STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

June 2, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David Lawrence Greene, M.D.

REDACTED

Robert Bogan, Esq.
NYS Department of Health
ESP – Corning Tower – Room 2512
Troy, New York 12180-2299

RE: In the Matter of David Lawrence Greene, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-92) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

REDACTED
James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER

OF

DAVID LAWRENCE GREENE, M.D.

DETERMINATION

AND

ORDER

BPMC #10-92

A hearing was held on May 19, 2010, at the offices of the New York State Department of Health ("the Petitioner"). A Notice of Referral Proceeding and a Statement of Charges, both dated February 17, 2010, were served upon the Respondent, **David Lawrence Greene, M.D.** Pursuant to Section 230(10)(e) of the Public Health Law, **Ravinder Mamtani, M.D.**, Chairperson, **James R. Dickson, M.D.**, and **Thomas W. King, Jr., M.P.A., P.E.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter. **John Wiley, Esq.**, Administrative Law Judge, served as the Administrative Officer.

The Petitioner appeared by **Thomas Conway, Esq.**, General Counsel, by **Robert Bogan, Esq.**, of Counsel. The Respondent appeared at the hearing and represented himself.

Evidence was received and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

BACKGROUND

This case was brought pursuant to Public Health Law Section 230(10)(p). The statute provides for an expedited hearing when a licensee is charged solely with a

violation of Education Law Section 6530(9). In such cases, a licensee is charged with misconduct based upon a prior criminal conviction in New York State or another jurisdiction, or upon a prior administrative adjudication regarding conduct that would amount to professional misconduct, if committed in New York. The scope of an expedited hearing is limited to a determination of the nature and severity of the penalty to be imposed upon the licensee.

In the instant case, the Respondent is charged with professional misconduct pursuant to Education Law Section 6530(9)(b) and (d). Copies of the Notice of Referral Proceeding and the Statement of Charges are attached to this Determination and Order as Appendix 1.

WITNESSES

For the Petitioner:	None
For the Respondent:	William Norcross, M.D. David Lawrence Greene, M.D.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to exhibits, denoted by the prefix "Ex." These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous.

1. David Lawrence Greene, M.D., the Respondent, was authorized to practice medicine in New York State on May 5, 2003, by the issuance of license number 228280 by the New York State Education Department (Petitioner's Ex. 4).

2. On August 8, 2008, the Arizona Medical Board ("the Board"), by a Findings of Fact, Conclusions of Law and Order, revoked the Respondent's license to practice

medicine and required him to pay administrative costs, based on failure to maintain adequate patient records, conduct or practice that is or might be harmful or dangerous to the health of patients or the public, and gross negligence, repeated negligence, or negligence resulting in harm to or the death of a patient (Petitioner's Ex. 5).

HEARING COMMITTEE CONCLUSIONS

The Hearing Committee concludes that the conduct of the Respondent would constitute professional misconduct under the laws of New York State, had the conduct occurred in New York State, pursuant to:

- New York Education Law Section 6530(3) - "Practicing the profession with negligence on more than one occasion;"
- New York Education Law Section 6530(4) - "Practicing the profession with gross negligence on a particular occasion;"
- New York Education Law Section 6530(5) - "Practicing the profession with incompetence on more than one occasion;"
- New York Education Law Section 6530(6) - "Practicing the profession with gross incompetence;" and
- New York Education Law Section 6530(32) - "Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient..."

VOTE OF THE HEARING COMMITTEE

FIRST SPECIFICATION

"Respondent violated New York Education Law Section 6530(9)(b) by having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state..."

VOTE: Sustained (3-0)

SECOND SPECIFICATION

"Respondent violated New York Education Law Section 6530(9)(d) by having his license to practice medicine revoked and/or having other disciplinary action taken by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation and/or other disciplinary action would, if committed in New York state, constitute professional misconduct under the laws of New York state..."

VOTE: Sustained (3-0)

HEARING COMMITTEE DETERMINATION

The record in this case discloses that the Respondent committed numerous instances of negligence, gross negligence, incompetence and gross incompetence. The following examples illustrate the inadequacies that the Respondent demonstrated while performing spinal surgery and post-spinal surgery care.

Patient DE

The standard of care is to avoid damage to vascular structures while performing surgery and, if excessive bleeding is encountered, to terminate the procedure and determine the source of the bleeding. During DE's surgery, there was excessive bleeding. The Respondent completed the surgery rather that locating the source of the bleeding and fixing the problem. As a result, DE died. (Petitioner's Ex. 5, pp. 10-12, 42).

Patient MB

The Respondent performed a posterior fusion for scoliosis. The standard of care requires that screws be "placed within the pedicle and vertebral body so as not to create a risk of damage to organs or vessels." (Petitioner's Ex. 5, p. 43) The Respondent placed two screws in dangerous locations, one near a lung and the other near the aorta. The patient was placed at risk of pneumothorax and erosion of the aorta. A second surgery

was performed by a different surgeon who removed the malpositioned screws. (Petitioner's Ex. 5, pp. 13-15, 43).

Patient MC

If the patient during an elective, two-stage surgical fusion procedure becomes unstable in anesthesia, the surgeon should delay the second stage to another day. During M.C.'s surgery, the anesthesiologist informed the Respondent that the patient was developing acidosis. The Respondent continued the surgical procedure to conclusion and the patient died. (Petitioner's Ex. 5, pp. 15-17, 43-44).

Patient DC

The patient suffered a foot-drop after surgery that was not present before surgery. The Respondent caused the foot-drop by negligently severing rootlets. (Petitioner's Ex. 5, pp. 20-21, 45).

Patient RW

A surgeon should listen for bowel sounds and check for abdominal distention when performing anterior/posterior lumbar surgery. The patient had an obstruction in his intestines when the Respondent discharged him, but the Respondent was unaware of this because he did not check for bowel sounds. The patient had to be readmitted. (Petitioner's Ex. 5, pp. 21-23, 45-46).

> The standard of care also requires a physician to advise patients about the effects and dangers of the medication he prescribes, especially in combination with other medication. The Board has established that Dr. Greene deviated from this standard by prescribing MS Contin to RW, without specifically advising him of its delayed effect or effect in combination with other sedatives, especially after RW said that he was "immune" to narcotics. RW suffered actual harm when he died of a drug overdose from a combination of pain and sedative medications. (Petitioner's Ex. 5, p. 46).

Patient AZ

A surgeon is expected to diagnose and treat post-surgery complications promptly. After the Respondent's surgery on AZ, the patient had the symptoms of a cerebral spinal fluid (CSF) leak. A CSF leak should be timely addressed to avoid infection. The Respondent failed to diagnose the CSF leak for eight weeks, during which time the patient developed bacterial meningitis. Also, AZ had to undergo three surgeries after the Respondent's initial surgery because of the Respondent's failure to diagnose accurately the post-operative complication. (Petitioner's Ex. 5, pp. 24-27, 46-47).

Patient RJ

It took the Respondent 30 attempts to insert a spinal cord stimulator in the patient. This is an act of incompetence. The Respondent failed to document RJ's neurological status for the next six weeks. This is negligence and inadequate recordkeeping. (Petitioner's Ex. 5, pp. 27-31, 47-48).

Patient SN

The Respondent placed a screw in the patient's back such that the screw abutted against a nerve root. After surgery, the Respondent should have, but did not, obtain a CT scan when SN developed radicular symptoms. The Respondent failed to diagnose this complication in a timely manner. The patient has developed chronic radiculopathy from the Respondent' placement of the screw. (Petitioner's Ex. 5, pp. 34-38, 48-49).

Against this overwhelming evidence, the Respondent offered documentary evidence from the Physician Assessment and Clinical Education (PACE) Program at the University of California, San Diego, and testimony from the PACE Program's Director, William Norcross, M.D. The position of the PACE Program is that the Respondent should not perform spinal surgery, but that he is competent to perform general orthopedic surgery if he consents to six months of monitoring (testimony of Dr. Norcross,

Respondent's Ex. E). Respondent's Ex. B is a collection of letters from three physicians and a nurse familiar with the Respondent's practice.

What all of the Respondent's documentary evidence lacks is an explanation of how such a good surgeon could have committed so many acts of negligence, gross negligence, incompetence and gross incompetence. Because this evidence does not address this issue, it is given very little weight.

There is a problem with the PACE recommendation that the Respondent be allowed to continue practicing medicine with the exception of spinal surgery. There is no reason to believe that the Respondent's negligent approach to his duties will end as soon as he stops performing spinal surgery. He will be the same physician that he was before. Such a physician is dangerous to his patients. The Petitioner recommended that the Respondent's license to practice medicine be revoked. This Hearing Committee agrees that no lesser sanction will adequately protect the public.

ORDER

IT IS HEREBY ORDERED THAT:

1. The license to practice medicine in New York State of the Respondent, David Lawrence Greene, M.D., is revoked.

2. This Order shall be effective upon service on the Respondent in accordance with the requirements of Public Health Law Section 230(10)(h).

DATED: Hopewell Junction, New York
_____, 2010
MAY 27, 2010

REDACTED

Ravinder Mamtani, M.D.
Chairperson

James R. Dickson, M.D.
Thomas W. King, Jr., M.P.A., P.E.

APPENDIX I

STATE OF NEW YORK DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSONAL MEDICAL CONDUCT

IN THE MATTER

OF

DAVID LAWRENCE GREENE, M.D.
CO-08-12-8182-A

NOTICE OF

REFERRAL

PROCEEDING

TO: DAVID LAWRENCE GREENE, M.D.

REDACTED

PLEASE TAKE NOTICE THAT:

An adjudicatory proceeding will be held pursuant to the provisions of New York Public Health Law §§230(10)(p) and New York State Administrative Procedures Act §§301-307 and 401. The proceeding will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct (Committee) on the 21st day of April, 2010, at 10:00 a.m., at the offices of the New York State Department of Health, Hedley Park Place, 433 River Street, 5th Floor, Troy, NY 12180.

At the proceeding, evidence will be received concerning the allegations set forth in the Statement of Charges, that is attached. A stenographic record of the proceeding will be made and the witnesses at the proceeding will be sworn and examined.

You may appear in person at the proceeding and may be represented by counsel who shall be an attorney admitted to practice in New York state. You may produce evidence and/or sworn testimony on your behalf. Such evidence and/or sworn testimony shall be strictly limited to evidence and testimony relating to the nature and severity of the penalty to be imposed upon the licensee. Where the charges are based on the conviction of state law crimes in other jurisdictions, evidence may be offered that would show that the conviction would not be a crime in New York State. The Committee also may limit the number of witnesses whose testimony will be received, as well as the length of time any witness will be permitted to testify.

If you intend to present sworn testimony, the number of witnesses and an estimate of the time necessary for their direct examination must be submitted to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. JAMES F. HORAN, ACTING DIRECTOR, BUREAU OF ADJUDICATION (Telephone: (518-402-0748), (henceforth "Bureau of Adjudication") as well as the Department of Health attorney indicated below, no later than ten (10) days prior to the scheduled date of the Referral Proceeding, as indicated above.

Pursuant to the provisions of New York Public Health Law §230(10)(p), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten (10) days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health, whose name appears below. You may file a written brief and affidavits with the Committee. Six (6) copies of all papers you submit must be filed with the Bureau of Adjudication at the address indicated above, no later than fourteen (14) days prior to the scheduled date of the Referral Proceeding, and a copy of all papers must be served on the same date on the Department of Health attorney, indicated below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide, at no charge, a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of New York State Administrative Procedure Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner demands, hereby, disclosure of the evidence that Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence, and a description of physical and/or other evidence that cannot be photocopied.

YOU ARE ADVISED, HEREBY, THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE (5) BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here _____

The proceeding may be held whether or not you appear. Please note that requests for adjournments must be made in writing to the Bureau of Adjudication, at the address indicated above, with a copy of the request to the attorney for the Department of Health, whose name appears below, at least five (5) days prior to the scheduled date of the proceeding. Adjournment requests are not routinely granted. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation. Failure to obtain an attorney within a reasonable period of time prior to the proceeding will not be grounds for an adjournment.

The Committee will make a written report of its findings, conclusions as to guilt, and a determination. Such determination may be reviewed by the administrative review board for professional medical conduct.

SINCE THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT SUSPENDS OR REVOKES YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE AND/OR IMPOSES A FINE FOR EACH OFFENSE CHARGED, YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
February 17, 2010

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

Inquiries should be addressed to:

Robert Bogan
Associate Counsel
New York State Department of Health
Office of Professional Medical Conduct
433 River Street – Suite 303
Troy, New York 12180
(518) 402-0828

STATE OF NEW YORK DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF DAVID LAWRENCE GREENE, M.D. CO-08-12-8182-A	STATEMENT OF CHARGES

DAVID LAWRENCE GREENE, M.D., Respondent, was authorized to practice medicine in New York state on May 5, 2003, by the issuance of license number 228280 by the New York State Education Department.

MB 03/05/10

FACTUAL ALLEGATIONS

August 8,

A On or about ~~October 14,~~ 2008, the Arizona Medical Board (hereinafter "Arizona Board"), by a Findings of Fact, Conclusions of Law an Order (hereinafter "Arizona Order 1), revoked Respondent's license to practice medicine and required him to pay administrative costs, based on failing or refusing to maintain adequate records on a patient; conduct or practice that is or might be harmful or dangerous to the health of the patient or the public; and gross negligence, repeated negligence, or negligence resulting in harm to or the death of a patient.

B. On or about February 11, 2009, the Arizona Board, by an Order on (hereinafter "Arizona Order 2"), re-adopted Arizona Order 1, set forth in Paragraph A, above.

C. The conduct resulting in the Arizona Board disciplinary actions against Respondent would constitute misconduct under the laws of New York State, pursuant to the following sections of New York State law:

1. New York Education Law §6530(3) (negligence on more than one occasion);
2. New York Education Law §6530(4) (gross negligence);
3. New York Education Law §6530(5) (incompetence on more than one occasion);
4. New York Education Law §6530(6) (gross incompetence); and/or
5. New York Education Law §6530(32) (failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient).

SPECIFICATIONS

FIRST SPECIFICATION

Respondent violated New York Education Law §6530(9)(b) by having been found guilty of improper professional practice or professional misconduct by a duly professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state, in that Petitioner charges:

1. The facts in Paragraphs A, B, and/or C.

SECOND SPECIFICATION

Respondent violated New York Education Law §6530(9)(d) by having his license to practice medicine revoked and/or having other disciplinary action taken by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation and/or other disciplinary action would, if committed in New York state, constitute professional misconduct under the laws of New York state, in that Petitioner charges:

2. The facts in Paragraphs A, B, and/or C.

DATED: February 17, 2010
Albany, New York

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct