STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H. , Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 14, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Lee A. Davis, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

William J. Cade, Esq.
Cade & Saunders, P.C.
4 Pine Street
Albany, New York 12207

Craig B. DuMond, M.D.
c/o William J. Cade, Esq.
Cade & Saunders, P.C.
4 Pine Street
Albany, New York 12207

RE: In the Matter of Craig B. DuMond, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-193) 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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.

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.

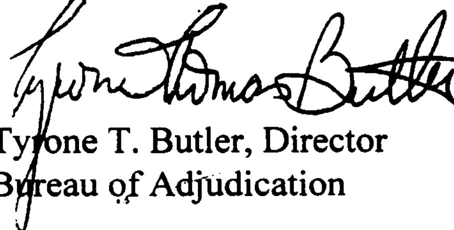
The notice of review served on the Administrative Review Board should be forwarded to:

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,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

COPY

IN THE MATTER OF CRAIG B. DuMOND, M.D.	DETERMINATION AND ORDER

BPMC #02-193

A Notice of Hearing, dated February 21, 2002 and a Statement of Charges, dated February 22, 2002, were served upon the Respondent, Craig B. DuMond, M.D. **WILLIAM K. MAJOR, JR., M.D. (CHAIR), PETER S. KOENIG, AND CHARLES J. VACANTI, M.D.,** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Lee A. Davis, Esq., Assistant Counsel. The Respondent appeared by Cade & Saunders, P.C., William J. Cade, Esq., of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service of Notice of Hearing And Statement of Charges:	February 22, 2002
Pre-Hearing Conference:	March 18, 2002
Hearings Held:	March 27, 2002 April 9, 2002 April 29, 2002 April 30, 2002
Witnesses for Petitioner:	Douglas Brown Louis Benton, Jr., M.D. Linda Tripoli
Witnesses for Respondent:	Robert McCaffrey, Ph.D. Mark P. Dentinger, M.D. Gary W. Wood, M.D. Richard L. Jacobs, M.D. C. David Merkel, M.D. Craig B. DuMond, M.D.
Deliberations Held:	May 22, 2002

STATEMENT OF CASE

Petitioner has charged Respondent with twenty-one specifications of professional misconduct. The charges relate to Respondent's surgical care and treatment of two patients. The charges include allegations of fraud, moral unfitness, false reports, gross negligence, negligence on more than one occasion, failure to maintain records, and excessive/unwarranted treatment. In an Answer dated March 11, 2002, Respondent denied the allegations.

A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. References in parentheses denote transcript page numbers or exhibits. These citations represent 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.

1. Craig B. DuMond, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State by the New York State Education Department's issuance of license number 134557 on June 9, 1978. (Pet. Exh. #4).

2. In a Consent Agreement and Order (BPMC #97-186), dated July 28, 1997, Respondent admitted that, with respect to three named patients, he failed to properly read and/or interpret the medical records and/or conditions which led Respondent to operate on the wrong anatomical area. Respondent further admitted that his actions constituted gross negligence within the meaning of Education Law §6530(4). (Pet. Ex. #9).

Patient A

Factual Allegations A, A.1, A.2 and A.3: SUSTAINED

Factual Allegation A.4: NOT SUSTAINED

3. Patient A reported to Respondent's office on February 21, 2001 with complaints of severe pain and disability in his right knee. (T. 257-258; Ex. 5, p. 11; Ex. 6, p.3)

4. Respondent provided medical care and treatment to Patient A, then a 72 year old male patient, from February 21, 2001 through March 12, 2001. (Ex. 5 and Ex. 6).

5. Respondent's history and physical examination of Patient A dealt exclusively with the patient's right knee. (T. 257-260, 447, 451-453; Ex. 5, pp. 20-21; Ex. 6, pp. 2-3).

6. X-rays reviewed by Respondent were for Patient A's right knee only. (Ex. 5, p. 20; Ex. 6, p.2).

7. Respondent's treatment plan provided for "Right Total Knee Arthroplasty". (Ex. 5, p. 20; Ex. 6, p. 2).

8. The "Consent to Operation or Other Procedure" regarding Patient A provided for "Right Total Knee Replacement" and was signed by Patient A and Respondent. Patient A's signature was not dated, but Respondent's signature was dated February 22, 2001. (Ex. 5, p.27).

9. On March 12, 2001, Respondent met with Patient A in the Ambulatory Surgical Unit ("ASU") at the Adirondack Medical

Center and reviewed with Patient A the procedure to be performed and the location of the procedure. Respondent marked his initials on Patient A's right knee, which had already received a Betadine preparation. (T. 273, 431, 439, 508; Ex. 5, p. 42).

10. Respondent confirmed his actions in the ASU with a notation in Patient A's chart dated March 12, 2001. (T. 273-274; Ex. 5, p. 47).

11. Respondent's "Interval Note" provided that Respondent "Will proceed with Total Knee Arthroplasty on R." (Ex. 5, p. 47).

12. X-rays of Patient A's right knee were reviewed by Respondent while in the operating room ("OR"). (T. 433).

13. Although the examination, treatment plan and all discussions indicated a replacement of the right knee, Respondent initiated the surgical events in the OR by placing Patient A's left leg in the stirrup. (T. 464).

14. Respondent placed a tourniquet on Patient A's left leg. (T. 459).

15. Respondent did not look for the initials he placed on Patient A's right knee in the ASU, nor did he realize that the leg upon which he placed the tourniquet had

not been shaved or prepared with Betadine, and did not have his initials. (T. 459, 508; Ex. 5, p. 42).

16. After Respondent placed the left leg in the stirrup and applied the tourniquet, the left knee was prepped for surgery. (T. 511).

17. Respondent proceeded to replace Patient A's left knee rather than the planned right knee. (Ex. 5, pp. 42, 47, 48, 57).

18. Placing the left leg in a tourniquet was the first act which led to the total knee replacement in the wrong knee. (T. 464).

19. Respondent failed to review the consent for surgery in the OR, which identified the right knee as the surgical knee. (T. 460).

20. The operating surgeon has the ultimate responsibility for determining the site of surgery. (T. 50, 474, 692).

21. Adherence to hospital procedures and protocols with respect to laterality does not absolve the surgeon of his ultimate responsibility to operate on the correct site. (T. 51, 693).

22. Respondent's failure to take necessary precautions in the operating room to identify the surgical

site failed to satisfy generally accepted standards of medicine. (T. 56).

23. Respondent's performance of a left total knee arthroplasty rather than the planned right total knee arthroplasty, without any examination or plan to perform such surgery, does not conform with generally accepted standards of practice. (T. 53, 700).

24. Obtaining and reviewing bilateral x-rays of the knees prior to a total knee replacement can be helpful in correlating the history of the patient with the pathology present in the knees. (T. 57).

Patient B

Factual Allegations B, B.1, B.6 - B.11: SUSTAINED

Factual Allegations B.2 - B.5: NOT SUSTAINED

25. Respondent provided medical care to Patient B, a 79 year old female from on or about October 12, 1996 through on or about October 15, 1996 at the Adirondack Medical Center (Ex. 7, p. 9).

26. Respondent treated Patient B for a suspected impacted subcapital fracture of the left hip (femur). His treatment included a percutaneous fixation of the hip with cannulated fixation screws. (Ex. 7, p. 9).

27. At the time of surgery, the patient was suffering from Parkinson's disease and dementia, which had been "fairly progressive over the past few months". (Ex. 7, p. 9).

28. Patient B arrived at the Lake Placid branch of the Adirondack Medical Center on October 11, 1996 at 11:18 p.m. (Ex. 7, p. 4).

29. The patient was examined in the emergency room by a physician's assistant, who ordered x-rays of her left hip. (T. 561; Ex. 7, p. 5).

30. The initial assessment indicated a fracture of the left femoral neck. (Ex. 7, pp. 5, 35).

31. This initial assessment was made by the physician's assistant. (T. 592, 615).

32. Patient B was admitted to the Adirondack Medical Center by Respondent and ordered transferred to the Saranac Lake facility. (Ex. 7, pp. 2, 6, 9, 41).

33. Respondent reviewed Patient B's x-rays and initially concluded that a fracture of the left femur was indicated. (T. 541, 557, 561).

34. Respondent acknowledged that the medical record which he reviewed on or about October 12, 1996 contained an x-ray that was taken on a previous admission. (T. 560).

35. The chart contained an x-ray of the patient's pelvis taken on March 5, 1995. (Ex. 8G).

36. In an interview with a medical coordinator and investigator from the Office of Professional Medical Conduct ("OPMC") Respondent acknowledged that the x-ray he interpreted as being positive for a fracture was the March 5, 1995 x-ray. This film demonstrated a fracture of the right hip, rather than the left hip. (T. 764).

37. The x-rays of Patient B placed into evidence at the hearing were copies of the original x-rays, and were of a very poor quality. (T. 709, 747).

38. Respondent's expert, Richard L. Jacobs, M.D. opined that the x-rays in evidence at the hearing were likely poor copies of original x-rays of unknown quality. (T. 746-747).

39. Dr. Jacobs admitted that the films contained in Exhibit 8 at hearing could be copies of original x-rays that were of a poor quality. (T. 754-755).

40. Respondent performed a history and physical examination of Patient B which was dictated on October 13, 1996. (T. 571-572; Ex. 7, pp. 10-11).

41. Due to Patient B's dementia, it was necessary for Respondent to obtain information from sources other than the patient. (T. 384-386, 741-743).

42. There are indications of some historical information obtained from outside sources in the history and physical examination dictated by Respondent. (Ex. 7, p. 10).

43. Respondent noted in his history of Patient B that "She mumbles most of the time apparently and does have purposeful movements, but is not at this capable of interacting in more sophisticated modalities, nor is she involved in any crafts or other purposeful activities in that sense." (Ex. 7, p. 10).

44. On physical examination, Respondent recorded that Patient B "...does murmur responses which seem to be affirmative or negative in an appropriate fashion, but volunteers very little other information or verbal responses of any type." (Ex. 7, p. 10).

45. Respondent noted in his discharge summary, dictated and transcribed on October 15, 1996 that Patient B's son informed him that the dementia "...has been fairly progressive over the past few months." (Ex. 7, p. 9).

46. On physical examination the only reference to pain relative to Patient B's hip noted by Respondent was that "...the hip is irritable". (Ex. 7, p. 11).

47. Dr. Benton, Dr. Merkel and Dr. Jacobs all testified that when examining a patient with a suspected subcapital fracture of the femur, it is important to document any source demonstrating significant pain. (T. 385-386, 647-648, 741-743).

48. The radiology report regarding the x-rays taken on October 11, 1996 was dictated on October 13, 1996 and transcribed on October 14, 1996. (T. 626; Ex. 7, p. 35).

49. The report prepared by M. Ghuman, M.D. concludes that "No fracture is outlined" regarding Patient B's left hip. (Ex. 7, p. 35).

50. Respondent did not speak with Dr. Ghuman prior to the surgery on October 14, 1996. (T. 565).

51. Physicians practicing at the Adirondack Medical Center had the capability to retrieve dictated reports prior to their transcription as of October, 1996. (T. 567).

52. Respondent failed to avail himself of this service to listen Dr. Ghuman's report prior to, or during Patient B's surgery. (T. 567-568).

53. Respondent acknowledged that after Patient B was anesthetized, he was unable to identify a fracture on any of the flat films taken of Patient B during the October, 1996 hospitalization. (T. 568).

54. The C-arm imager in the operating room enabled one to take x-rays in an arc of 180 degrees. (T. 603).

55. Respondent admitted that, using the C-arm imager, he was unable to identify a fracture in Patient B's left femur at the time she was anesthetized on October 14, 1996. (T. 613-614).

56. During his interview with the personnel from OPMC on October 18, 2001, Respondent indicated that at that point in the surgery he realized that the fracture he had previously seen might have been on Patient B's right side as shown in the March 5, 1995 x-ray film. (T. 764).

57. After a discussion with his assistant in the OR, Respondent elected to insert the screws in Patient B's left femur based upon his clinical examination of the patient. (T. 524-525, 560, 789-790; Ex. 7, p. 13).

58. The clinical examination performed by Respondent and the x-ray films taken on October 11, 1996 are not sufficient to diagnose a fracture in Patient B's left femur. (T. 133).

59. The findings of the clinical examination must be supported by objective evidence before concluding that a fracture is present. (T. 134-135,379,384).

60. A CT scan is helpful in providing a clearer picture of a suspected fracture of the femur. (T. 135-136, 413, 651, 730).

61. Respondent's failure to order pre-operative diagnostic tests to rule out or confirm a sub capital fracture of the left femur was not in accord with generally accepted standards of practice. (T. 138).

62. Respondent's failure to consult with the radiologist when he was unable to diagnose a fracture based on the x-ray films did not meet generally accepted standards of practice. (T. 140).

63. It is the surgeon's responsibility to properly identify the person for whom a x-ray film was taken and to identify when it was taken. (T. 144, 741).

64. The purpose of an operative note is to record the surgery actually performed on a patient. (T. 147).

65. If anything out of the ordinary occurs during the procedure, it should be part of the operative note. (T. 147).

66. If Respondent had a question as to whether or not a fracture existed at the time of Patient B's surgery, it

would be appropriate to place that information in the operative note. (T. 150, 378).

67. The information contained in Respondent's "clarification" dated October 29, 1996 (Ex. 7, p. 13) should have been recorded in the operative note. (T. 150-151, 378).

68. If the information in Respondent's "clarification" was accurate, that information should have been contained in the patient's discharge summary. (T. 151-152; Ex. 7, p. 9).

69. Respondent testified that he was unable to demonstrate a fracture at the time of surgery based upon the x-rays taken on October 11, 1996 and the C-arm images available to him in the operating room. (T. 568).

70. Respondent's clinical examination of the patient was insufficient to diagnose a fracture of Patient B's left femur. (T. 133, 379, 380-381).

71. Based upon the lack of objective evidence of a fracture, the "Post-Op Diagnosis" described in Respondent's operative note (Ex. 7, p. 24) does not meet generally accepted standards of practice. (T. 153-154).

72. Respondent's failure to inform Patient B's son of the questionable diagnosis fell below the minimum standard of care. (T. 157).

CONCLUSIONS OF LAW

Respondent is charged with twenty-one specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding, the

purpose of which is solely to protect the welfare of patients dealing with State-licensed practitioners. Id.

Gross Negligence is negligence that is egregious, i.e., negligence involving a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995).

Fraudulent Practice is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine. Choudhry v. Sobol, 170 A.D.2d 893, 566 N.Y.S.2d 723 (3rd Dept. 1991), citing Brestin v. Commissioner of Education, 116 A.D.2d 357, 501 N.Y.S.2d 923 (3rd Dept. 1986). In order to sustain a charge that a licensee was engaged in the fraudulent practice of medicine, the hearing committee must find that (1) a false representation was made by the licensee, whether by words, conduct or concealment of that which should have been disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation. Sherman v. Board of Regents, 24 A.D.2d 315, 266 N.Y.S.2d 39 (3rd Dept. 1966), aff'd, 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967).

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony.

Louis J. Benton, Jr., M.D. testified on behalf of Petitioner. Dr. Benton is an experienced, board certified orthopedic surgeon. Dr. Benton testified in a reasoned, unbiased manner. When he agreed with questions posed by Respondent, he did so without hesitation. His answers were clearly stated and in direct response to the question asked. Dr. Benton was a credible witness.

Robert J. McCaffrey, Ph.D. testified on behalf of Respondent. Dr. McCaffrey is a licensed psychologist, with a specialization in neuropsychology. Dr. McCaffrey testified about his evaluation of Respondent. Dr. McCaffrey testified that Respondent was not impaired for the practice of medicine. He further stated that Respondent should not be an attending surgeon, given his history of past errors. The Committee found Dr. McCaffrey to be a credible witness.

Mark P. Dentinger, M.D. testified on behalf of Respondent. Dr. Dentinger is a board certified neurologist. He examined Respondent and concluded that Respondent suffers from no neurological impairment that would limit his ability to practice medicine. There is nothing in the record to dispute this conclusion.

Gary W. Wood, M.D., a board certified radiologist, also testified on behalf of Respondent. He testified in a forthright fashion and was a credible witness.

Richard L. Jacobs, M.D., a board certified orthopedic surgeon, testified on behalf of Respondent. He mostly provided balanced testimony. However, Dr. Jacobs refused to answer a hypothetical question regarding Patient B posed by Petitioner's counsel, declaring "...that's a bad word, assume. I won't assume anything." (T. 740). Dr. Jacobs persisted in his refusal to answer the question, despite the fact that the record is replete with instances where he answered hypothetical questions posed by Respondent's counsel. (*See*, e.g., T., pp. 708, 713, 714, 720, 727, 728, 729, 731). Dr. Jacobs' unwillingness to answer Petitioner's question reflected negatively on the Committee's estimation of his credibility. On balance, the Hearing Committee gave greater credence to Dr. Benton's testimony, rather than that of Dr. Jacobs.

Linda Tripoli testified on behalf of Petitioner. Ms. Tripoli is a registered nurse and an investigator with OPMC. She assisted in conducting an interview with Respondent. Ms. Tripoli provided testimony regarding specific portions of the interview. She demonstrated exact recall of the questions posed during the interview and the responses given to those questions. Ms. Tripoli was candid in her responses on cross-examination, and able to explain apparent discrepancies with specificity and authority. The Committee found Ms. Tripoli to be a credible witness.

C. David Merkel, M.D. testified on behalf of Respondent. Dr. Merkel is the former chief of surgery and current member of the board of directors at the Adirondack Medical Center. He was also a business and medical partner of Respondent at the time of Patient B's October, 1996 surgery.

Dr. Merkel testified that he was the one who suggested that Respondent add an addendum to Patient B's medical record, which was inserted as the "clarification" note found in Ex. 7, at p. 13 (T. 346-347). Dr. Merkel testified that he had concerns about Respondent's initial chart entry following Patient B's surgery because of x-ray laterality issues. (T. 636-637). However, the "clarification" written by Respondent did not address this issue. Indeed, the memorandum prepared by

Dr. Merkel following his investigation (Ex. 18) does not reflect any concern over laterality.

Dr. Merkel's testimony was evasive, uncertain and clearly biased in favor of Respondent. Moreover, given the obvious conflict of interest presented by Dr. Merkel's dual roles as chief of surgery and partner of Respondent at time of the events in question, the Hearing Committee discounted his testimony.

Respondent testified on his own behalf, and clearly has an interest in the outcome of the case. He was argumentative at times, particularly on cross-examination and in response to questions posed by the Committee regarding the October 29, 1996 "clarification" note in Patient B's record. His answers were frequently unresponsive to the questions, and went on at unnecessary length, in an attempt to justify his actions. Respondent's repeated denials regarding his knowledge of the OPMC investigation were incredulous - so much so that the Committee discounted his testimony.

Patient A

There is no dispute that Respondent's replacement of Patient A's left knee, rather than the right knee, was a deviation from the standard of care. This was confirmed by every physician witness who was asked, including Respondent.

Despite the fact that Respondent initialed the correct limb prior to surgery as required by hospital protocol, he placed the patient's left leg in the stirrup, applied the tourniquet and proceeded to operate on the left knee. Notwithstanding his prior history of wrong location surgery, Respondent made no attempt, once in the OR, to verify the correct surgical site. Neurological and neuropsychological evaluations revealed no evidence of any impairment which may have caused Respondent to mistake left for right. Under the circumstances, the Hearing Committee concluded that Respondent's failure to verify the surgical site, and the subsequent operation on the incorrect limb was sufficiently egregious as to warrant a finding of gross negligence. Accordingly, the Twelfth Specification was sustained.

The Committee further concluded that the medical records for Patient A accurately reflected the medical care that was rendered to the patient. Therefore, the Nineteenth Specification (as applied to Patient A) was not sustained. The Committee further concluded that there was no indication in the record for surgery on the left knee. Thus, the operation performed by Respondent was not warranted by the patient's condition. As a result, the Committee voted to sustain the Twentieth Specification.

Patient B

Respondent failed to properly focus on his care of Patient B until it was too late. After the patient was brought to the OR and anesthetized, Respondent first realized that none of the x-rays taken during the patient's current admission showed a fracture. He decided to proceed with the surgery, based upon his initial examination of the patient. The patient was severely demented at the time of that examination and could not provide meaningful information about her injury and pain. Respondent's only notation regarding the extent of the patient's pain was that the hip was "irritable". (Ex. #7, pp. 10-11, 13). The clinical examination provided insufficient evidence to diagnose a subcapital fracture of the patient's left femur.

Generally accepted standards of practice required objective evidence from diagnostic studies supporting the clinical findings in order to conclude that a fracture is present. At the very least, Respondent was obligated to inform the patient's family of the uncertainty of his diagnosis and discuss the merits of obtaining further studies versus proceeding with the surgery. Instead, Respondent went ahead and pinned the patient's hip, when he knew or should have known that the femur was likely not fractured. The Hearing Committee unanimously concluded that this represented a particularly

egregious departure from the standard of care, and demonstrated gross negligence by Respondent. Accordingly, the Committee voted to sustain the Thirteenth Specification.

Petitioner has charged Respondent with four specifications of fraudulent practice, four specifications of moral unfitness, and three specifications of willful filing of false reports. These specifications are based on Factual Allegations B.2 through B.5. In essence, Respondent is charged with making various inaccurate entries in the medical record, when he knew that he was under investigation by OPMC regarding another patient, and when he knew that Patient B's femur was not fractured. (emphasis supplied). He is similarly charged for failing to inform Patient B's son (her legal representative) that her leg was not fractured. (emphasis supplied).

These charges are all fatally flawed. Based upon the record, it is impossible to conclude that Respondent **knew** that the leg was not fractured. He should have known or strongly suspected that it wasn't fractured, based on the x-rays. However, there is insufficient evidence to infer the knowledge and intent necessary to sustain these charges. Accordingly, the Hearing Committee voted to dismiss the First through Fourth (fraudulent practice), Fifth through Eighth (moral unfitness), and Ninth through Eleventh (false reports) Specifications.

Respondent is also charged with four specifications of gross negligence based upon Factual Allegations B.2 through B.5. The Hearing Committee further concluded that these allegations do not warrant findings of gross negligence, and voted to dismiss the Fourteenth through Seventeenth Specifications.

Respondent has been found guilty of two specifications of gross negligence, based upon his treatment of Patients A and B. Therefore, it is clear that he is also guilty of negligence on more than one occasion. As a result, the Hearing Committee voted to sustain the Eighteenth Specification.

The Nineteenth Specification charges Respondent with failing to maintain medical records which accurately reflect the care and treatment of each patient. The Committee voted to dismiss this specification, because it concluded that the records did accurately reflect the care Respondent provided for each patient, as far as it went. The problem, especially with regard to Patient B, was that Respondent *didn't* consider the possibility that the leg was not fractured; *didn't* consider the risks and benefits of operating versus postponing surgery to consult with the radiologist or schedule additional diagnostic studies, and *didn't* discuss the treatment options with the patient's family.

Lastly, the Committee concluded that the Twenty-First Specification, which charged that Respondent performed unnecessary surgery on Patient B, should be sustained. This determination was based on the lack of objective evidence of a fracture of the left femur.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determined, by a vote of 2 - 1, that Respondent's license to practice medicine as a physician in New York State should be limited to prohibit Respondent from performing any surgery or other invasive procedures. In addition, his license should be further limited to allow him to practice only in an Article 28 facility, acceptable to the OPMC, which will provide ongoing supervision of his medical practice. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Hearing Committee gave strong consideration to revoking Respondent's medical license. Respondent has repeatedly exercised extremely poor judgement, resulting in his

operating on the wrong anatomical site, and performing other unnecessary surgery. No neurological basis for his behavior has been found. The prior disciplinary action taken by the board has done little to improve his practice. Respondent has demonstrated little insight into the problem. To the contrary, Respondent repeatedly sought to blame others - the radiologist; the OR tech, and the nurses, rather than acknowledge his own flaws. Absent any mitigating circumstances, revocation would be the only sanction which would adequately protect the public.

However, a majority of the Hearing Committee did find mitigating circumstances, which they believe warrant a lesser sanction. Respondent's misconduct was limited to the poor judgement exercised in the operating room. There is no evidence which indicates that he is not capable practicing medicine safely, as long as he avoids surgery. In addition, Respondent has demonstrated support from the local medical community. At the same time, the members of the Committee strongly believe that Respondent should not be allowed to practice independently. He should only be allowed to practice in an environment where there are quality assurance mechanisms in place to monitor his performance.

Accordingly, the majority of the Hearing Committee determined that Respondent's license should be limited to

prohibit the performance of any surgery, either as primary surgeon or assistant, as well as to prohibit any other invasive procedures. This would serve to minimize the risk of Respondent making another wrong site error. Further, Respondent's license should be limited to allow the practice of medicine only under direct supervision in an Article 28 facility. Respondent shall be required to obtain prior approval of such Article 28 facility from the OPMC prior to resuming his medical practice.

The dissenting member of the Hearing Committee voted to revoke Respondent's medical license. In his opinion, there was insufficient mitigation demonstrated to warrant a less severe sanction. Further, he does not believe that the sanction crafted by the majority will adequately protect the public.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The Twelfth, Thirteenth, Eighteenth, Twentieth and Twenty-First Specifications of professional misconduct, as set forth in the Statement of Charges, (Petitioner's Exhibit #1) are **SUSTAINED**;

2. The First through Eleventh, Fourteenth through Seventeenth, and Nineteenth Specifications of professional misconduct, as set forth in the Statement of Charges are **DISMISSED**;

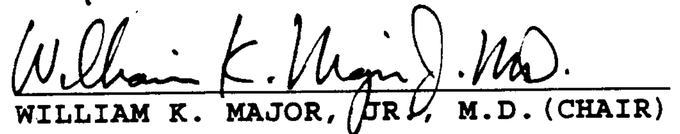
3. Respondent's license to practice medicine as a physician in New York State be and hereby is **LIMITED TO PROHIBIT THE PERFORMANCE OF SURGERY OR OTHER INVASIVE PROCEDURES, IN ANY CAPACITY. FURTHER, THE LICENSE SHALL BE LIMITED TO ALLOW THE PRACTICE OF MEDICINE ONLY IN AN ARTICLE 28 FACILITY, ACCEPTABLE TO THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT**;

4. Respondent shall not be permitted to practice medicine until he has obtained employment in an Article 28 facility, and received the prior approval of said facility from the Office of Professional Medical Conduct;

5. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon

Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Troy, New York
June 12 ,2002



WILLIAM K. MAJOR, JR., M.D. (CHAIR)

PETER S. KOENIG
CHARLES J. VACANTI, M.D.

TO: Lee A. Davis, Esq.
Assistant Counsel
New York State Department of Health
Corning Tower Building - Room 2512
Empire State Plaza
Albany, New York 12237

Craig B. DuMond, M.D.
c/o William J. Cade, Esq.
Cade & Saunders, P.C.
4 Pine Street
Albany, New York 12207

William J. Cade, Esq.
Cade & Saunders, P.C.
4 Pine Street
Albany, New York 12207

APPENDIX I

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

IN THE MATTER OF CRAIG B. DUMOND, M.D.	STATEMENT OF CHARGES

CRAIG B. DUMOND, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 9,1978, by the issuance of license number 134557 by the New York State Education Department. Respondent is not currently registered with the New York State Education Department to practice medicine.

FACTUAL ALLEGATIONS

A. Respondent provided medical care and treatment to Patient A (patients are identified in Appendix A, attached hereto), a male patient 72 years old when treated, from on or about February 21, 2001 through on or about March 12, 2001 at the Adirondack Surgical Group and Adirondack Medical Center in Saranac Lake, New York for severe degenerative joint disease of the ***right*** knee, with a treatment plan of a ***right*** total knee arthroplasty. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent performed a ***left*** total knee arthroplasty on Patient A, rather than the planned ***right*** total knee arthroplasty: without the consent of Patient A; and/or without prior examination of the left knee; and/or without any prior documentation of the pathology of the left knee; and/or without discussion of the pathology of the left knee with Patient A; and/or without recording the consent, examination or discussion;

2. Respondent failed to identify Patient A's right knee as the operative knee in the operating room immediately prior to commencing surgery by employing such medically accepted methods as, but not limited to: reviewing his entries in Patient A's medical chart; and/or reviewing the surgical consent form; and/or reviewing the x-rays; and/or identifying his initials that he placed on Patient A's right knee; and/or failed to record that he took the aforementioned precautions in the operating room immediately prior to commencing surgery;

3. Respondent failed to obtain, and/or review, and/or consider pre-operative x-rays of Patient A; and/or failed to record that pre-operative x-rays were obtained, reviewed and considered; and

4. Respondent failed to obtain and review up to date pre-operative bilateral knee x-rays ~~and x-ray templating of the right knee~~ for total knee replacement; and/or failed to record the obtaining and reviewing of such x-rays.

amended 3/27/02

B. Respondent provided medical care and treatment to Patient B, a female patient 79 years old and suffering from Parkinson's disease with dementia when treated, from on or about October 12, 1996 through on or about October 15, 1996 at the Adirondack Medical Center for trauma subsequent to a fall, including a possible impacted subcapital fracture of the left hip. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent performed a percutaneous fixation of Patient B's left hip with cannulated fixation screws, when he knew, or should have known that there was no fracture of Patient B's left femur;

2. Respondent made the following post-operative entry in Patient B's chart when Respondent knew he was under investigation by the Office of Professional Medical Conduct (hereinafter OPMC) for an alleged pinning of a wrong hip in a patient in or about January 1996: "Op. Note, Internal fixation left sub-cap femur FX," when he knew that Patient B did not have a fracture of her left femur at the time he made the chart entry;

3. Respondent dictated the following Operative Note entry in Patient B's chart when Respondent knew he was under investigation by the OPMC for an alleged pinning of a wrong hip in a patient in or about January 1996: "Postop Diagnosis: Pin fixation of impacted subcapital fracture left hip," when he knew that Patient B did not have a fracture of her left hip at the time he dictated the note;

4. At a time that Respondent knew he was under investigation by the OPMC for an alleged pinning of a wrong hip in a patient in or about January 1996, he dictated and signed in Patient B's Discharge Summary that the final diagnosis was an: "Impacted subcapital fracture left hip," when he knew that Patient B did not have a fracture of her left hip;

5. Respondent failed to inform Patient B's son (who signed the consent for surgery and was Patient B's legal representative,) in his post-operative conversation with him that Patient B's left femur was not fractured, and that the fixation of the cannulated screws was unnecessary; and/or failed to record he informed Patient B's son;

6. Respondent's diagnosis of a subcapital fracture of Patient B's femur and the subsequent surgery on Patient B's hip was inappropriately based solely upon his clinical evaluation of the severely demented patient;

7. Respondent failed to obtain, review and/or consider appropriate pre-operative x-rays of Patient B's left hip; and/or failed to record that appropriate pre-operative x-rays of the left hip were obtained, reviewed and considered;

8. Respondent misinterpreted the pre-operative x-rays of Patient B's left hip to confirm a fracture of Patient B's left hip;

9. Respondent failed to consult pre-operatively with the radiologist who reviewed the pre-operative x-rays of Patient B's left hip, and/or failed to listen to the radiologist's dictated report to determine whether a fracture of the left hip was indicated by the x-rays; and/or failed to record his consultation with the radiologist and/or his report;

10. Respondent failed to order adequate pre-operative diagnostic tests to rule out or confirm a fracture of the left femur, such as, but not limited to, MRI, CT scan, bone scan, or tomograms; and/or failed to record the ordering of such studies; and

11. Respondent relied upon outdated x-rays of Patient B's ***right*** hip to confirm a fracture of the ***left*** hip.

SPECIFICATION OF CHARGES

FIRST THROUGH FOURTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. Paragraphs B and B.2;
2. Paragraphs B and B.3;
3. Paragraphs B and B.4; and
4. Paragraphs B and B.5.

FIFTH THROUGH EIGHTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

5. Paragraphs B and B.2;
6. Paragraphs B and B.3;
7. Paragraphs B and B. 4; and
8. Paragraphs B and B.5.

NINTH THROUGH ELEVENTH SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

9. Paragraphs B and B.2;
10. Paragraphs B and B.3; and
11. Paragraphs B and B.4.

TWELFTH THROUGH SEVENTEENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

12. Paragraphs A and A.1;
13. Paragraphs B and B.1;
14. Paragraphs B and B.2;
15. Paragraphs B and B.3;
16. Paragraphs B and B.4 and
17. Paragraphs B and B.5.

EIGHTEENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

18. Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.1, B and B.2, B and B.3, B and B.4, B and B.5, B and B.6, B and B.7, B and B.8, B and B.9, B and B.10 and B and B.11.

NINETEENTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

19. Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, B and B.2, B and B.3, B and B.4, B and B.5, B and B.7, B and B.9 and B and B.10.

TWENTIETH AND TWENTY-FIRST SPECIFICATIONS

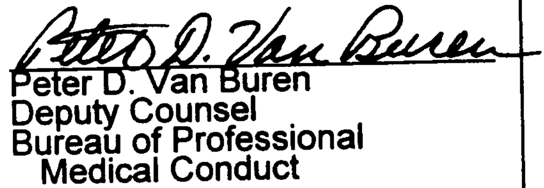
UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

20. Paragraphs A and A.1; and

21. Paragraphs B and B.1.

DATED: February 22, 2002
Albany, New York



Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct