NEW YORK
THE STATE OF LEARNING

THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

October 31, 1990

David G. LaPointe, Physician
7 Murray Street
P.O. Box 2162
Glens ~~Fals~~ Falls, N.Y. 12801

Re: License No. 097257

Dear Dr. LaPointe:

Enclosed please find Commissioner's Order No. 10993. This Order and any penalty contained therein goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order is a surrender, revocation or suspension of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. In such a case your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er
Enclosures

CERTIFIED MAIL- RRR
cc: William J. Cade, Esq.
Cade & Saunders, P.C.
4 Pine Street
Albany, N.Y. 12207

REPORT OF THE
REGENTS REVIEW COMMITTEE

DAVID G. LaPOINTE

CALENDAR NO. 10993

# The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

**DAVID G. LaPOINTE** **No. 10993**

who is currently licensed to practice
as a physician in the State of New York.

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**REPORT OF THE REGENTS REVIEW COMMITTEE**

DAVID G. LaPOINTE, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced and on February 9, February 10, February 29, and May 31, 1988, and January 8, 1990 hearings were held before a hearing committee of the State Board for Professional Medical Conduct. A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

The hearing committee rendered a report of its findings, conclusions, and recommendation, a copy of which, without attachment, is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent was guilty of

the first specification of the charges based on abandoning a patient to the extent indicated in its report, and the third specification of the charges, and not guilty of the remaining charges. The hearing committee recommended that respondent's license to practice as a physician in the State of New York be suspended for two years; that said suspension be stayed upon condition that respondent perform one hundred hours of public service in a manner and at a time and place as directed by the Board for Professional Medical Conduct; and that said suspension be vacated upon satisfactory completion of said public service.

The Commissioner of Health recommended to the Board of Regents that the findings of fact, conclusions and recommendation of the hearing committee be accepted. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On August 10, 1990 respondent appeared before us in person and was represented by an attorney, William J. Cade, Esq., who presented oral argument on respondent's behalf. Daniel J. Persing, Esq., presented oral argument on behalf of the Department of Health.

Petitioner's recommendation, which is the same as the Commissioner of Health's recommendation, as to the measure of discipline to be imposed, should respondent be found guilty, was: "Suspension of license for two years; stay of the suspension with

performance of one hundred hours public service; and, suspension be vacated upon satisfactory completion of said public service."

Respondent elected not to make a recommendation as to the measure of discipline to be imposed, should respondent be found guilty.

We have considered the record as transferred by the Commissioner of Health in this matter.

Education Law §6509(10) provides that professional misconduct includes a "willful violation by a licensed physician of subdivision eleven of section two hundred thirty of the public health law". We note that the statement of charges herein does not specifically mention the element of willfulness. In addition, the hearing committee states at page 9 of its report: "It is concluded that the sustained facts (Findings of Fact 2, 3, 4 and 13) constitute a technical failure by Respondent to report professional misconduct."

A "technical failure" to report professional misconduct is not sufficient to sustain a charge under Education Law §6509(10). The violation of Public Health Law §230(11) must be willful to come under Education Law §6509(10). Nowhere has the hearing committee or Commissioner of Health addressed the necessary element of willfulness. In fact, the hearing committee seems to have dismissed this essential element by concluding there is present only a technical failure to report professional misconduct. In our

unanimous opinion, the third specification of the charges cannot be sustained because the essential element of willfulness has not been established.

We are in agreement with the Commissioner of Health and the hearing committee as to the substance of the appropriate measure of discipline in this case. However, we note that the hearing committee and Commissioner of Health have formulated the penalty in an unauthorized fashion by creating a conditional stay. Our subsequent recommendation eliminates this unauthorized conditional stay.

We unanimously recommend the following to the Board of Regents:

1. The hearing committee's 14 findings of fact be accepted, and the Commissioner of Health's recommendation as to those findings of fact be accepted;
2. The hearing committee's conclusions as to the question of respondent's guilt be accepted, except that the hearing committee's conclusion as to the third specification of the charges not be accepted, and the Commissioner of Health's recommendation as to the hearing committee's conclusions be accepted, except that the Commissioner of Health's recommendation as to the hearing committee's conclusion as to the third specification of the charges not be accepted;

3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;

4. Respondent be found guilty, by a preponderance of the evidence, of the first specification of the charges based on abandoning a patient to the extent indicated in the hearing committee report, and not guilty of the remaining charges; and

5. Respondent's license to practice as a physician in the State of New York be suspended for two years and respondent be required to perform 100 hours of public service upon the specification of the charges of which we recommend respondent be found guilty, that execution of said suspension be stayed, and that said public service be performed within six months of the effective date of the order of the Commissioner of Education to be issued herein, said public service to be selected by respondent and previously approved, in writing, by the Executive Director of the Office of Professional Discipline and respondent shall submit satisfactory written proof of performing such public service, within ten days after the completion thereof, to the Executive Director of the Office of Professional Discipline.

**DAVID G. LaPOINTE (10993)**

Respectfully submitted,

JORGE L. BATISTA

HERBERT BERNETTE EVANS

GEORGE POSTEL

Chairperson

Dated: 9/17/90

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

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| IN THE MATTER | : | STATEMENT |
| OF | : | OF |
| DAVID G. LaPOINTE, M.D., | : | CHARGES |

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The State Board for Professional Medical Conduct, upon information and belief, charges and alleges as follows:

1. DAVID G. LaPOINTE, M.D., hereinafter referred to as the Respondent, was authorized to engage in the practice of medicine in the State of New York on August 29, 1966 by the issuance of License Number 097257 by the State Education Department.

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period Glens Falls, New York 12801..

3. The Respondent is charged with professional misconduct within the purview of N.Y. Educ. Law §6509 (McKinney Supp. 1987) as set forth in the attached Specifications.

EXHIBIT "A"

FIRST SPECIFICATION

4. The Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6509(9) (McKinney 1985) in that he engaged in unprofessional conduct within the meaning of 8 NYCRR 29.2(a)(1) (1987), by abandoning or neglecting a patient or client under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care, specifically:

On or about September 10, 1985 at Glens Falls Hospital, Dr. LaPointe assisted Dr. Larry Greenberg in the surgery of Patient A.[1] Dr. Greenberg discontinued surgery leaving the patient with fecal contamination of the abdomen from a perforated large bowel with multiple segments of small intestine that were lacerated and torn so that there was free communication between the small intestine and peritoneal cavity.

Dr. Greenberg failed to anastomose and repair the area of perforated, torn or segmented small intestine and perforated large bowel. Due to this inadequate surgery, the patient's life was in danger and an immediate re-operation and repair was necessary. Dr. LaPointe, as

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[1] All patients are identified in Appendix A

assistant surgeon was aware of this patient's condition, yet failed to take adequate and timely measures to have this patient receive the necessary surgical repair.

SECOND SPECIFICATION

5. Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6509(10) (McKinney 1985), in that he violated N.Y. Pub. Health Law §230(11)(a) (McKinney Supp. 1987) by failing to report information which reasonably appeared to show that Dr. Larry Greenberg was guilty of professional misconduct, specifically:

Amended 2-24-88 KAL

On or about August 3, 1984, Dr. LaPointe assisted Dr. Greenberg in surgery on Patient B at Glens Falls Hospital. During this operation, Dr. Greenberg released the clamp on the patient's aorta which resulted in the immediate exsanguination and death of the patient. This was done while the patient's vital signs were stable. Dr. LaPointe failed to notify an appropriate executive committee or peer review committee of Glens Falls Hospital or the State Board of Professional Medical Conduct, of Dr. Greenberg's actions.

## THIRD SPECIFICATION

6. Respondent is charged with professional misconduct within the meaning of N.Y. Educ. Law §6509(10) (McKinney 1985), in that he violated N.Y. Pub. Health Law §230(11)(X) (McKinney Supp. 1987) by failing to report information which reasonably appeared to show that Dr. Larry Greenberg was guilty of professional misconduct, specifically:

Amended 1-29-88 AM

On or about September 10, 1985 at Glens Falls Hospital, Dr. LaPointe assisted Dr. Larry Greenberg in the surgery of Patient A. Dr. Greenberg discontinued surgery leaving the patient with fecal contamination of the abdomen from perforated large bowel with multiple segments of small intestine that were lacerated and torn so that there was free communication between the small intestine and peritoneal cavity.

Dr. Greenberg failed to anastomose and repair the area of perforated, torn or segmented small intestine and perforated large bowel. Due to this inadequate surgery, the patient's life was in danger and an immediate re-operation and repair was necessary. Dr. LaPointe failed to notify an appropriate executive committee or peer review committee of Glens Falls Hospital or the Board of Professional Medical Conduct, of Dr. Greenberg's actions.

DATED: Albany, New York
January 14, 1988

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

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

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| IN THE MATTER | : | REPORT OF |
| OF | : | THE HEARING |
| DAVID G. LaPOINTE, M.D. | : | COMMITTEE |

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Mario B. LoMonaco, M.D., Chairperson, Morton M. Kleinman, and George W. Melcher, M.D., duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Gerald H. Liepshutz, Esq., served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this report.

## SUMMARY OF CHARGES

Respondent was charged with the following acts of professional misconduct as more fully set forth in a copy of the Statement of Charges attached hereto.

1. Unprofessional conduct by abandoning or neglecting a patient or client under and in need of immediate

EXHIBIT "B"

professional care without making reasonable arrangements for the continuation of such care (FIRST SPECIFICATION)

2. Failing to report information which reasonably appeared to show that another physician was guilty of professional misconduct (SECOND SPECIFICATION)

3. Failing to report information which reasonably appeared to show that another physician was guilty of professional misconduct (THIRD SPECIFICATION)

## SUMMARY OF PROCEEDINGS

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| Notice of Hearing and Statement of Charges dated: | January 14, 1988 |
| Department of Health (Petitioner) appeared by: | 1. Joseph Cahill, Esq.<br>Associate Counsel<br>(first five hearing days)<br><br>2. Daniel J. Persing, Esq.<br>Assistant Counsel<br>(balance of proceeding) |
| Respondent appeared by: | Cade & Saunders, Esqs.<br>4 Pine Street<br>Albany, New York 12207<br>By: William J. Cade, Esq. |
| Intrahearing conferences on the record without the presence of of Hearing Committee for legal determinations: | February 10, 1988<br>March 1, 1988<br>May 31, 1988<br>January 9, 1990 |
| Hearing dates: | February 9, 1988<br>February 10, 1988 |

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| | February 29, 1988<br>May 31, 1988<br>January 8, 1990 |
| Hearing Committee deliberations: | March 12, 1990 |
| Adjournments: | 1. April 28, 1988, due to actual engagement of Respondent's counsel<br><br>2. May 5, 1988, due to unavailability of Respondent's counsel<br><br>3. May 6, 1988, due to unavailability of Respondent's counsel<br><br>4. Respondent's motion to adjourn without date for court review granted on May 31, 1988 without objection by Petitioner during intrahearing conference not in presence of Hearing Committee. Hearing resumed on January 8, 1990. |
| Hearing Committee absences: | None |

Significant legal determinations:

1. Exhibits 19 and 20 marked in evidence during intrahearing conference of May 31, 1988. Exhibit 5B marked in evidence during intrahearing conference of January 9, 1990. Exhibit 19, concerning a legal matter decided by the administrative officer in Petitioner's favor at the conference of May 31, 1988, was not distributed to the Committee.

2. Administrative officer's decision in letter to parties dated February 13, 1990 regarding stipulation previously entered into by parties

concerning the scope of the charges involving Patient A. See also submissions by Petitioner and Respondent dated January 23, 1990 and February 16, 1990, respectively.

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| Witnesses for Petitioner: | Andrea C. Eichler, R.N.<br>Barbara Schwemmlein, R.N.<br>John R.N. Bulova, M.D.<br>David A. Collins, M.D.<br>William C. Ellis, M.D.<br>David H. Thompson, M.D.<br>Carl E. Bredenberg, M.D. |
| Witnesses for Respondent: | Barry A. Gold, Esq.<br>David G. LaPointe, M.D.<br>Respondent<br>Daniel F. O'Keeffe, M.D. |

## FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Many of the findings were adopted by the Hearing Committee, in whole or in part, from the proposed findings submitted by the parties. Numbers in parentheses refer to transcript pages unless otherwise noted. These citations represent evidence found persuasive by the Hearing Committee while arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All findings were made by unanimous vote.

1. David G. LaPointe, M.D., Respondent, was authorized to practice medicine in New York State on August 29, 1966 by the

issuance of license number 097257 by the New York State Education Department (uncontested).

FIRST SPECIFICATION: Abandoning or neglecting a patient -- Patient A

2. On September 10, 1985, at Glens Falls Hospital, Respondent assisted Dr. Larry Greenberg in the surgery of Patient A. Dr. Greenberg discontinued surgery leaving the patient with fecal contamination of the abdomen from perforations of multiple segments of small intestine that were lacerated and torn so that there was free communication between the small intestine and peritoneal cavity (Exhibit 4 - p. 297).

3. Dr. Greenberg failed to anastomose and repair the area of perforated, torn or segmented small intestine (Exhibit 4 - p. 297).

4. Due to this inadequate surgery, the patient's life was in danger and an immediate re-operation and repair was necessary (Tr. 407, 905-906).

5. Respondent, as assistant surgeon, was aware of Patient A's condition. He did not agree with the decision to terminate the procedure and he believed a continued effort should have been made. Respondent was aware that the patient would likely die in her condition following termination of the procedure

at 12:40 p.m. on September 10, 1985 (Tr. 170, 641, 835, 891, 905-906; Exhibit 5B-pp. 168-171).

6. Following the termination of the procedure, Respondent failed to take adequate and timely measures to have the patient receive the necessary surgical repair. Respondent did nothing in that regard. As a physician involved in the initial surgery, Respondent had a duty to do something to take the necessary action to preserve the life of Patient A (Tr. 407-408).

7. The Hearing Committee adopts the view of the head of the surgery department who subsequently told Respondent that ". . . if you see something that you grossly disagree with, you have got to do something." (Tr. 171-172).

8. An assisting surgeon has an obligation to go at the conclusion of an insufficient operation to whatever authority is appropriate and available to ensure that the re-operation is done (408).

SECOND SPECIFICATION: Failing to report professional misconduct -- Patient B

9. Respondent was the assistant surgeon for an operative procedure on Patient B performed on August 8, 1984 (TR. 33-34, 89; Exhibit 2).

10. The operative procedure involved the repair of a leaking abdominal aortic aneurysm (Exhibit 2).

11. Regarding the allegation that the primary surgeon released a clamp on Patient B's aorta resulting in immediate exsanguination and death, the Hearing Committee was not convinced by a preponderance of the evidence that the primary surgeon released a clamp on the patient's aorta. The position of the clamp was the subject of much speculation and confusion (Tr. 356, 430). Therefore, it was not proved that a reportable incident of professional misconduct had occurred on August 8, 1984.

THIRD SPECIFICATION: Failing to report professional misconduct -- Patient A

12. See Findings of Fact 2, 3 and 4 herein.

13. Respondent did not notify an appropriate executive committee or peer review committee of Glens Falls Hospital, or the Board of Professional Medical Conduct, of the actions of Dr. Greenberg, the primary surgeon (Tr. 183, 329).

14. Respondent knew that the hospital administration was aware of the incident at approximately 9:30 p.m. or nine hours after the operation on Patient A when the department chairman telephoned him (Tr. 165-169, 186).

## CONCLUSIONS

The following conclusions were reached pursuant to the Findings of Fact herein. All conclusions resulted from a unanimous vote of the Hearing Committee.

FIRST SPECIFICATION: Abandoning or neglecting a patient -- Patient A

Findings of Fact 2 through 8 herein support the conclusion that the factual allegations in paragraph 4. of the Statement of Charges should be sustained, except for the charge regarding the patient's large bowel. It is further concluded that Respondent's failure to take action (Findings of Fact 5 and 6) constituted abandoning a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care (Findings of Fact 6, 7 and 8).

SECOND SPECIFICATION: Failing to report professional misconduct -- Patient B

Inasmuch as the Hearing Committee found that the occurrence of professional misconduct had not been proved by a preponderance of the evidence regarding the primary surgeon (Finding of Fact 11), it is concluded that this charge of failing

to report professional misconduct against Respondent should not be sustained.

THIRD SPECIFICATION: Failing to report professional misconduct -- Patient A

It is concluded that the sustained facts (Findings of Fact 2, 3, 4 and 13) constitute a technical failure by Respondent to report professional misconduct. Although this Specification should be sustained, the Hearing Committee notes as a mitigating circumstance that the law requiring Respondent to report (Public Health Law Section 230.11) does not state a timeframe within which a report must be made. In this matter, Respondent learned approximately nine hours after the incident that the hospital administration knew of the incident (Finding of Fact 14).

RECOMMENDATION

Pursuant to the Findings of Fact and Conclusions herein, the Hearing Committee unanimously recommends that the FIRST SPECIFICATION (abandoning a patient) and the THIRD SPECIFICATION (failing to report profession misconduct -- Patient A) be sustained and that the SECOND SPECIFICATION (failing to report professional misconduct -- Patient B) not be sustained.

The Hearing Committee further unanimously recommends that Respondent's license to practice medicine by suspended for two years; that said suspension be stayed upon condition that Respondent perform one hundred hours of public service in a manner and at a time and place as directed by the Board for Professional Medical Conduct; and that said suspension be vacated upon satisfactory completion of said public service.

DATED: Rochester, New York
April 10, 1990

Respectfully submitted,

Mario B. LoMonaco, M.D.

Mario B. LoMonaco, M.D, Chairperson

Morton M. Kleinman
George W. Melcher, M.D.

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

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IN THE MATTER :

OF :

DAVID G. LAPOINTE, M.D. :

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COMMISSIONER'S

RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on February 9, 1988, February 10, 1988, February 29, 1988, May 31, 1988 and January 8, 1990. Respondent, David G. LaPointe, M.D., appeared by William J. Cade, Esq. The evidence in support of the charges against the Respondent was presented by Joseph Cahill, Esq. and Daniel J. Persing, Esq.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full;

B. The Recommendation of the Committee should be accepted; and

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

EXHIBIT "C"

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
May 18, 1990

DAVID AXELROD, M.D.
Commissioner of Health
State of New York

ORDER OF THE COMMISSIONER OF
EDUCATION OF THE STATE OF NEW YORK

DAVID G. LaPOINTE

CALENDAR NO. 10993

The University of the State of New York

IN THE MATTER

OF

**DAVID G. LaPOINTE**
(Physician)

**DUPLICATE ORIGINAL VOTE AND ORDER NO. 10993**

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 10993, and in accordance with the provisions of Title VIII of the Education Law, it was

**VOTED (October 19, 1990):** That, in the matter of DAVID G. LaPOINTE, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The hearing committee's 14 findings of fact be accepted, and the Commissioner of Health's recommendation as to those findings of fact be accepted;
2. The hearing committee's conclusions as to the question of respondent's guilt be accepted, except that the hearing committee's conclusion as to the third specification of the charges not be accepted, and the Commissioner of Health's recommendation as to the hearing committee's conclusions be accepted, except that the Commissioner of Health's recommendation as to the hearing committee's conclusion as to the third specification of the charges not be accepted;
3. The hearing committee's and Commissioner of Health's recommendations as to the measure of discipline be modified;

4. Respondent is guilty, by a preponderance of the evidence, of the first specification of the charges based on abandoning a patient to the extent indicated in the hearing committee report, and not guilty of the remaining charges; and

5. Respondent's license to practice as a physician in the State of New York be suspended for two years and respondent be required to perform 100 hours of public service upon the specification of the charges of which respondent was found guilty, that execution of said suspension be stayed, and that said public service be performed within six months of the effective date of the order of the Commissioner of Education to be issued herein, said public service to be selected by respondent and previously approved, in writing, by the Executive Director of the Office of Professional Discipline and respondent shall submit satisfactory written proof of performing such public service, within ten days after the completion thereof, to the Executive Director of the Office of Professional Discipline;

and that the Commissioner of Education be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

**and it is**

**ORDERED**: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

DAVID G. LaPOINTE (10993)

IN WITNESS WHEREOF, I, Thomas Sobol, Commissioner of Education of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand and affix the seal of the State Education Department, at the City of Albany, this 26th day of October 1990.

Thomas Sobol

Commissioner of Education