BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Hunter Scott Greene, M.D. Physician's & Surgeon's Certificate No. A 84651 Respondent.	Case No. 800-2017-038762

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on December 4, 2020.

IT IS SO ORDERED November 5, 2020.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
RYAN J. YATES
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **HUNTER SCOTT GREENE, M.D.** **6403 Coyle Avenue, Suite 170** **Carmichael, CA 95608** **Physician's and Surgeon's Certificate No. A 84651** Respondent.	Case No. 800-2017-038762 OAH No. 2020020448 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Ryan J. Yates, Deputy Attorney General.

2. Respondent Hunter Scott Greene, M.D. (Respondent) is represented in this proceeding by attorney Ian Scharg, Esq., whose address is: 400 University Avenue, Sacramento, CA 95825-6502. On or about September 17, 2003, the Board issued Physician's and Surgeon's Certificate No. A 84651 to Hunter Scott Greene, M.D. (Respondent). The Physician's and

Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-038762, and will expire on September 30, 2021, unless renewed.

JURISDICTION

3. Accusation No. 800-2017-038762 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 8, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

4. A copy of Accusation No. 800-2017-038762 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-038762. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-038762, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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9. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

10. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-038762, a true and correct copy of which is attached hereto as Exhibit A, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 84651 to disciplinary action.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

1. IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 84651 issued to Respondent Hunter Scott Greene, M.D., shall be Publicly Reprimanded by the Medical Board of California under Business and Professions Code section 2227, subdivision (a)(4), in resolution of Accusation No. 800-2017-038762, attached as Exhibit A. This Public Reprimand, which is issued in connection with Accusation No. 800-2017-038762, is as follows:

2. Between on or about February 3, 2012, and June 22, 2013, you committed repeated negligent acts in your care and treatment of Patient A, in that you failed to failed to perform, order, and/or review preoperative x-rays in order to determine whether physeal closure of Patient A's femoral heads occurred; you incorrectly relied on intra-operative C-arm images to determine femoral head physeal closures; you prematurely removed hardware from Patient A's hips; you failed to perform, order, and/or review postoperative x-rays, following hardware removal from Patient A's hips; and you failed to maintain adequate and accurate records regarding Patient A. The aforementioned is more fully described in Accusation No. 800-2017-038762.

3. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent.

Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

5. A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

6. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Ian Scharg, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 8/31/2020

HUNTER SCOTT GREENE, M.D.
Respondent

I have read and fully discussed with Respondent Hunter Scott Greene, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 8/31/2020

IAN SCHARG
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 9/3/20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

RYAN J. YATES
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2017-038762

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO JAN. 8 2020
BY A. GERRONA ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Hunter Scott Greene, M.D.** **6403 Coyle Ave., Ste 170** **Carmichael, CA 95608** **Physician's and Surgeon's Certificate No. A 84651,** Respondent.	Case No. 800-2017-038762 **A C C U S A T I O N**

PARTIES

1. Christine J. Lally (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 17, 2003, the Medical Board issued Physician's and Surgeon's Certificate No. A 84651 to Hunter Scott Greene, M.D. (Respondent). The Physician's

and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2021, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 118 of the Code states, in pertinent part:

"(a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.

"(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

"(c) As used in this section, 'board' includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and 'license' includes 'certificate,' 'registration,' and 'permit.'"

5. Section 2427 of the Code states, in pertinent part:

"(a) Except as provided in Section 2429, a license which has expired may be renewed at any time within five years after its expiration on filing an application for renewal on a form prescribed by the licensing authority and payment of all accrued renewal fees and any other fees required by Section 2424. If the license is not renewed within 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if

any. Except as provided in Section 2424, renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee or accrued renewal fees are paid, or on the date on which the delinquency fee or the delinquency fee and penalty fee, if any, are paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date set forth in Section 2422 or 2423 which next occurs after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed."

6. Section 2227 of the Code provides in pertinent part that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

7. Section 2234 of the Code states, in pertinent part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"..."

8. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

9. Respondent's license is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts during the care and treatment of Patient A,[1] as more particularly alleged hereinafter:

10. Respondent is an orthopedic surgeon, who works on staff at Mercy San Juan Hospital (Mercy), located in Carmichael, California. Patient A was a then ten (10) year old male minor, who presented to Respondent, following a playground accident. Specifically, on or about January 1, 2012, Patient A injured his left leg on a slide. Patient A was examined by his primary care physician and x-rays were taken, which indicated that Patient A had suffered a left hip Slipped Capital Femoral Epiphysis (SCFE).[2]

11. Patient A was referred to an orthopedist, who examined him on or about January 24, 2012, and arrangements were made for surgery. Prior to surgery, on or about February 2, 2012, Patient A suffered another fall and aggravated his hip pain. Additional x-rays showed that the SCFE had worsened. Patient A then presented to Respondent, who admitted him to Mercy.

12. On or about February 3, 2012, Respondent operated on each of Patient A's hips. During the operation, Respondent inserted single bone screws across each femoral capital physis.[3] No complications resulted from this procedure.

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[1] Patient names and information have been redacted to protect privacy. All witnesses will be identified in discovery.

[2] Slipped Capital Femoral Epiphysis, or SCFE, is a condition in which a child's hip (the top part of the femur, or ball of the ball and socket joint of the hip) slips through the cartilaginous growth plate (physis).

[3] Screws inserted into the femur, through the growth plate, and into the femoral head.

13. On or about July 24, 2012, Patient A was seen by a physician's assistant, who noted that Patient A was doing well, and an operation to remove the bone screws from Patient A's hips was scheduled for Patient A's winter break from school.

14. On or about November 27, 2012, Respondent saw Patient A for a preoperative visit. Respondent noted that Patient A was complaining of bilateral hip pain. During the visit, Respondent failed to request preoperative x-rays.

15. Following the visit, Respondent made incorrect notations to the medical record. Specifically, Respondent incorrectly copied Patient A's original complaint of hip pain—from Patient A's first visit with Respondent, on January 24, 2012—as if it was the current complaint from Patient A's November 27, 2012, visit. Instead, it appears as if the information was copied and pasted between the two (2) dates. Additionally, Respondent failed to clearly document Patient A's informed consent information. Specifically, Patient A's November 27, 2012, medical note regarding informed consent contains both Respondent's name as well as the name of a physician's assistant. However, the note does not state in the narrative whether Respondent or the physician's assistant explained the procedure, its indications, its alternatives, its risks, and its expected benefits to Patient A and his parents.

16. On or about December 2, 2012, a physician's assistant performed a preoperative examination on Patient A. No preoperative x-rays were ordered or taken. Following the examination, Respondent reviewed and counter-signed the physician assistant's examination notes.

17. On or about December 3, 2012, Respondent operated on Patient A. During the operation, Respondent removed the screw hardware from Patient A's hip. Instead of performing preoperative hip x-rays to establish whether Patient A's physes had closed—which would warrant removal of the screws—Respondent inappropriately relied on intraoperative fluoroscopic/C-arm images, which resulted in Respondent incorrectly interpreting that Patient A had physeal closure. However, the surgery ended without any known complications. Following the surgery, Respondent failed to order and/or review postoperative x-rays of Patient A's hip.

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18. On or about December 13, 2012, Patient A was seen by Respondent for the final time. Patient A was noted to be doing well, without complaints of pain, and was advised that he could progress to normal activity. During the visit, Respondent failed to order and/or review postoperative x-rays of Patient A's hip.

19. On or about December 26, 2012, through on or about January 2, 2013, Patient began dragging his right leg, while walking.

20. On or about June 22, 2013, Patient A fell, while at the beach and developed severe right hip pain that prevented him from walking. He went to Sutter Amador Hospital, where he was examined and x-rays were taken. A right hip slipped capital femoral epiphysis was diagnosed, and a radiologist determined from the x-rays that Patient A's epiphyses had not yet fused. Patient A was transferred to UC Davis, and orthopedic consultation diagnosed Patient A with a right displaced slipped capital femoral epiphysis.

21. On June 23, 2013, Patient A underwent bilateral operative internal fixation[4] surgery with single bone screws. During and following the corrective surgery, no additional complications arose.

22. During his care and treatment of Patient A, Respondent committed the following repeated negligent acts:

A. Failing to perform, order, and/or review preoperative x-rays in order to determine whether physeal closure of the femoral heads occurred;

B. Incorrect reliance on the intra-operative C-arm images to determine femoral head physeal closures;

C. Premature removal of hardware from Patient A's hips, on or about December 3, 2012;

D. Failing to perform, order, and/or review postoperative x-rays, following hardware removal from Patient A's hips;

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[4] Internal fixation is a surgery in which the bones are held together with hardware, such as metal pins, plates, rods, or screws. After the bone heals, this hardware isn't removed.

E. Failing to maintain adequate and accurate records, following the November 27, 2012, visit with Patient A; and

F. Unclear documentation of informed consent.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

23. Respondent's license is subject to disciplinary action under section 2266 of the Code, in that he failed to maintain adequate and accurate medical records relating to his care and treatment of Patient A, as more fully described in paragraphs 9 through 22, above, and those paragraphs are incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 84651, issued to Hunter Scott Greene, M.D.;

2. Revoking, suspending or denying approval of Hunter Scott Greene, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Hunter Scott Greene, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: JAN. 8, 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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