awakening.

144. A progress note by a medical assistant dated September 2, 2006, noted that RJ was intact neurologically and could be discharged.

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[62] Greene Ex. 104.
[63] Greene Ex. 103.
[64] Greene Ex. 105.

[65] T. 734, ll. 4-17.
[66] T. 669, ll. 10-12, 20-22.

145. Dr. Greene testified at the hearing that he had positioned the spinal cord stimulator over RJ's cervical dura at C3, C4 to mask RJ's symptoms.[67]

146. In an office note from CORE dated September 1, 2006, Dr. Greene noted that he "had to reposition the stimulator because it was a little too close to his right cervical nerve root C3 and C4."[68] No neurological examination was recorded.

147. Dr. Greene's subsequent office note from CORE dated September 13, 2006, noted that RJ's wound was healing well, the paddle was in excellent position, and RJ's right arm pain was slowly diminishing.[69] Dr. Greene placed RJ on Medrol Dosepack for the residual right arm symptoms. No neurological examination was recorded.

148. On October 23, 2006, Dr. Greene noted that RJ had increased pain since he had started physical therapy.[70] Dr. Greene advised RJ to stop the physical therapy. Dr. Greene noted that RJ was neurologically intact except for numbness of the right hand. Dr. Greene noted RJ's previous diagnosis of carpal tunnel syndrome, expressed concern about a double crush syndrome, and placed RJ's right arm in a splint.

149. On or about November 2, 2006, Dr. Greene's partner at CORE, Dr. Appel, saw RJ.[71] Dr. Appel documented that RJ had more pain with the spinal cord stimulator on than off and appeared myelopathic with a Hoffman's sign of the right upper extremity, 3 beats of clonus in the lower extremities, and weakness of the right upper extremity. Dr. Appel recommended an MRI scan and removal of the spinal cord stimulator.

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[67] T. 837-841.
[68] Greene Ex. 103.
[69] *Id.*
[70] *Id.*
[71] *Id.*

150. On November 20, 2006, Dr. Greene removed the spinal cord stimulator that he had previously implanted in RJ.[72] On the pre-surgical physical, he recorded no nerve deficits. Dr. Greene documented his removal of the spinal cord stimulator and noted that, as he pulled it, some of the titanium sensors came off. Dr. Greene accounted for finding 15 of the 16 titanium beads.

151. An MRI of RJ dated December 12, 2006 recorded a signal alteration in the posterior cord at C3-C4 and C4-C5 with a somewhat cystic appearance at C4-C5. It was noted that this was not seen in prior studies and may have indicated a myelomalacia. Also noted was the central disc protrusion at C3-C4 and a right paracentral disc protrusion at C4-C5, which appeared unchanged.

152. Dr. Greene transferred RJ to his partner Dr. Appel, who on December 15, 2006 noted that RJ had significant pain of the right upper extremity with some gait abnormalities and clumsiness of the right upper extremity. Dr. Appel noted RJ's MRI scan evidenced myelomalacia at C3-C4 and C4-C5 and recommended a surgical decompression.

153. On December 27, 2006, Dr. Porter consulted on RJ's case. Dr. Porter recommended an anterior diskectomy at C3-C4, C4-C5, and plate removal at C5-C6 for cervical spondylosis with cord compression and a myelopathy at C3-C4 and C4-C5. This was completed on February 22, 2007.

154. RJ was seen by neurologist Dr. Kahlon on May 22, 2007. Dr. Kahlon diagnosed RJ with chronic pain syndrome and cervical radiculopathy post cervical spine surgery. RJ has been under the care of a physician for pain management since March 2007.

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[72] Greene Ex. 106.

155. Dr. Greene testified that the signal intensity at C4-C5 was below where he placed the spinal cord stimulator at C2.[73]

156. Dr. Saiz noted that RJ was doing well until physical therapy and that the MRI demonstrated that RJ's myelomalacia was a progression of his underlying condition, not due to Dr. Greene's placement of the spinal cord stimulator.[74] RJ had severe spinal stenosis that progressed, with reversal of cervical lordosis, bulging, and impingement of the cord from the front and back.[75] Dr. Saiz explained that the cystic changes on the MRI were below Dr. Greene's surgery and that the architectural changes in RJ's spine (front and back) most likely caused the signal changes.[76]

157. Dr. Moczynski's investigative report to the Board noted that "[t]here is a very high adverse event rate in spinal cord stimulator procedures reported in various studies between 30% and 75%."[77]

**DC (Case No. MD-07-0885A)**

158. DC was a 79-year-old female on whom Dr. Greene had performed surgery on February 15, 2007. His operative report documents his revision laminectomy at L3-S1 with foraminotomies on the left at L3-S1. Dr. Greene testified that he discharged DC on February 16, 2007 with instructions to see him for follow up in another two weeks.[78]

159. DC stated that she returned to the CORE institute on February 26, 2007 for staple removal. Although there is no dictated summary of her visit, CORE's check-out

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[73] T. 855-856.
[74] T. 671, 674.
[75] T. 674-677, 680-81.
[76] T. 676-677.
[77] Board Ex. CC.
[78] T. 559.

sheet shows that DC was seen, her staples were removed, and was told to return in four weeks.[79]

160. Dr. Greene testified that his typical follow up regimen is to see laminectomy patients at two weeks, six weeks, three months and six months.[80] It is the patients' responsibility to schedule successive appointments before they leave after an appointment, but sometimes they do not.[81]

161. DC called CORE on March 4, 2007, stating that she was doing well and was ready for physical therapy and requesting an authorization from CIGNA for her therapy.[82] Dr. Greene provided the referral.[83]

162. DC and CORE coordinated for a physical therapy appointment on April 4, 2007.[84]

163. On June 4, 2007, DC complained to her primary care provider at CIGNA that she had not benefitted from Dr. Greene's surgery and that she was dissatisfied with the care she had received at CORE because Dr. Greene "took approximately seven weeks to send her to her 'rehabilitation' and . . . when she calls she doesn't get any answer."[85]

164. The first follow up report from CORE was from a physician's assistant and was dated July 3, 2007. The physician's assistant reported that DC stated that "although she was doing well at her two-week checkup following the surgery and sutures were removed, she was not able to start physical therapy until several weeks later, and she is

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[79] Greene Ex. 95A.
[80] T. 560-61, 568.
[81] T. 563.

[82] Greene Ex. 95B; T. 564.
[83] Greene Ex. 95C; T. 565.
[84] Greene Ex. 96; T. 566.
[85] Greene Ex. 97.

here today indicating that her pain has returned to almost baseline in intensity in the same distribution that she had before."[86]

165. Dr. Greene and Dr. Saiz testified that Dr. Greene had met the standard of care for the follow up of DC. Dr. Greene saw DC two weeks post-surgery and instructed her to return to the office in four weeks, but she had not made an appointment. Instead, DC called on March 4, 2007, requesting CORE's assistance in scheduling physical therapy.

**CD (Case No. MD-07-0857A)**

166. CD was a 36-year-old male upon whom Dr. Greene performed L5-S1, laminectomy, and instrumented fusion on May 25, 2007.[87] On June 4, 2007, CD returned to Dr. Greene, complaining of left groin and hip pain.[88] Because x-rays did not reveal any problems, Dr. Greene ordered a CT scan.

167. A CT scan was performed on CD on June 8, 2007. John Simon, M.D. reported in relevant part as follows:

> The right S1 screw is contained totally within the osseous structures; however, the left S1 screw does extend out of the anterior cortex approximately 1.1 cm, the tip lying 2 to 3 mm from the common iliac vein. There is approximately 5.5 mm of anterolisthesis of L5 on S1. Bony fusion masses are seen posteriorly as well. There is soft tissue stranding postoperatively. Extensive streak artifact from posterior fusion hardware limits evaluation of the immediately adjacent soft tissues for fluid collection and abscess. No definite collections are seen; however, no contrast was administered. . . .[89]

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[86] Greene Ex. 98.
[87] Greene Ex. 72.

[88] Greene Ex. 73A.
[89] Greene Ex. 74.

168. On June 9, 2007, Dr. Greene's progress note reflects that he informed DC that he "had looked at his previous CAT scan. His screws look fine, no issues here."[90]

169. On August 31, 2007, DC was seen by another physician, Jonathan C. Landsman, M.D. Dr. Landsman reported the extension of the S1 screw beyond the anterior cortex, but reported that he was not able to download the CT scan itself. Dr. Landsman ordered a hard copy of the June 8, 2007 CT scan and ordered an MRI of DC's lumbar spine.[91]

170. Because DC felt that Dr. Greene had misrepresented the results of the June 8, 2007 CT scan, he made a complaint to the Board.

171. Dr. Greene testified that, although the placement of the S1 screw in DC was suboptimal, the screw was definitely in the safe zone.[92]

172. Dr. Saiz testified that the placement of the S1 screw was acceptable and within the standard of care. There is no standard of care on whether to discuss screw placement, unless the screw poses a risk of neurovascular injury.[93] Dr. Greene's failure to discuss placement of the S1 screw with DC was within the standard; DC was not harmed thereby.

173. Dr. Greene testified that, although the placement of the S1 screw was acceptable and will not harm DC, in retrospect he should have explained it to DC.[94]

**SN (Case No. MD-07-0936A)**

174. SN was a 65-year-old female patient with diagnoses of spinal stenosis and degenerative scoliosis. SN had no neurological deficits.

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[90] Greene Ex. 73B.
[91] Greene Ex. 75.
[92] T. 578-580; Ex. 129.
[93] T. 686-687.
[94] T. 581, 975.

175. On April 10, 2007, Dr. Greene operated on SN, accomplishing a laminectomy at L2-L5, transforaminal interbody fusions at L3-L5, and a posterior instrumented fusion at T-10 to L5 with a dural repair at L4-L5.[95]

176. Dr. Greene testified that, to ensure acceptable screw placement, he used palpation, visualization, neurophysiological monitoring, intraoperative x-rays (fluoroscopy), and post-operative x-rays.[96] Dr. Greene testified that these methods all showed acceptable screw placement.[97]

177. Dr. Greene's progress note for April 11, 2007 documented that SN had right lower extremity pain secondary to nerve root irritation and an elevated white blood cell scan, which he noted was secondary to steroids that he had prescribed to her for nerve root irritation. An April 11, 2007 x-ray report noted that SN was post-instrumental fusion of the thoraco-lumbar spine.

178. Dr. Greene reported on April 12, 2007 that SN continued to have right lower extremity pain. He reported on April 13, 2007 that SN's right lower extremity pain was resolving and that she was ready for transfer.

179. SN was discharged from the hospital on April 13, 2007. Dr. Greene's discharge note indicated that SN had nerve root irritation post surgery and had been given steroids. He attributed SN's continued elevated white blood cell count to having been given steroids.

180. On April 23, 2007, Dr. Greene examined SN at his office at CORE. He reported that she was "having a little bit of right hip pain, but that is getting a little bit better." Dr. Greene also noted that SN's "wound does not appear to be infected" but "just look[ed]

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[95] Greene Ex. 86.
[96] T. 867-868.
[97] T. 869.

like it [was] not completely healing appropriately."[98] Dr. Greene did not think that antibiotics were necessary.

181. On April 30, 2007, Dr. Greene noted that SN's wound had "started to breakdown a little bit" and noted "significant redness around the incision." Dr. Greene noted that SN's wound had "not frankly broken down and dehisced."[99] Dr. Greene noted that he had placed SN on antibiotics three days earlier.

182. On May 4, 2007, Dr. Greene reported that SN did not have significant drainage and that the drainage she was having was "serous or serosanguineous, nothing purulent." SN's neurological examination was intact, although she was having "significant right-sided radicular-type symptoms."[100] Dr. Greene ordered a CT scan, a Sed Rate, CRP, and CBC.

183. An MRI scan of SN taken May 5, 2007 was reported as demonstrating dorsal enhancement of the L2-L5 suggestive of an early epidural abscess and soft tissue swelling posterior at L4-L5 compressing the dorsal portion of the dural sac. The abdominal CT scan was reported as showing no intra-abdominal abnormality.

184. On May 10, 2007, Dr. Greene performed surgery on SN to treat the wound infection and to evaluate the hardware.[101] Dr. Greene reported that, "even though two CAT scans showed the pedicle screws were in excellent position, it looked to me as if at L5, there was potentially nerve root slightly hitting up against some of the threads of one of the L5 screws. In addition, at the L4 screw, the pedicle, when I put the screw in, appeared to be loose at some of the medial bone and maybe this was impinging on the exiting nerve root." Dr. Greene removed the two screws.

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[98] Greene Ex. 90.
[99] *Id.*
[100] *Id.*
[101] Greene Ex. 92.

185. SN continued to complain of pain through physical therapy, eventually requiring a walker, although in September and October 2007 Dr. Greene noted that she was "slowly improving."[102]

186. On September 5, 2007, SN was evaluated by Dr. Greene's partner, David Jacofsky, M.D., who reported that she had had left lower extremity discomfort since Dr. Greene's second procedure. Dr. Jacofsky ordered an EMG, which was taken on September 6, 2007. On September 13, 2007, Dr. Jacofsky reviewed the EMG and noted that SN's EMG demonstrated a chronic right L5 radiculopathy and bilateral L4 radiculopathies.

187. On October 1, 2007, Dr. Jacofsky reported that there was no evidence of infection and that SN was improving.

188. Dr. Greene testified that he had met the standard of care intraoperatively and post-operatively because all monitoring techniques showed acceptable screw placement and SN did not complain of post-operative nerve root pain in a dermatomal distribution to implicate a screw. Further, he had followed SN closely, obtained a CT scan on May 4, 2007, which was reported as normal, and had returned SN to surgery on May 10, 2007.[103]

189. Dr. Saiz agreed that Dr. Greene had met the standard of care and that SN did not have symptoms of a screw abutting against a nerve root, which typically results in intractable, obvious pain.[104] Dr. Greene had ordered a CT scan earlier than he would have to identify SN's pathology.[105]

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[102] Greene Ex. 93A and 93B.
[103] T. 887-90.
[104] T. 688-91, 694-95.
[105] T. 696-97.

190. Dr. Greene and Dr. Saiz both testified that Dr. Greene had not harmed SN and that the screw placement did not cause her symptoms.[106]

191. Dr. Moczynski testified that, when he reviewed the May 4, 2007 CT scan of SN, he had seen the mal-positioned screw that Dr. Greene later documented in his surgery. Dr. Greene had not personally reviewed the CT scan and had relied on the doctor who had reported it. If Dr. Greene had ordered a CT scan immediately after the first surgery, or when SN began reporting symptoms, he might have recommended surgery earlier.[107]

**DR. GREENE'S PARTICIPATION IN THE PACE PROGRAM**

192. Dr. Greene voluntarily participated in the PACE program after the Board summarily suspended his license. Dr. Norcross testified that, although it is not unheard of, it is unusual for a physician to voluntarily participate in the PACE evaluation program.

193. Dr. Norcross testified that the physician in charge of the orthopaedic program is Wayne Akeson, M.D.

194. Phase 1 of the PACE program involves administration of a 2-day examination to evaluate the physician's clinical competence and communication skills. Phase 2 is 5-day clinical evaluation, during which the physician accompanies other physicians and is evaluated in patient care. After Phase 2, five to seven physicians, including three from different specialties, conduct a multi-disciplinary meeting to evaluate the physician.

195. Dr. Norcross testified that he understood that Dr. Greene planned to pursue a general orthopaedic surgery practice. Dr. Norcross testified that Dr. Greene scored 97%

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[106] T. 890, 697, 742.
[107] T. 355-56.

on Phase 2 and 89% at the end of Phase 1 of the PACE program. On cross-examination, Dr. Norcross admitted that Dr. Greene had scored in the 10th or lowest percentile on ethics and communication.

196. Dr. Norcross testified that Dr. Akeson had been provided with the Board's August 7, 2007 order of censure on the first five surgical complications in case no. MD-06-0143A. The PACE program had not been provided any information regarding the 13 patient complaints at issue in this case. The additional complaints might have affected Dr. Norcross' opinion of Dr. Greene's safety to practice.

197. Dr. Norcross testified that Dr. Greene displayed a solid fund of knowledge and clinical judgment.

198. Dr. Norcross testified that the PACE program evaluates its attendees critically because it knows that licensing boards are relying on its judgment. Dr. Norcross testified that Dr. Greene had shown an excellent attitude and demeanor toward his participation in the PACE program. Dr. Norcross testified that a physician's PACE evaluations were a good predictor of future behavior.

199. In Dr. Norcross' opinion, Dr. Greene is safe to practice with a proctoring requirement. Dr. Norcross explained that any hospital would require some proctoring of a physician who had recently been granted or been restored privileges.

**ADDITIONAL TESTIMONY**

200. Dr. Greene testified that, during the August 9, 2008 formal interview, he misunderstood that the Board was requesting all surgical complications – not only surgical mistakes (complications from surgical techniques) of the type being discussed during his interview in case no. MD-06-0143A. He therefore did not discuss all complications related to surgery if such complications were recognized or known risks of surgery. He admitted at the hearing that he should have disclosed to the Board complications involving patients DE

(DIC and death), DK (infection and case migration), RJ (neurologic change), and SN (infection and foot deficit).

201. Dr. Greene testified that, while he was in medical school, he was interested in both spinal orthopaedic surgery and a general orthopaedic surgery that focused on sports medicine. He felt that he had chosen the wrong fork in the road when he had decided to become a spinal surgeon. He does not wish to continue performing spinal surgery, in part because some of the cases at issue here have made him unwilling to expose patients to the unavoidable risks of spinal surgery. He wishes to continue his medical career as a general orthopaedic surgeon.

202. Dr. Greene testified about and had admitted into evidence articles from medical journals about the high rate of complications, including complications of the sort that occurred in his care of the thirteen patients at issue, during complex, multi-level and/or revision spinal surgery. He testified as to the large number of spinal surgeries that he had performed. Even considering the complications that occurred in the cases at issue, his rate of complication was lower than the overall reported rate for comparable cases. For some of his patients, he had "hit a home run" and obtained extraordinary relief of symptoms.

203. Dr. Greene had admitted into evidence letters from his former partners, spinal surgeons Dr. Appel, Dr. Jacofsky, and Dr. Saiz, who all have personal experience with Dr. Greene on many cases, attesting to his judgment and skills. Dr. Jacofsky's letter stated that Dr. Greene's rates while at CORE were comparable to other spinal surgeons and that the complication rates "are higher in this type of high risk patient population despite the fact that these are some of the most talented surgeons in the country."[108]

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[108] Greene Ex. 3.

204. Dr. Moczynski conceded that there is no question that Dr. Greene has undergone extensive training by quality programs. Dr. Moczynski questioned whether Dr. Greene is safely able to practice, given his obvious lapses in judgment and errors attributable to limited technical proficiency. These deficiencies cannot be remedied by additional training or oversight.

205. In response to the suggestions from PACE and Dr. Norcross' testimony, Dr. Moczynski offered the opinion that Dr. Greene should, at a minimum, be precluded from any clinical practice involving direct patient care, and should be restricted to an administrative practice. The Board's attorney requested that the Administrative Law Judge recommend that Dr. Greene's license be revoked and that he be assessed the costs of this proceeding.

## CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter.[109] The Board properly referred Dr. Greene's request for hearing to the Office of Administrative Hearings.[110]

2. The Board bears the burden of proof and must establish that Dr. Greene committed unprofessional conduct as defined by applicable statute by a preponderance of the evidence.[111] Dr. Greene bears the burden to establish affirmative defenses by the same evidentiary standard.[112]

3. "A preponderance of the evidence is such proof as convinces the trier of fact that the contention is more probably true than not."[113] A preponderance of the evidence is "[t]he greater weight of the evidence, not necessarily established by the greater number of

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[109] *See* A.R.S. § 32-1401 *et seq.*
[110] *See* A.R.S. § 41-1092.03(B).
[111] *See* A.R.S. § 41-1092.07(G)(2); A.A.C. R2-19-119(A) and (B)(1); *see also Vazanno v. Superior Court*, 74 Ariz. 369, 372, 249 P.2d 837 (1952).
[112] *See* A.A.C. R2-19-119(B)(2).
[113] Morris K. Udall, ARIZONA LAW OF EVIDENCE § 5 (1960).

witnesses testifying to a fact but by evidence that has the most convincing force; superior evidentiary weight that, though not sufficient to free the mind wholly from all reasonable doubt, is still sufficient to incline a fair and impartial mind to one side of the issue rather than the other."[114]

**Case No. MD-07-0728A**

**DE**

4. The standard of care requires a physician to perform a surgical procedure in a manner to avoid injury to vascular structures and, if excessive bleeding is encountered, to terminate the procedure and determine the source of the bleeding.

5. The Board established that Dr. Greene more like than not departed from this standard during his May 15, 2007 surgery on DE, when he encountered excessive bleeding and continued the procedure rather than terminating it. As a result, DE died.

6. A physician is required to maintain adequate medical records, which means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document results, indicate advice and cautionary warnings that the physician has provided to the patient, and sufficient information to allow another practitioner to assume continuity of the patient's care at any point in the course of treatment.[115]

7. Dr. Greene deviated from this standard because he did not document pathology for DE that necessitated the surgical intervention or any discussion of alternative treatments.

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[114] BLACK'S LAW DICTIONARY at page 1220 (8th ed. 1999).

**DK**

8. Dr. Greene admitted at the hearing that he should have disclosed the surgical complications in DK's case in response to the Board's questions at the August 9, 2007 formal interview in Case No. MD-06-1043A.

**MB**

9. The standard of care requires that a patient having posterior fusion for scoliosis, the screws be placed within the pedicle and vertebral body so as not to create a risk of damage to organs or vessels.

10. The Board has established that Dr. Greene deviated from this standard by placing at least one screw in MB's spine that was malpositioned and by failing to recognize that the screw was malpositioned.

11. MB suffered harm in that she required a second surgery for removal of the malpositioned screws. In addition, MB was at risk for significant complications as a result of the malpositioned screws, including a pneumothorax and erosion of the aorta, which could have resulted in massive bleeding and death.

**MC**

12. The standard of care requires that, during an elective, two-stage surgical fusion procedure, if the patient becomes unstable in anesthesia, the surgeon should delay the posterior portion to another time.

13. The Board has established that Dr. Greene deviated from this standard of care by continuing with the posterior portion of the surgery although he had been notified that

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[115] A.R.S. § 32-1401(2).

MC was developing acidosis. After Dr. Greene decided to proceed with the elective surgery, MC died.

14. The Board has not established that Dr. Greene caused a vascular injury to MC or that he should have been aware of excessive bleeding during surgery and investigated its cause.

**WR**

15. The standard of care requires that, when a patient requires surgery, the surgeon should perform the surgery in an efficient and appropriate manner and avoid injury to adjacent vascular structures.

16. The Board has not established that Dr. Greene deviated from this standard. Even though Dr. Greene lacerated WR's vena cava during the surgery, the evidence shows that such laceration was within the known surgical risks and appropriately addressed by Dr. Greene.

**TB**

17. The standard of care requires that a patient with failed prior back surgeries should be carefully evaluated and that, if there is increased cardiac risk, the recommendation should take that into consideration. TB's cardiologist cleared him for surgery, after discussing its cardiac risks. The Board therefore has not established that Dr. Greene deviated from this standard in his care of TB.

18. The standard of care requires that surgery be performed carefully and appropriately to avoid increased nerve injury. Although TB had a foot drop post-surgery, which neurological deficit he did not exhibit pre-operatively, there is no evidence that any surgical error by Dr. Greene caused the deficit. The Board therefore has not established that Dr. Greene deviated from this standard in his care of TB.

19. The standard of care requires that, if a dural tear occurs during surgery, the surgeon should repair it. Dr. Greene presented evidence that dural tears are notoriously difficult to spot and are frequently not noted during surgery. He appropriately repaired the tear after TB exhibited symptoms. The Board therefore has not established that Dr. Greene deviated from this standard in his care of TB.

**DC (Case No. MD-07-0738A)**

20. The standard of care for a patient with a neurologic injury due to extrusion of cement into the spinal canal post-Kyphoplasty requires that the physician present the patient with options, benefits, risks, and complications of treatment. Surgical intervention should be accomplished in a manner to prevent further nerve injury if possible. The patient's pre-operative and post-operative neurological evaluation should be accurately recorded.

21. The Board has established that Dr. Greene deviated from this standard in his care of DC. She suffered a foot-drop that was not present pre-operatively. Dr. Greene's disclaimer in operative report that he did not sever the rootlets is not credible, especially in light of DC's post-operative neurological deficit. Unlike the case of TB, there is evidence that Dr. Greene negligently injured DC.

22. In addition, the Board has established that Dr. Greene deviated from the standard by not discussing less invasive treatment options with DC, especially in light of her normal EMG.

**RW (Case No. MD-07-0762A)**

23. The standard of care for an anterior/posterior lumbar approach is that the physician should monitor for abdominal distention and the presence of bowel sounds. This responsibility cannot be delegated to nurses. The Board has established that RW had an ileus when Dr. Greene discharged him that that Dr. Greene deviated from this standard by

not checking RW for bowel sounds before discharging him. RW suffered actual harm in his readmission.

24. The standard of care also requires a physician to advise patients about the effects and dangers of the medication he prescribes, especially in combination with other medication. The Board has established that Dr. Greene deviated from this standard by prescribing MS Contin to RW, without specifically advising him of its delayed effect or effect in combination with other sedatives, especially after RW said that he was "immune" to narcotics. RW suffered actual harm when he died of a drug overdose from a combination of pain and sedative medications.

**AZ (Case No. MD-07-0763A)**

25. The standard of care requires that, if a post-surgery complication occurs, the surgeon should diagnose the complication through a careful history, physical examination, and appropriate diagnostic studies. If the complication is beyond the scope of the surgeon's training and expertise, he should obtain appropriate consultation.

26. Clear serous draining post-spine surgery should raise concern for a CSF leak. A CSF leak should be timely addressed to prevent the possibility of infection. If the surgeon must perform additional surgery to resolve a CSF leak, he should resolve the problem. The Board has established that Dr. Greene deviated from this standard of care.

27. Dr. Greene's December 20, 2005 progress note for AZ reflects a mechanism for the dural tear that is inconsistent with the histories obtained by other physicians. This inaccurate history may have contributed to his failure to appropriately manage the dural tear.

28. The Board has established that Dr. Greene, as a result of his September 23, 2005 surgery on AZ, created a dural tear posteriorly, which was unrelated to the area of the IDET procedure, and that he failed to diagnose a CSF leak for almost eight weeks, despite

having surgically revisited the area and failing to correlate the non-purulent fluid with a possible CSF leak. Dr. Greene, on his third surgery on AZ, failed to identify the posterior dural tear and ascribed the CSF leak to a more ancient surgical procedure.

29. AZ, as a result of the dural tear and delayed diagnosis of that tear, had apparently sustained bacterial meningitis. Additionally, AZ had to undergo three additional surgical procedures after Dr. Greene's initial fusion on September 23, 2005. AZ has chronic pain and requires Fentanyl patches and has evidence of arachnoiditis on an MRI scan at the surgical area. Dr. Greene placed AZ at increased of harm for a more significant episode of meningitis and was at risk of additional neurological changes or death.

**RJ (Case No. MD-07-0768A)**

30. The standard of care for a patient who is a candidate for an implanted spinal cord stimulator is to have the procedure performed in a manner to avoid injury to the spinal cord. After surgery of the cervical spine, the patient should have a documented neurological evaluation. If the patient has changing neurologic condition, appropriate diagnostic studies should be performed.

31. Dr. Greene's argument that the evidence does not show that his September 23, 2006 surgery caused a neurologic injury to RJ is based in large part on the absence of any record of a neurological change until the December 12, 2006 MRI. This absence in turn is based on Dr. Greene's failure to perform a documented neurological examination of RJ in his immediately post-surgery office notes of September 1, 2006 and September 13, 2006. However, Dr. Greene's office note of October 23, 2006 stated that RJ was neurologically intact.

32. Dr. Greene performed a laminectomy on August 16, 2006 at the C3-C4 level to place the spinal cord simulator initially. This is one of the levels at which the signal

alteration was noted on the December 12, 2006 MRI. Both Dr. Greene and Dr. Saiz testified that Dr. Greene placed the paddle, after 30 attempts, at the C2 level during the September 1, 2006 revision, which could not have injured C3-C4 or C4-C5. This location is not reflected in the operative report.

33. The Board has established that Dr. Greene deviated from the standard of care by making 30 attempts to place the spinal cord stimulator during the September 1, 2006 revision and by failing to document RJ's neurological status for the next six weeks.

34. But the Board has not established that Dr. Greene caused actual harm to RJ.

**DC (Case No. MD-07-0885A)**

35. The standard of care requires a physician to monitor a patient post-operatively to evaluate recovery.

36. The Board has not established that Dr. Greene deviated from this standard in his care of DC. Although Dr. Greene advised DC to schedule a follow up appointment when he removed her staples, she failed to schedule an appointment.

**CD (Case No. MD-07-0857A)**

37. The standard of care requires that test results be accurately recorded and communicated to patients. The Board has established that Dr. Greene failed to accurately record or to communicate the results of the June 8, 2007 CT scan to CD.

38. The Board has not established that Dr. Greene's failures potentially or actually harmed CD.

**SN (Case No. MD-07-0936A)**

39. The standard of care requires a physician to perform a procedure in an appropriate manner. An orthopaedic spinal surgeon should place pedicle screws to avoid causing nerve or vascular injury. A patient should be monitored post-surgery for progress

and complications. A patient with persistent symptoms of radicular symptoms after surgery should be evaluated for possible nerve root impingement.

40. The Board has established that Dr. Greene deviated from this standard of care by placing the L5 screw in his April 10, 2007 surgery on SN such that it abutted against the nerve root.

41. The Board has established that Dr. Greene also deviated from the standard of care by failing to obtain a CT scan when SN developed radicular symptoms post-operatively. Dr. Greene failed to diagnose surgical complications in a timely manner.

42. The Board has established that SN suffered harm in that she developed chronic right radiculopathy due to Dr. Greene's placement of the screw.

**FACTORS IN MITIGATION AND AGGRAVATION**

43. The patients in the cases at issue illustrate that candidates for spinal surgery generally have multiple concomitant morbidities. Dr. Greene established that the risks inherent in complex spinal surgeries are much greater than and are not comparable to the kinds of surgery in which Dr. Moczynski has had most of his experience.

44. But Dr. Greene has not disqualified Dr. Moczynski as an expert. Dr. Moczynski is an orthopedic surgeon, has been involved in spinal surgeries, and is competent to testify. Dr. Greene's criticism goes to the weight to be given his testimony in each case.

45. The inherent risk of a surgical procedure cannot exonerate a surgeon's error. A surgical error cannot be inferred from a poor result but must be based on evidence of the surgeon's specific errors.

46. Most of the cases, viewed alone, would be the kind of result that might occur once in a surgeon's career. The sheer volume of cases created grounds for special concern. In general, "evidence of other crimes, wrongs, or acts is not admissible to prove

the character of a person in order to show action in conformity therewith."[116] In a licensing case, however, the protection of the public requires, at some point, that the sheer volume of established error be considered.

47. Dr. Greene is entitled to defend against these complaints. But his continued insistence that he made no mistakes in his care of patients, only in his disclosure to the Board and to patients, is considered a factor in aggravation. For example, Dr. Greene continued to insist that there was no problem in his screw placement in MB's case, even with the CT scan in front of him and after Dr. Saiz testified that the screw placement was problematic. It does not appear that Dr. Greene is capable of recognizing evidence of that he may have made a mistake in the care of any patient.

48. The Board noted several issues that repeated throughout the review of Dr. Greene. In the ten cases in which the Administrative Law Judge recommends that the Board find that Dr. Green deviated from the standard of care and violated applicable statute, three patients died (MC, DE, and RW); two patients experienced excessive bleeding (MC and DE); three patients showed evidence of malpositioned screws (MB, CD, and SN); two patients suffered nerve injury (RJ and SN); five patients raised issues of surgical judgment concerning whether to initiate or terminate a procedure (MC, DC (kyphoplasty removal), AZ, RJ, and SN); and five patients' medical records were deficient (RW, DC, RW, MB, and SN).

49. The Board has established that Dr. Greene's care of these ten patients constituted 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

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[116] Ariz. R. Evid. 404(b).

the public"); A.R.S. § 32-1401(27)(jj) ("[k]nowingly making a false or misleading statement to 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").

## ORDER

Based on the foregoing, the Board orders that License No. 32747 for the practice of allopathic medicine previously issued to David L. Greene, M.D. be revoked. Pursuant to A.R.S. § 32-1451(M) and 41-1007, Respondent shall reimburse administrative costs.

## RIGHT TO PETITION FOR REHEARING OR REVIEW

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

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

DATED THIS 8th day of August, 2008.

THE ARIZONA MEDICAL BOARD

By _____
LISA WYNN
Executive Director

ORIGINAL of the foregoing filed this 8th day of August, 2008 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 8th day of August, 2008, to:

David L. Greene, M.D.
Address of Record

Paul J. Giancola
*Snell & Wilmer, LL.P.*
One Arizona Center
Phoenix AZ 85004-2202

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