

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **DAVID L. GREENE, M.D.**

4 Holder of License No. **32747**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-07-0728A

**INTERIM FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER
FOR SUMMARY SUSPENSION OF
LICENSE**

7 **INTRODUCTION**

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

14 **INTERIM FINDINGS OF FACT**

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

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

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

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

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

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

19 **Patient DE**

20 6. DE, a seventy-two year-old female patient, died in the recovery room on May 15,
21 2007 after undergoing an extensive spine surgery performed by Respondent on this same date.

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

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

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

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

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

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

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

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

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

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

18 15. DE died after the extensive spinal surgical procedure.

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

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

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

4 **Patient DK**

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

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

18 20. An infectious disease specialist evaluated DK on July 10, 2007 and obtained a
19 history that DK had a draining wound with erythema from about one week post surgery. This
20 physician noted DK had been on Bactrim and Cipro. DK's SED Rate was 112 and her WBC was
21 20.7. This physician recommended Vancomycin. Respondent's operative report of this same day
22 documented his debridement and irrigation of an infected lumbar spine wound, and removal of an
23 interbody cage. Respondent also found pockets of purulence about the hardware and also had to
24 repair an iatrogenic dural tear that occurred with removal of the hardware. A consult by another
25 physician noted DK had a MRSA infection of the spine. On July 15, 2007 DK was discharged from

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

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

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

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

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

20 INTERIM CONCLUSIONS OF LAW

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

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

1 DATED this 20th day of August 2007

2 [SEE



ARIZONA MEDICAL BOARD

3
4 By
5 Timothy C. Miller, J.D.
6 Executive Director

7 ORIGINAL of the foregoing filed this
8 20th day of August 2007, with:

9 Arizona Medical Board
10 9545 East Doubletree Ranch Road
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12 EXECUTED COPY of the foregoing
13 mailed by US Mail this 20th day of
14 August 2007 to:

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