

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.

Board Case No. MD-06-1043A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Decree of Censure and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 August 9, 2007. David L. Greene, M.D., ("Respondent") appeared before the Board with legal
9 counsel Paul J. Giancola for a formal interview pursuant to the authority vested in the Board by
10 A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law
11 and Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of the
14 practice of allopathic medicine in the State of Arizona.

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

17 3. The Board initiated case number MD-06-1043A after receiving a complaint
18 regarding Respondent's care and treatment of a seventy-seven year-old female patient ("LO").
19 The complainant, a nurse, also informed the Board that she was aware of a significant number of
20 additional poor patient outcomes. The Board reviewed six patient records in total and found
21 deviations from the standard of care in five cases. Respondent met the standard of care in the
22 sixth case. However, when viewed with the other five cases, all cases indicate poor surgical
23 judgment with regard to indications for surgery and intraoperative decisions coupled with poor
24 surgical technique.
25

Patient PH

4. Respondent initially evaluated PH, a seventy-one year-old female, on January 28, 2005 noting she had intense low back pain and severe right leg pain of four weeks duration. Respondent noted PH's past medical history of hypertension and physical findings of a weak and painful iliopsoas and diminished sensation of her right groin. Imaging studies demonstrated a large right paracentral disc herniation at T12-L1 and a significant right paracentral disc herniation at L2-L3. Respondent recommended a two level discectomy and a one level fusion at T12-L1. PH's MRI scan reported by another physician on January 17, 2005 noted multi-level disc protrusions T8 through T12 and multilevel spinal stenosis of the lumbar spine with left lateral disc bulge at L2-L3 and right lateral disc bulge at L3-L4.

5. Respondent's operative report of January 29, 2005 was dictated on February 1, 2005 and documents his T12-L1 and L2-L3 laminectomy/discectomy with a posterior spinal fusion T10 to L1 with pedicle screw fixation. Respondent noted no complications during the procedure and that PH's blood pressure remained stable. A Critical Care Specialist ("Dr. M") was consulted on January 29, 2005 and noted he saw PH for hypotension and oliguria. Dr. M. noted PH had surgical replacement of 1.4 liters of lactated ringors, 8.4 liters of normal saline and one liter of cell saver infusion (540 cc). PH's blood pressure was 86/42 and her pulse rate was 92. Dr. M diagnosed hypovolemic shock and oliguric renal insufficiency and recommended crystalloid resuscitation with mannitol diuresis. PH died on January 31, 2005.

6. A February 2, 2005 pathology report notes a final diagnosis of a laceration of the abdominal aorta, retroperitoneal hematoma and peritoneal effusion (2 liters), no evidence of myocardial infarction, bilateral pleural effusions (1 liter) each and bibasilar congestion. In Respondent's dictated report of a meeting with PH's family on February 5, 2005 he states he reviewed PH's abdominal CT scan with a general surgeon on January 31, 2005 noting the large retroperitoneal hematoma and decided to watch the hematoma conservatively and transfuse PH

1 "since in the vast majority of cases it is very very difficult to localize the source of the bleeding."

2 Respondent noted passing out copies of the autopsy report and noting the laceration of the aorta.

3 7. Respondent's discharge summary dictated on February 8, 2005 notes PH's date of
4 death of January 31, 2005 and a discharge diagnosis of disc herniation at T12-L1 and L2-L3,
5 retroperitoneal hemorrhage, bilateral pleural effusion, myocardial infarction and death.
6 Respondent documented PH's hemoglobin was 7.5 in the morning of January 31, 2005 and she
7 was transfused with two units later that evening and it was 6.8 at about 6:30 p.m. and then 5. PH
8 died at 10:20 that evening.

9 8. The standard of care requires a physician to recognize a complication of surgery,
10 diagnose it expeditiously and treat it appropriately with exploration or, at a minimum, contrast
11 vascular studies.

12 9. Respondent deviated from the standard of care by failing to expeditiously diagnose
13 and manage PH's laceration of the aorta despite PH's continued need for transfusions and a
14 large retroperitoneal bleed.

15 10. PH died of hypovolemic shock as a result of an iatrogenic laceration of the aorta
16 that Respondent did not detect for two days despite dropping blood pressures and hemoglobins.

17 **Patient RD**

18 11. RD, a fifty-one year-old male, was seen by a physician on June 8, 2004
19 complaining of low back pain and pain radiating down the left leg. RD saw another physician ("Dr.
20 E") on September 30, 2004. Dr. E noted RD's left leg pain and an MRI scan with an eccentric disc
21 at L5-S1 on the left and subsequently recommended epidural steroid injections. On November 4,
22 2004 another physician's electrodiagnostic studies suggested bilateral chronic lumbar
23 radiculopathy at L5-S1. On December 10, 2004 Dr. E noted RD had minimal leg pain and
24 primarily back pain and suggested he seek a second opinion with an orthopedic surgeon.
25

1 12. Respondent evaluated RD on January 1, 2005 noting RD's left low back pain and
2 left leg pain. Respondent noted RD was 5'7", 170 pounds with tenderness of the left low back and
3 positive straight leg raising of forty degrees on the left. Respondent recommended a complete
4 discectomy with interbody fusion and posterior fusion of L5-S1.

5 13. Respondent performed the procedures on February 2, 2005 documenting
6 transforaminal lumbar interbody fusion of L5-S1 with posterior pedicle screw fixation and fusion
7 with autograft, BMP and fluoroscopy. There is no documentation in the records that Respondent
8 verified screw fixation under fluoroscopy. Respondent noted RD could dorsiflex and plantar flex
9 his toes in the recovery room. Respondent's post-surgery notes document RD's lower right
10 extremity pain on February 3, 2005 with no left leg pain. His subsequent notes of February 4, and
11 5 document continued right lower extremity pain with complaints of weakness of the right foot on
12 February 5 and a right foot drop.

13 14. Respondent's progress note of February 6, 2005 documents no left leg pain, but
14 right leg pain and weakness of dorsiflexion and plantar flexion of the right foot. Respondent
15 ordered an AFO. RD underwent a CT scan on February 7, 2005 – five days post-surgery.
16 Respondent documented the CT scan as demonstrating mal-position of the S-1 right screw with
17 violation of the medial pedicle. Respondent returned RD to surgery on February 8, 2005.
18 Respondent's operative report documents his hardware revision of L5-S1 on the right for a mal-
19 positioned right S-1 pedicle screw and notes he found the screw abutting the nerve root, which
20 was swollen, but appeared intact.

21 15. RD was admitted to another facility on February 11, 2005 for severe right low back
22 pain and right leg pain. RD was discharged on February 19, 2005 on Elavil, Neurontin, Zanaflex,
23 Valium, Oxycontin and Oxycodone for pain control. Respondent's February 25, 2005 office record
24 noted RD was two weeks post-op with weakness of the S-1 root on the right. Respondent placed
25 him on Neurontin. A March 22, 2005 EMG/NCV from another physician documents RD had

1 chronic denervation at L4-S1 on the right and S1 on the left. Respondent's April 5, 2005 office
2 record noted the hardware in good position, but that RD did not have any significant dorsiflexion
3 or plantar flexion.

4 16. The standard of care requires a physician performing a discectomy, interbody
5 fusion and postero-lateral fusion with pedicle screw instrumentation to document the positions of
6 the pedicle screws with fluoroscopy to prevent nerve or dural injury.

7 17. Respondent deviated from the standard of care by failing to document with
8 intraoperative fluoroscopy the position of the right S-1 pedicle screw.

9 18. RD developed severe right leg pain with foot drop.

10 Patient JD

11 19. Respondent initially reevaluated JD, a thirty-five year-old male, on April 7, 2005. JD
12 presented with a history of mid-back pain after a motor vehicle accident. JD complained of
13 increased pain with increased activity and that he had difficulty sleeping. Respondent noted JD
14 had pain over the lower thoracic spine and that x-rays demonstrated an apparent old
15 compression fracture of T-8. JD had a past history of tumor resection from beneath his left
16 scapula in 1999. Respondent recommended an MRI.

17 20. The MRI report of April 29, 2005 demonstrated a superior end plate compression
18 fracture deformity of T8 demonstrating mild wedging with bright signal intensity suggesting a sub-
19 acute fracture and apparent hemangioma of the superior posterior body of T-9. A bone scan
20 reported on June 21, 2005 demonstrated focal activity of T-8 suggesting an acute or sub-acute
21 compression fracture. A CT scan of the thoracic spine demonstrated a mild compression
22 deformity of the superior endplate of T-8 and two ossific densities of T-9.

23 21. Respondent again evaluated JD on June 16, 2005, noted the radiographic studies
24 and normal laboratory work-up and recommended a biopsy. On July 6, 2005 Respondent
25 performed a trans-pedicular biopsy of T-8 and T-9. Respondent's office note of July 13, 2005

1 records JD had a biopsy of T-8 and T-9 with no evidence of infection or malignancy and he
2 recommended a kyphoplasty with bone graft for JD's apparent persistently painful fractures.

3 22. On July 25, 2005 Respondent performed a Percutaneous Kyphoplasty T-8 and T-9
4 with allograft and fluoroscopy control. In his report, Respondent noted that placement of his
5 dilator and working cannula at T-8 was difficult and required three attempts. Respondent then
6 used the drill and fan curette to prepare for the placement of the allograft. Respondent repeated
7 this same procedure at T-9. On awaking, JD had no sensation below T-9. A subsequent MRI
8 demonstrated an epidural hematoma.

9 23. Respondent returned JD to surgery on this same day for a laminectomy of T-8 and
10 T-9 with evacuation of an epidural hematoma and dural repair. Respondent noted at surgery
11 there was a dural tear and a significant irreparable spinal cord injury. Another physician evaluated
12 JD in neurologic consultation and noted JD had decreased sensation below T-8, no motor
13 strength in the lower extremities, and no reflexes in the lower extremities. It was his impression
14 that JD had traumatic cord myelopathy. JD was transferred to another facility for rehabilitation on
15 July 29, 2005.

16 24. The standard of care requires a physician to perform a kyphoplasty for
17 osteoporotic compression fractures or relatively recent history of traumatic compression fractures.

18 25. Respondent deviated from the standard of care by performing kyphoplasty on a
19 thirty-five year-old patient who had neither osteoporotic compression fractures nor relatively
20 recent history of traumatic compression fractures.

21 26. JD is a paraplegic as a result of the spinal cord injury.

22 Patient LO

23 27. Respondent initially evaluated LO on October 5, 2005. LO had back and lower
24 extremity pain in the right more than the left that had increased over the prior few years. LO had
25 tried physical therapy and chiropractic care and was taking Fiorcet, Percocet, Methocabamol,

1 Neurontin, Atenolol, Amytryptiline and Lovastatin. Respondent's examination of LO revealed level
2 shoulders and iliac crests, tenderness of the lumbar spine and no neurological deficit. LO's x-rays
3 revealed degenerative scoliosis of the lumbar spine of forty degrees with a lateral listhesis at L3-
4 L4. An MRI scan revealed lumbar spinal stenosis of L3-L4 and L4-L5. Respondent recommended
5 a laminectomy of L3-L4 and L4-L5, a fusion with pedicle instrumentation from T11 to S1 and
6 interbody fusions. A Persantine myocardial perfusion study interpreted by another physician on
7 November 16, 2005 was an abnormal study with antero-apical ischemia. On November 17, 2005
8 this physician cleared LO as a low risk surgical candidate for spine surgery.

9 28. Respondent's preoperative evaluation notes of January 1, 2006 document he
10 reviewed the procedure and the risks and complications of the procedure with LO and noted her
11 laboratory results (after LO donated blood for an auto-transfusion) as slightly anemic, Hb-10.1
12 and Hct of 29.5. Respondent's operative report of January 6, 2006 notes he placed pedicle
13 screws from T11-S1, performed a laminectomy at L3-L5 and an interbody cage at L3-L4. After
14 more than four hours of surgery Respondent was preparing the L4-L5 disc space for an interbody
15 cage and encountered significant bleeding. Respondent packed the area and LO's blood
16 pressure diminished precipitously. Respondent removed the right sided screws, closed the wound
17 with staples, turned the patient and began resuscitation as LO arrested. LO was stabilized and
18 Respondent obtained a vascular surgery consult. Another physician ("Dr. R") was called to the
19 operating room to perform an exploratory laparotomy. As Dr. R started the procedure, LO
20 arrested again. Dr. R quickly exposed the retroperitoneal area and found a retroperitoneal
21 hemorrhage (estimated at 400 cc) from an inferior vena cava injury. Dr. R controlled the bleeding
22 with direct pressure as resuscitative attempts continued, but the attempts were unsuccessful and
23 LO died. Dr. R dissected the area post-mortem and noted a posterior perforation of the vena
24 cava. In his operative report, Respondent noted he violated the disc space.

1 29. The estimated blood loss from the procedure was listed as 800 cc. The anesthesia
2 record reflects LO was given 3000cc of normal saline, 1900 cc of lactated Ringors', nine units of
3 packed cells (2250cc) and one unit of platelets (total 7250cc) during the four and one-half hour
4 procedure and code. Stat blood work obtained during the code was recorded as an Hct of 16 and
5 Hb of 5.4. Another stat blood work at 13:40 is recorded as Hct of 19 and HB of 6.5.

6 30. Respondent maintained the aortic laceration was not iatrogenic during the surgery
7 because LO would have died on the table. According to Respondent, an aortic tear of 1.7
8 centimeters during a procedure would be fatal at that time. However, the autopsy report notes the
9 abdominal aorta laceration corresponding to L2-L3 – the area where he performed the surgery.

10 31. The standard of care requires a physician performing surgery on the spine to
11 identify excessive bleeding intra-operatively with a decreased blood pressure as a possible
12 vascular injury; to terminate the procedure and obtain a vascular surgery consult.

13 32. Respondent deviated from the standard of care when, after he lacerated the vena
14 cava, he delayed the corrective measures by removing the pedicle screws prior to closure and
15 turning LO for abdominal exploration.

16 33. The standard of care requires a physician to consider the patient's age, evaluation,
17 prior treatment failures, co-morbidities and the extent of the planned surgery before proceeding
18 with an extensive elective surgery.

19 34. Respondent deviated from the standard of care by showing poor surgical judgment
20 in deciding to proceed with LO's aggressive elective surgery knowing she was a seventy-seven
21 year-old patient with a documented history of cardiac disease and pre-operative anemia.

22 35. LO arrested and could not be successfully resuscitated during the procedure after
23 an intra-operative complication – laceration of the inferior vena cava.
24
25

Patient GG

36. Respondent evaluated GG, a seventy-three year-old male patient, who presented with a history of chronic back pain secondary to arachnoiditis from multiple back surgeries in the remote past. GG had been more comfortable with a prior spinal cord stimulator that had stopped functioning. Respondent recommended a new spinal cord stimulator.

37. Respondent performed the procedure on June 13, 2006 and documented the hardware removal, T-11 laminectomy, implantation of a new spinal cord stimulator, and creation of a new battery pocket. On June 20, 2006 GG had problems with delayed healing of the battery pocket and Respondent recommended wet to dry dressings. Respondent performed a second procedure on June 26, 2006 and documented his irrigation and debridement of the lumbar spine and creation of a new battery pocket of the buttock. Respondent cultured the wound and washed the battery and leads with Betadine and re-implanted them.

38. Respondent saw GG on July 6, 2006 with erythema about the spinal incision. On July 18, 2006 Respondent noted purulent drainage from the battery pouch area. On September 9, 2006 Respondent documented problems with the battery not charging, but noted the wound was okay. On September 7, 12, and 21, 2006 Respondent documented continued drainage from the battery pouch area. Respondent started GG on Cipro. On November 10, 2006 another physician removed the spinal cord stimulator and battery and debrided the upper and lower back wounds. On February 5, 2007 Respondent performed irrigation and debridement of thoracic and lumbar spine wounds and a 21 cm scar revision.

39. The standard of care if an infection develops post-surgery requires it be debrided and that hardware from the area of prior infection or potential infection not be re-implanted.

40. Respondent deviated from the standard of care by re-implanting hardware from a potentially infected area.

1 41. GG required additional surgery as a result of the subsequent infection of all the
2 hardware areas and could have developed an epidural abscess with tracking of the infection
3 along the leads.

4 **Patient DB**

5 42. Respondent evaluated DB, a fifty-three year-old male patient, in 2006 for severe
6 cervical spondylosis and spinal cord compression. Respondent performed surgery on August 10,
7 2006 and documented an anterior cervical discectomy and fusion of C3-C7 with plate and
8 screws. Post-operatively DB developed a cervical hematoma resulting in respiratory compromise
9 that required emergent intubation and a return to surgery on August 11, 2006 at which time
10 Respondent evacuated a cervical wound hematoma. Respondent's office records of October 17,
11 2006 document a screw backing out of the distal plate. On January 20, 2007 Respondent
12 performed a procedure to remove the loose screw. On February 9, 2007 Respondent
13 documented DB was doing well, but may need a posterior fusion.

14 43. A patient with severe cervical spondylosis and spinal cord compression is a
15 candidate for surgical decompression and fusion. The standard of care requires the surgery be
16 accomplished with care and all bleeding controlled and a post-surgical drain utilized to prevent
17 hematoma formation. Although Respondent met the standard of care in this case, it is concerning
18 when viewed with the cases above.

19 **Complications in the Last Sixteen Months**

20 44. Respondent maintained that over the past year and one-half he has not had any
21 major technical complications; no surgical complications such as vessel injuries, bowel injuries,
22 nerve root injuries, paraplegia, quadriplegia, and no deaths secondary to technical complications;
23 he had one cervical hematoma in a patient who did not disclose he was a drinker; and one patient
24 who, immediately post-op of an uneventful L5-S1 fusion began having increasing numbness and
25 tingling and motor weakness in her lower extremities. Respondent maintained he returned the

1 patient to surgery and there was no evidence of hematoma and within eight hours from the index
2 procedure, the patient was normal neurologic function.

3 **Finding of Immediate Effectiveness**

4 45. It is necessary for this decision to take immediate effect to protect the public health
5 and safety. A.A.C. R4-16-102(B).

6 **CONCLUSIONS OF LAW**

7 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
8 and over Respondent.

9 2. The Board has received substantial evidence supporting the Findings of Fact
10 described above and said findings constitute unprofessional conduct or other grounds for the
11 Board to take disciplinary action.

12 3. The conduct and circumstances described above constitutes unprofessional
13 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be
14 harmful or dangerous to the health of the patient or the public"); and A.R.S. § 32-1401(27)(II)
15 ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence
16 resulting in harm to or the death of a patient.").

17 **ORDER**

18 Based upon the foregoing Findings of Fact and Conclusions of Law,

19 IT IS HEREBY ORDERED:

20 1. Respondent is issued a Decree of Censure for multiple mishandled surgical
21 complications and poor clinical judgment.

22 2. Respondent is placed on probation for two years with the following terms and
23 conditions:

24 a. Respondent shall maintain a log of all operative procedures he performs. The log
25 shall include the identity of the patient; the indications for the procedure performed; the outcome of

1 the procedure; and any complications experienced. Respondent shall submit the log to the Board
2 each month.

3 b. Respondent is subject to periodic chart reviews by Board Staff. Respondent shall
4 cooperate fully with Board Staff and provide the charts when requested.

5 c. Respondent must notify all hospitals, surgery centers, etc., where he is on staff or
6 has privileges to immediately report any complications to the Board. Respondent is responsible for
7 ensuring the reports are filed.

8 d. Respondent must report to the Board within five calendar days any malpractice
9 cases that are filed or any actions taken against his privileges by any facility.

10 e. Respondent shall obey all federal, state, and local laws and all rules governing the
11 practice of medicine in Arizona.

12 f. Respondent shall submit quarterly declarations under penalty of perjury on forms
13 provided by the Board, stating whether there has been compliance with all conditions of probation.
14 The declarations must be submitted on or before the 15th of March, June, September, and
15 December each year beginning on December 15, 2007.

16 3. In the event Respondent should leave Arizona to reside or practice outside the
17 State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall
18 notify the Executive Director in writing within ten days of departure and return or the dates of non-
19 practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during
20 which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent
21 residence or practice outside Arizona or of non-practice within Arizona, will not apply to the
22 reduction of the probationary period.

23 **RIGHT TO APPEAL TO SUPERIOR COURT**

24 Respondent is hereby notified that this Order is the final administrative decision of the
25 Board and that Respondent has exhausted his administrative remedies. Respondent is advised

1 that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to
2 Title 12, Chapter 7, Article 6.

3 DATED this 16th day of August 2007.



THE ARIZONA MEDICAL BOARD

By [Signature]
TIMOTHY C. MILLER, J.D.
Executive Director

8 ORIGINAL of the foregoing
9 16th day of August, 2007 with.

10 Arizona Medical Board
11 9545 East Doubletree Ranch Road
12 Scottsdale, Arizona 85258

12 Executed copy of the foregoing
13 mailed by U.S. Mail this
16th day of August, 2007, to:

14 Paul Giancola
15 Snell & Wilmer, LLP
16 400 East Van Buren
17 Phoenix, Arizona 85004 2202

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

20 [Signature]
21
22
23
24
25

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.

Board Case No. MD-07A-070728-MDX

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**
(License Revocation)

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

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

17 **FINDINGS OF FACT**

- 18 1. The Arizona Medical Board ("the Board") is the duly constituted authority for the
19 regulation and control of the practice of allopathic medicine in the State of Arizona.
- 20 2. Respondent David L. Greene, M.D. graduated from the University of Virginia
21 School of Medicine in 1997. Between 1997 and 1998, Dr. Greene completed a general
22 surgery internship at Maricopa Medical Center and, between 1998 and 2000, he started an
23 orthopaedic surgery residency at Maricopa Medical Center in Phoenix. After the residency
24 program at Maricopa Medical Center was placed on probation, between 2000 and 2003,
25

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

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

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

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

13 6. The Board received a complaint regarding Dr. Greene's care and treatment of
14 LO. LO's daughter, who was a nurse, filed a complaint and also informed the Board that
15 she was aware of other poor patient outcomes. The Board opened an investigation and
16 assigned Case No. MD-08-1043A to the initial complaint and five other cases.

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

20 8. On August 9, 2007, the Board conducted a formal interview of Dr. Greene under
21 A.R.S. § 32-1451(H). During the interview, in response to Board members' direct question,
22 Dr. Greene represented to the Board that, during the preceding year and a half, he had not
23

24 ¹ See Ex. 7 (Dr. Greene's curriculum vitae).

25 ² Dr. Greene's closing statement at 1.

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

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

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

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

16 12. In the Findings of Fact, Conclusions of Law, and Order in Case No. MD-06-
17 1043A, the Board concluded that Dr. Greene had committed unprofessional conduct in five
18 of the six patient files reviewed, in relevant part as follows:

19 12.1 On January 29, 2005, Dr. Greene had performed T12-L1 and L2-L3
20 laminectomy/discectomy with a posterior spinal fusion T10 to L1 with pedicle screw fixation
21 on PH. Dr. Greene's operative report noted no complications and that PH's blood pressure
22 remained stable. PH died on January 31, 2005. A February 2, 2005 pathology report
23

24 ³ See Ex. UU (transcript of formal interview proceedings) at 10, ll. 22-23; 64-66, ll. 13-4.

25 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).

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

5 12.2 On February 2, 2005, Dr. Greene performed transforaminal lumbar interbody
6 fusion of L5-S1 with posterior pedicle screw fixation on RD, a 51-year-old male patient who
7 had been referred by another physician for a second opinion on treatment of back pain.
8 After Dr. Greene's surgery, RD had developed severe right leg pain with foot drop. The
9 Board concluded that Dr. Greene had deviated from the standard of care by failing to use
10 intraoperative fluoroscopy to document the position of the right S-1 pedicle screw to
11 prevent nerve or dural injury.

12 12.3 Between April and June 2005, Dr. Greene evaluated JD, a 35-year-old male,
13 who presented with a history of mid-back pain following a motor vehicle accident several
14 years earlier. X-rays and an MRI demonstrated an old compression fracture of T-8. On
15 July 25, 2005, Dr. Greene performed a Percutaneous Kyphoplasty at T-8 and T-9 with
16 allograft and fluoroscopy control. Dr. Greene reported that placement of his dilator and
17 working cannula at T-8 was difficult and required three attempts. On awakening, JD had
18 no sensation below T-9. The Board concluded that Dr. Greene had departed from the
19 standard of care, which required a physician to perform a kyphoplasty for osteoporotic
20 compression fractures or traumatic compression fractures with relatively recent history, by
21 performing surgery on a 35-year-old patient who had neither. As a result of the spinal
22 injury that occurred during Dr. Greene's surgery, JD had been rendered a paraplegic.

23 12.4 LO was a 77-year-old female patient who complained of back and lower
24 extremity pain. On January 6, 2006, Dr. Greene placed pedicle screws from T11-S1,
25 performed a laminectomy at L3-L4 and an interbody cage at L3-L4. After more than four

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

16 12.5 GG was a 73-year-old male who had a history of chronic back pain who
17 reported relief with a spinal cord stimulator, which had quit working. On June 13, 2006, Dr.
18 Greene removed old hardware and implanted a new spinal cord stimulator and created a
19 new battery pocket. After GG had problems with delayed healing, on June 26, 2006, Dr.
20 Greene performed surgery to create a new battery pocket in GG's buttock, cultured the
21 wound, washed the battery and leads with Betadine and re-implanted them. Over the next
22 four months, Dr. Greene documented continued drainage from the battery pocket, noted
23 that the battery had failed to charge, and prescribed Cipro. On November 10, 2006,
24 another physician removed the stimulator and debrided the upper and lower back wounds.
25

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

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

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

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

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

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

20 18. On August 31, 2007, the Board issued an initial complaint in Case No. MD-07-
21 0728A, involving the care that Dr. Greene rendered to patients DE and DK. The Board
22 referred the complaints involving DE and DK to Dr. Moczynski for investigation.

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

25 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 Salz, 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

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

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

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

10 **Dr. Saiz**

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

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

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

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

24 **Dr. Norcross**

1 32. William Arthur Norcross, M.D. graduated from Duke University School of
2 Medicine in 1974. Between June 1974 and June 1977, he completed a residency in family
3 medicine at the University of California at San Diego ("UCSD"). He has been licensed as a
4 medical doctor since September 1975.⁶

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

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

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

13 **Requirements for Expert Testimony**

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

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

24 _____
25 ⁶ Dr. Norcross' curriculum vitae is Greene Ex. 143.

⁷ Greene Ex. 128.

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

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

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

8 **DE**

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

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

19 41. Post-surgery, DE was monitored in the hospital, transfused and given epogen.
20 Her hemoglobin increased from 9.3 on May 12, 2007 to 11.2 on May 14, 2007. DE's
21 coagulopathy studies were within normal limits with a PT of 12.0 and an INR of 1.0. DE's
22 liver studies showed only mildly elevated AST.

23 42. On May 15, 2007, Dr. Greene returned DE to surgery for the second stage of
24 her procedure. His only assistant was a surgical assistant. Dr. Greene's operative report
25

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

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

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

13 45. Dr. Greene expedited the normally 8-hour procedure to 5½ hours and
14 emergently proceeded to the recovery room. Upon arrival in the recovery room, staff
15 documented that DE was mottled, had a bruised tense abdomen, and was pulseless.

16 46. Within one minute of arriving in the recovery room DE coded and was
17 resuscitated with a return of pulse and electrical activity. DE received an additional four
18 units of packed red blood cells and four units of fresh frozen plasma, but continued to bleed
19 from multiple areas – nose, eyes, IV sites, and wound. Coagulation studies were drawn
20 and the results were drastically different from those drawn before DE's surgery, which
21 demonstrated that DE's clotting ability was severely compromised, with a PT of 61, INR of
22 17, platelets of 21, and fibrinogen below 60. DE's abdomen was distended. Dr. Greene
23

24 _____
25 ⁸ T. 37 at ll. 4-5.

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

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

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

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

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

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

23 52. Dr. Moczynski noted that Hepatitis C is a slowly progressing disease and that
24 DE had been cleared for surgery.
25

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.

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

3 61. Dr. Greene ordered a CT scan of MB, which was taken on November 17,
4 2005. His report noted that the T-10 screw was not in the pedicle and the T-11 screw went
5 through the costovertebral joint. On December 7, 2005, Dr. Greene noted the
6 malpositioned screws, but called them "acceptable."

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

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

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

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

23 64. When Dr. Saiz was shown Dr. Crandall's records and an image of MB's
24 screws, he admitted on cross-examination that "[t]hat screw is not within the bone and it is
25

⁹ Greene Ex. 23-20; T. 818-820; 825; 827, In. 10-20; 829-830; Ex. 15C; T. 608-610.

¹⁰ Greene Ex. 54, 55.

¹¹ Board's Ex. L, Tab 19.

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

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

8 **MC**

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

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

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

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

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

23 ¹² T. 715, ll. 10-14.

24 ¹³ T. 827-828, 868.

¹⁴ T. 828-30, 613.

¹⁵ Greene Ex. 57, 59.

25 ¹⁶ Greene Ex. 59.

¹⁷ Greene Ex. 58.

1 71. The pH in MC's arterial blood gases were measured at 7.43 at 10:59 a.m.,
2 7.33 at 12:16 p.m., 7.32 at 3:13 p.m., and 7.17 at 5:19 p.m.¹⁸ Dr. Greene testified that the
3 normal range was 7.35 to 7.45.²⁰

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

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

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

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

17 76. MC was taken post-surgery for an emergency heart catheterization and was
18 given a dose of Heparin. Her hemoglobin dropped from 15.3 (normal) at 1845 hours to 4.4
19 at 2215 hours.²⁴ The physician who performed the catheterization reported that it
20
21

22 ¹⁸ Greene Ex. 57.

23 ¹⁹ Greene Ex. 58.

24 ²⁰ T. at 9845, I. 21.

²¹ T. 533-534, II. 1-15, 537 II. 1-7.

²² T. 539, II. 19-25; 537, II. 1-23.

²³ See Greene Ex. 57.

²⁴ T. 540, 542, 546-47; Greene Ex. 132).

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

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

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

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

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

16 WR

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

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

21
22
23 ²⁵ T. 717, l. 25.

24 ²⁶ T. 718, l. 8-17.

25 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

³⁰ Greene Ex. 71B.

³¹ T. 423-427; Greene Ex. 129, 34, 35; T. 619-620.

³² *Greene Ex. 63.*

³³ Greene Ex 84, 65.

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

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

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

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

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

16 The three factors that come to mind are, number one, scar
17 tissue, mobilization of the nerves as well as straightening out
18 the general scoliosis in all predispose nerves to change post-
19 op.

20

21 This was a technically difficult case and there was nothing in
22 [Dr. Greene's] technique that caused the patient's change
23 aside from the main purpose of the surgery which was
24 deformity correction.

25 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 of 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 Kyphoplasty³⁹ 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

अ T. 85, ll. 4-9.

T. 241-42, I. 23-1.

³⁸ 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 "He has tried all narcotics, but says he is basically immune to them all."

⁴¹ Greene Ex. 77.

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

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

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

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

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

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

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

24
25 ⁴² Greene Ex. 85.

1 113. Dr. Greene testified that he did not own a stethoscope. He did not remember
2 whether he had borrowed a stethoscope to listen for RW's bowel sounds. Instead he relied
3 on nurses' notes, which documented bowel sounds and flatus on December 16, 17, 18,
4 and 19, 2005 and a bowel movement on December 17, 2005.⁴³

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

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

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

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

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

21 119. Dr. Moczynski testified that MS Contin was a time-release pain medication
22 that was indicated for chronic pain control. It was not recommended for acute post-surgical
23 pain control. The danger of prescribing a time-release medication for acute pain was that
24

25 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.

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

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

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

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

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

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

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

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

24 ⁴⁴ T. 498.

25 ⁴⁵ Board Ex. X.

⁴⁶ Greene Ex. 113.

⁴⁷ Greene Ex. 115.

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

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

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

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

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

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

23
24 ⁴⁸ *Id.*

⁴⁹ Greene Ex. 118.

⁵⁰ Greene Ex. 115.

⁵¹ *Id.*

⁵² Greene Ex. 111.

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

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

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

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

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

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23
24
25 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 MRI⁵⁷ 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.

55 T. 765.

66 T. 647-655.

⁵⁷ **Greene Ex. 133.**

50 T. 656.

T. 659.

⁶⁰ **Greene Ex. 102.**

Greene Ex. 103.

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

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

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

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

18 144. A progress note by a medical assistant dated September 2, 2006, noted that
19 RJ was intact neurologically and could be discharged.
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23 ⁶² Greene Ex. 104.

24 ⁶³ Greene Ex. 103.

25 ⁶⁴ Greene Ex. 105.

⁶⁵ T. 734, ll. 4-17.

⁶⁶ T. 689, ll. 10-12, 20-22.

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

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

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

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

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

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22
23 ⁶⁷ T. 837-841.

24 ⁶⁸ Greene Ex. 103.

25 ⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

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

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

11 152. Dr. Greene transferred RJ to his partner Dr. Appel, who on December 15,
12 2006 noted that RJ had significant pain of the right upper extremity with some gait
13 abnormalities and clumsiness of the right upper extremity. Dr. Appel noted RJ's MRI scan
14 evidenced myelomalacia at C3-C4 and C4-C5 and recommended a surgical
15 decompression.

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

20 154. RJ was seen by neurologist Dr. Kahlon on May 22, 2007. Dr. Kahlon
21 diagnosed RJ with chronic pain syndrome and cervical radiculopathy post cervical spine
22 surgery. RJ has been under the care of a physician for pain management since March
23 2007.

24
25 ⁷² Greene Ex. 106.

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

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

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

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

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

18 159. DC stated that she returned to the CORE institute on February 26, 2007 for
19 staple removal. Although there is no dictated summary of her visit, CORE's check-out
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23 ⁷³ T. 855-858.

24 ⁷⁴ T. 671, 674.

⁷⁵ T. 674-677, 680-81.

⁷⁶ T. 676-677.

25 ⁷⁷ Board Ex. CC.

⁷⁸ T. 559.

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

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

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

10 162. DC and CORE coordinated for a physical therapy appointment on April 4,
11 2007.⁸⁴

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

16 164. The first follow up report from CORE was from a physician's assistant and
17 was dated July 3, 2007. The physician's assistant reported that DC stated that "although
18 she was doing well at her two-week checkup following the surgery and sutures were
19 removed, she was not able to start physical therapy until several weeks later, and she is
20
21

22 ⁷⁹ Greene Ex. 95A.

23 ⁸⁰ T. 560-61, 568.

⁸¹ T. 563.

24 ⁸² Greene Ex. 95B; T. 564.

⁸³ Greene Ex. 95C; T. 565.

25 ⁸⁴ Greene Ex. 96; T. 566.

⁸⁵ Greene Ex. 97.

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

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

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

9 166. CD was a 36-year-old male upon whom Dr. Greene performed L5-S1,
10 laminectomy, and instrumented fusion on May 25, 2007.⁸⁷ On June 4, 2007, CD returned
11 to Dr. Greene, complaining of left groin and hip pain.⁸⁸ Because x-rays did not reveal any
12 problems, Dr. Greene ordered a CT scan.

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

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

25 ⁸⁶ Greene Ex. 98.

⁸⁷ Greene Ex. 72.

⁸⁸ Greene Ex. 73A.

⁸⁹ Greene Ex. 74.

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

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

8 170. Because DC felt that Dr. Greene had misrepresented the results of the June
9 8, 2007 CT scan, he made a complaint to the Board.

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

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

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

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

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

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24 ⁹⁰ Greene Ex. 73B.

⁹¹ Greene Ex. 75.

⁹² T. 578-580; Ex. 129.

⁹³ T. 686-687.

⁹⁴ T. 581, 975.

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

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

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

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

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

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

24 ⁹⁵ Greene Ex. 86.

25 ⁹⁶ T. 867-868.

⁹⁷ T. 869.

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

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

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

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

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

24 ⁹⁸ Greene Ex. 90.

25 ⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ Greene Ex. 92.

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

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

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

12 188. Dr. Greene testified that he had met the standard of care intraoperatively and
13 post-operatively because all monitoring techniques showed acceptable screw placement
14 and SN did not complain of post-operative nerve root pain in a dermatomal distribution to
15 implicate a screw. Further, he had followed SN closely, obtained a CT scan on May 4,
16 2007, which was reported as normal, and had returned SN to surgery on May 10, 2007.¹⁰³

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

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24 ¹⁰² Greene Ex. 93A and 93B.

25 ¹⁰³ T. 887-90.

¹⁰⁴ T. 688-91, 694-95.

¹⁰⁵ T. 696-97.

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

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

9 DR. GREENE'S PARTICIPATION IN THE PACE PROGRAM

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

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

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

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

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24 ¹⁰⁶ T. 890, 697, 742.

25 ¹⁰⁷ T. 355-56.

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

4 196. Dr. Norcross testified that Dr. Akeson had been provided with the Board's
5 August 7, 2007 order of censure on the first five surgical complications in case no. MD-06-
6 0143A. The PACE program had not been provided any information regarding the 13
7 patient complaints at issue in this case. The additional complaints might have affected Dr.
8 Norcross' opinion of Dr. Greene's safety to practice.

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

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

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

19 **ADDITIONAL TESTIMONY**

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

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

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

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

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

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25 ¹⁰⁸ 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

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).

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

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

6 **DE**

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

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

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

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

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

1
2 **DK**

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

6 **MB**

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

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

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

17 **MC**

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

21 13. The Board has established that Dr. Greene deviated from this standard of care
22 by continuing with the posterior portion of the surgery although he had been notified that
23
24

25 ¹¹⁵ A.R.S. § 32-1401(2).

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

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

6 WR

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

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

14 TB

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 28. The Board has established that Dr. Greene, as a result of his September 23,
24 2005 surgery on AZ, created a dural tear posteriorly, which was unrelated to the area of the
25 IDET procedure, and that he failed to diagnose a CSF leak for almost eight weeks, despite

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

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

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

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

17 31. Dr. Greene's argument that the evidence does not show that his September
18 23, 2006 surgery caused a neurologic injury to RJ is based in large part on the absence of
19 any record of a neurological change until the December 12, 2006 MRI. This absence in
20 turn is based on Dr. Greene's failure to perform a documented neurological examination of
21 RJ in his immediately post-surgery office notes of September 1, 2006 and September 13,
22 2006. However, Dr. Greene's office note of October 23, 2006 stated that RJ was
23 neurologically intact.

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

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

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

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

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

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

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

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

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

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

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

22 39. The standard of care requires a physician to perform a procedure in an
23 appropriate manner. An orthopaedic spinal surgeon should place pedicle screws to avoid
24 causing nerve or vascular injury. A patient should be monitored post-surgery for progress
25

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

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

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

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

11 **FACTORS IN MITIGATION AND AGGRAVATION**

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

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

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

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

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

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

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

20 49. The Board has established that Dr. Greene’s care of these ten patients
21 constituted unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) (“[f]ailing or
22 refusing to maintain adequate records on a patient”); A.R.S. § 32-1401(27)(q) (“[a]ny
23 conduct or practice that is or might be harmful or dangerous to the health of the patient or
24

25 ¹¹⁶ Ariz. R. Evid. 404(b).

1 the public"); A.R.S. § 32-1401(27)(jj) ("[k]nowingly making a false or misleading statement
2 to the board . . ."); and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the Board determines is
3 gross negligence, repeated negligence, or negligence resulting in harm to or the death of
4 a patient").

5 **ORDER**

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

9 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

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

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

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day of August, 2008.

THE ARIZONA MEDICAL BOARD

By

LISA WYNN

Executive Director

ORIGINAL of the foregoing filed this
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
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

#246199

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

Board Case No. MD-07A-070728-MDX-rhg

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

ORDER ON REHEARING

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

7 On February 4, 2009, this matter came before the Arizona Medical Board ("Board")
8 for oral argument and consideration of the Administrative Law Judge (ALJ) Diane
9 Mihalsky's proposed Findings of Fact, Conclusions of Law and Recommended Order
10 after rehearing of the issue of the penalty in this case. David Greene, M.D.,
11 ("Respondent") was not present but was represented by legal counsel Paul Giancola.
12 Assistant Attorney General Anne Froedge represented the State. Chris Munns, Assistant
13 Attorney General with the Solicitor General's Section of the Attorney General's Office was
14 present and available to provide independent legal advice to the Board.

15 The Board, having considered the ALJ's Decision on rehearing and the entire
16 record in this matter, hereby issues the following Order.

17 **IT IS HEREBY ORDERED THAT:**

- 18
- 19 1. The ALJ's Decision on rehearing is rejected in its entirety because the
- 20 Board concludes that the serious nature of Respondent's misconduct
- 21 demonstrates that he is unfit for licensure to practice medicine.
- 22 2. The Findings of Fact, Conclusions of Law and Order of revocation dated
- 23 August 8, 2008, attached hereto and incorporated herein by this reference
- 24 are re-adopted; and
- 25

1 3. Pursuant to A.R.S. §§ 32-1451(M) and 41-1007, Respondent shall
2 reimburse the costs of the rehearing.

3 **RIGHT TO APPEAL TO SUPERIOR COURT**

4 Respondent is hereby notified that this Order is the final administrative decision of
5 the Board and that the Respondent has exhausted his administrative remedies.
6 Respondent is advised that an appeal to superior court in Maricopa County may be taken
7 from this decision pursuant to Title 12, Chapter 7, article 6, within thirty-five (35) days
8 from the date this decision is served.

9 DATED this 11th day of February, 2009.



10 THE ARIZONA MEDICAL BOARD

11 By Amada B. M.
12 for LISA WYNN
13 Executive Director

14 ***

15 ORIGINAL of the foregoing filed this
16 11th day of February, 2009 with:

17 Arizona Medical Board
18 9545 East Doubletree Ranch Road
19 Scottsdale, Arizona 85258

20 COPY OF THE FOREGOING FILED
21 this 11th day of February, 2009 with:

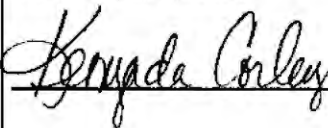
22 Cliff J. Vanell, Director
23 Office of Administrative Hearings
24 1400 W. Washington, Ste 101
25 Phoenix, AZ 85007

Executed copy of the foregoing
mailed by U.S. Mail this
11th day of February, 2009 to:

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

1 Paul J. Giancola Esq.
2 Snell and Wilmer LLP
3 400 E. Van Buren
4 Phoenix, AZ 85004
5 Attorneys for Respondent

6 Anne Froedge
7 Assistant Attorney General
8 Office of the Attorney General
9 CIV/LES
10 1275 W. Washington
11 Phoenix, AZ 85007

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13 _____

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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

David L. Greene, M.D.,

Holder of License No32747
For the practice of Allopathic Medicine
In the State of Arizona

MD-07-0763A, et. al.

**ORDER GRANTING
MOTION FOR
REHEARING OR
REVIEW**

On October 8, 2008, the Arizona Medical Board met to consider Dr. David L. Greene's ("Respondent") motion for rehearing or review of the Board's Order of August 8, 2008. Paul Giancola appeared as attorney on behalf of Respondent. The Board was represented by Assistant Attorney General Dean Brekke. Christopher Munns of the Solicitor General's Office was present to provide independent legal advice. After full consideration of the record in this matter and the arguments of the parties, the Board voted to GRANT Respondent's request for rehearing to consider newly discovered material evidence under A.A.C. R4-16-103(D), namely recently completed Physician Assessment and Clinical Education ("PACE") evaluation results regarding Dr. Greene.

ORDER

Respondent's Motion for Rehearing or Review is GRANTED. The Board will refer the case to the Office of Administrative Hearings to conduct further hearing related to the August 2008 PACE evaluation results and for the administrative law judge to submit an updated recommended decision accounting for the new evidence.

Dated this 14TH of OCTOBER, 2008



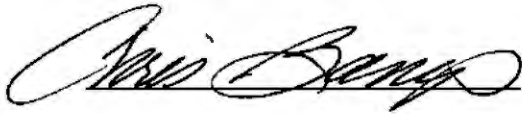
Arizona Medical Board

Lisa Wynn, Executive Director

Executed copy of the foregoing
mailed by U.S. Mail this 14th day
of October 2008, to:

Paul J. Giancola, Esq.
Snell & Wilmer, L.L.P.
One Arizona Center
400 E. Van Buren
Phoenix, Arizona 85004-2202
Attorney for Respondent

Dean Brekke, Esq.
Assistant Attorney General
1275 West Washington
Phoenix, Arizona 85007

A handwritten signature in cursive script, appearing to read "Chris Benge", written in black ink.