LICENSE NO. N-8183

IN THE MATTER OF	BEFORE THE DISCIPLINARY
THE LICENSE OF	PANEL OF THE
CHRISTOPHER DANIEL DUNTSCH, MD	TEXAS MEDICAL BOARD

ORDER OF TEMPORARY SUSPENSION
(WITHOUT NOTICE OF HEARING)

On June 26, 2013, came to be heard before the Disciplinary Panel ("Panel") of the Texas Medical Board ("Board"), composed of Irvin E. Zeitler, Jr., DO, Manuel G. Guajardo, MD, and Frank Denton, members of the Board duly in session, the matter of the Application for Temporary Suspension (WITHOUT NOTICE OF HEARING) of the license of Christopher Daniel Duntsch, M.D. ("Respondent"). Respondent did not appear in person and Christopher Palazola represented Board staff. Based on evidence submitted, the Board through this Panel makes the following Findings of Fact and Conclusions of Law and enters this Order of Temporary Suspension (WITHOUT NOTICE OF HEARING):

FINDINGS OF FACT

1. Respondent is a Texas physician and holds Texas Medical License No. N-8183, issued by the Board on December 9, 2010, which was in full force and effect at all times material and relevant to this Order. All jurisdictional requirements have been satisfied.

2. At the direction and approval of Irvin E. Zeitler, Jr., D.O., President of the Board, Irvin E. Zeitler, Jr., Chair, Manuel G. Guajardo, MD, and Frank Denton, members of the Board, were appointed to sit as a Disciplinary Panel in this matter, pursuant to the Medical Practice Act, TEX. OCC. CODE ANN. Title 3, Subtitle B (the "Act") §164.059(a) and 22 TEX. ADMIN. CODE §187.56.

3. The Panel convened without Notice, pursuant to §164.059(c) of the Act.

4. Respondent practices in Austin, Texas. On his public profile, Respondent lists his primary specialty as Psychiatry.

5. Respondent practices in Plano, Texas. On his public profile, Respondent lists his

primary specialty as Neurological Surgery.

6. Respondent's treatment of four patients significantly violated the standard of care.

Patient 1

a. Patient 1 initially consulted with Respondent on or about January 24, 2012, and was admitted for a surgical procedure to be conducted by Respondent on or about February 2, 2012.

b. During surgery and postoperatively, Patient 1 suffered complications including excessive blood loss and quadriparesis.

c. Respondent made inappropriate operative decisions to utilize materials and procedures which were contraindicated.

d. Respondent failed to recognize and immediately correct Patient 1's spinal cord compression on an emergent basis postoperatively.

e. Respondent failed to order necessary neuro-imaging studies in a timely manner postoperatively.

f. Respondent misinterpreted diagnostics conducted preoperatively and postoperatively, leading to inaccurate diagnoses.

g. Respondent failed to identify anterior compressive pathology, and failed to perform the required anterior corrective surgery.

Patient 2

a. Patient 2 was admitted for a surgical procedure to be conducted by Respondent on or about March 12, 2012.

b. Patient 2 suffered a complication of retroperitoneal hemorrhage that was not recognized or addressed by Respondent.

c. Respondent failed to develop a differential diagnosis including hemorrhage, preventing proper imaging and surgical exploration with repair that could have saved the patient's life.

Patient 3

a. Patient 3 initially consulted Respondent on or about March 6, 2012 and was admitted for surgical procedure to be conducted by Respondent on or about July 24, 2012.

b. Respondent misinterpreted preoperative diagnostics and misrepresented

diagnostic findings, leading to incorrect diagnoses.

c. Respondent failed to preoperatively identify critically important anatomical and structural issues that could impact the planned procedure.

d. Respondent's inadequate preoperative planning led to an increased risk of complications.

e. Respondent's operative management led to Patient 3 suffering excessive blood loss, leading to hypotension and diminished oxygen carrying capacity. Respondent failed to appropriately address this blood loss.

f. Respondent removed bone from an area that was not required by any clinical or anatomical standards, resulting in injury to the vertebral artery.

g. On or about July 25, 2012, Patient 3 was found unresponsive in her hospital room. Hospital staff was unable to reach Respondent for approximately an hour and a half.

h. The vertebral artery injury and excessive blood loss suffered by Patient 3 likely led to the cascade of events, including stroke, ultimately resulting in her death.

Patient 4

a. Patient 4 initially consulted Respondent on or about May 16, 2013 and was admitted for surgical procedure to be conducted by Respondent on or about June 10, 2013.

b. Respondent's preoperative evaluation of the patient was substandard and led to an operative plan that would not address Patient 4's serious underlying conditions.

c. Respondent's performance of the surgery on Patient 4 demonstrated poor judgment and insufficient knowledge of the regional anatomy that Respondent encountered.

d. Respondent was poorly prepared to manage the technical difficulties encountered during Patient 4's surgery and persisted in attempting to enter a disc space in spite of complications compromising the procedure.

e. Respondent failed to manage severe complications postoperatively. Specifically, Respondent failed to immediately identify a retained sponge

which was evident on the early postoperative chest x-ray, and failed to identify an esophageal injury sustained by the patient.

7. Respondent has engaged in a pattern of failing to follow appropriate preoperative planning standards, and failing to recognize and respond to complications during surgery and postoperatively. This pattern of practice places Respondent's patients at significant risk of harm and has resulted in at least two patient deaths.

8. Respondent is additionally unable to practice medicine with reasonable skill and safety due to impairment from drugs or alcohol.

9. On or about June 17, 2013 Respondent's privileges were summarily suspended at University General Hospital Dallas following the procedure performed by Respondent on Patient 4.

10. Based on the above Findings of Fact, the Panel finds an imminent peril to the public health, safety, or welfare that requires immediate effect of this Order of Temporary Suspension on the date rendered.

CONCLUSIONS OF LAW

Based on the above Findings of Fact, the Panel concludes the following:

1. Section 164.059 of the Act authorizes the Disciplinary Panel to temporarily suspend or restrict the medical license of Respondent if the Disciplinary Panel determines from evidence presented to it that the Respondent's continuation in the practice of medicine would constitute a continuing threat to the public welfare.

2. Based on the evidence presented and the Findings of Fact set forth herein, the Disciplinary Panel finds that Respondent violated various sections of the Medical Practice Act, specifically:

a. Respondent has committed a prohibited act or practice within the meaning of Section 164.051(a)(1) of the Act, based on Respondent's commission of an act prohibited under Section 164.052 of the Act.

b. Respondent has committed a prohibited act or practice within the meaning of Section 164.051(a)(3) of the Act, based on Respondent's violation of a Board rule, specifically Board Rule 165.1, which requires the maintenance of adequate medical records.

c. Respondent has committed a prohibited act or practice within the meaning of Section 164.051(a)(6) of the Act, based on Respondent's failure to practice medicine in an acceptable professional manner consistent with public health and welfare, as further defined by Board Rules: 190.8(1)(A), failure to treat patient according to the generally accepted standard of care; 190.8(1)(B), negligence in performing medical services; 190.8(1)(C), failure to use proper diligence in one's professional practice; 190.8(1)(D), failure to safeguard against potential complications; and 190.8(1)(F), failure to timely respond in person when on-call or when requested by emergency room or hospital staff.

d. Respondent has committed a prohibited act or practice within the meaning of Section 164.051(a)(7) of the Act, based on Respondent's being subject to disciplinary action by peers, including removal, suspension, limitation of hospital privileges or other disciplinary action.

e. Respondent has committed a prohibited act or practice within the meaning of Section 164.052(a)(4) of the Act, based on Respondent using alcohol or drugs in an intemperate manner that could endanger a patient's life.

f. Respondent has committed a prohibited act or practice within the meaning of Section 164.052(a)(5) of the Act, based upon Respondent's unprofessional or dishonorable conduct that is likely to deceive or defraud the public, or injure the public.

4. Based on the evidence presented and the above Findings of Fact and Conclusions of Law, the Panel determines that Respondent's continuation in the practice of medicine would constitute a continuing threat to the public welfare.

ORDER

Based on the above Findings of Fact and Conclusions of Law, the Panel ORDERS that:

1. Respondent's Texas Medical License No. N-8183 is hereby TEMPORARILY SUSPENDED.

2. This Order of Temporary Suspension (WITHOUT NOTICE OF HEARING) is effective on the date rendered.

3. Notice of this Order of Temporary Suspension (WITHOUT NOTICE OF HEARING) shall be given immediately to Respondent.

4. A hearing on the Application for Temporary Suspension (WITH NOTICE) will hereby be scheduled before a Disciplinary Panel of the Board at a date to be determined as soon as practicable, at the offices of the Board, unless such hearing is specifically waived by the Respondent.

5. This Order of Temporary Suspension (WITHOUT NOTICE OF HEARING) shall remain in effect until such time as a hearing on the Application for Temporary Suspension (WITH NOTICE) is conducted and a Disciplinary Panel enters an order, or until superseded by an Order of the Board.

[SIGNATURE PAGE TO FOLLOW]

Signed and entered this June 26, 2013.

Irvin E. Zeitler, D.O., Chair
Disciplinary Panel
Texas Medical Board