



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

October 1, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

PUBLIC

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

Dear Parties:

Enclosed please find the Determination and Order (No. 02-193) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

A handwritten signature in black ink, appearing to read "Tyrone T. Butler". The signature is written in a cursive style with a large initial 'T'.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

In the Matter of

Craig B. DuMond, M.D. (Respondent)

**A proceeding to review a Determination by a
Committee (Committee) from the Board for
Professional Medical Conduct (BPMC)**

Administrative Review Board (ARB)

Determination and Order No. 02-193

COPY

**Before ARB Members Grossman, Lynch, Pellman, Price and Briber
Administrative Law Judge James F. Horan drafted the Determination**

**For the Department of Health (Petitioner):
For the Respondent:**

**Lee A. Davis, Esq.
William J. Cade, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent, a surgeon, committed professional misconduct by performing unnecessary surgery on one patient and by performing surgery on the wrong anatomical area in a second patient. The Committee voted to limit the Respondent License to practice medicine in New York State (License) by prohibiting the Respondent from performing surgery and by restricting the Respondent to practice, under supervision, in a licensed medical facility. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney 2002), the Petitioner asks the ARB to modify that Determination by sustaining additional misconduct charges against the Respondent and by revoking the Respondent's License. After reviewing the hearing record and review submissions from the parties, the ARB affirms the Committee's Determination on the charges, but overturns the Committee's Determination on the penalty. We revoke the Respondent's License, because the Respondent has repeatedly exercised poor judgment in performing surgery, has failed to correct errors after prior disciplinary action and has shown little insight into his practice deficiencies.

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(2-4), 6530(20-21), 6530(32) & 6530(35) (McKinney Supp. 2002) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- engaging in conduct that evidences moral unfitness,
- willfully filing a false report,
- failing to maintain accurate records, and,
- ordering excessive treatment unwarranted by a patient's condition.

The charges concerned surgery that the Respondent performed on two persons, Patients A and B. The record refers to the Patients by initials to protect privacy. The charges also alleged that the Respondent deliberately withheld information about Patient B with the intent to deceive. A hearing on the charges followed before the Committee that rendered the Determination now on review.

The Committee found that the Respondent performed left knee replacement on Patient A incorrectly, rather than right knee replacement. The Committee found further that the Respondent inserted screws into Patient B's left femur, to treat a fracture, with no objective evidence that a fracture existed in the Patient's femur. The Committee concluded that such conduct amounted to practicing with gross negligence in treating both Patients and to practicing with negligence on more than one occasion. The Committee concluded further that the surgery on Patient B amounted to a procedure unwarranted by the Patient's condition. The Committee's Determination also included a finding that the Respondent entered into a Consent Agreement and Order with BPMC in 1997, in which the Respondent admitted that he performed surgery on three patients in the wrong anatomical area.

The Committee dismissed the charges that the Respondent practiced fraudulently, engaged in conduct that evidenced moral unfitness, willfully filed a false report and failed to maintain accurate records. The Committee found all those charges resulted from the allegation that the Respondent knew that there was no fracture in Patient B's leg and that Respondent made inaccurate entries deliberately in medical records and failed to inform Patient A's legal representative, her son. The Committee found the charges flawed and found no proof in the record that the Respondent knew there was no fracture.

The Committee voted to limit the Respondent's License, to prohibit him from performing surgery or any invasive procedures and to restrict the Respondent to practice under direct supervision in a facility holding a license under Pub. Health Law Article 28. The Committee noted that they considered revoking the Respondent's License, because the Respondent repeatedly exercised poor judgement in operating on the wrong anatomical area and that the Respondent demonstrated little insight into the problem. A majority of the Committee found a mitigating factor, because the Respondent exercised the poor judgement only in the operating room. The Committee majority found that they could protect the public by removing the Respondent from performing surgery and placing the Respondent in an environment in which mechanisms existed to monitor the Respondent's performance. The Committee's dissenting member found no mitigating circumstances in the case and voted for revocation.

Review History and Issues

The Committee rendered their Determination on June 14, 2002. This proceeding commenced on June 28, 2002, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and the Respondent's brief. The record closed when the ARB received the Petitioner's brief on July 31, 2002.

The Petitioner asks that the ARB overturn the Committee's Determination on the charges and sustain the fraud, moral unfitness and false records charges. The Petitioner argues that proving those charges depended on proof that the Respondent knew he made misrepresentations, rather than the Committee's conclusion that proving the charges required a showing that the Respondent knew there was a fracture. The Petitioner argues that the ARB can draw an inference from the evidence that the Respondent knew he was making misrepresentations concerning Patient's B's condition. The Petitioner also asks that the ARB overturn the Committee and revoke the Respondent License. The Petitioner argues that the repeated acts of gross negligence, standing alone, provide sufficient grounds for revocation.

The Respondent argues that the Committee voted for a penalty consistent with the Committee's factual findings and the Respondent asks the ARB to defer to the fact finders in their judgement concerning the penalty. The Respondent requests, that if the ARB concludes that the Committee failed to articulate sufficiently the grounds for limiting the Respondent's License, that the ARB should remand to the Committee for further deliberations and clarification.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent practiced with gross negligence and negligence on more than one occasion and that the Respondent subjected Patient B to a procedure unwarranted by the Patient's condition. Neither party challenged the Determination on those charges. The ARB rejects the Petitioner's request that we overturn the Committee and sustain the fraud, moral unfitness and false report charges. We reject the Respondent's request that we remand this case to

the Committee, rather than overturning the Committee. We overturn the Committee and revoke the Respondent's License.

The Petitioner asked that the ARB find that evidence in the record would support an inference that the Respondent made knowing misrepresentations concerning Patient B's condition. The finds no such evidence in the record. The Committee concluded that the Respondent knew or should have known that there was no fracture in Patient B's left femur, but the Committee concluded that it was impossible to find conclusively that the Respondent knew there was no fracture. The ARB agrees with the Committee and we agree that without the finding that the Respondent knew there was no fracture, the Committee could make no inference concerning knowledge, intent or willfulness sufficient to sustain the fraud, moral unfitness or false report charges.

The Committee's Determination indicated that, in making their penalty Determination, the Committee gave strong consideration to revoking the Respondent's License, because:

- the Respondent repeatedly exercised extremely poor judgement, resulting in surgery in the wrong anatomical area and performing other unnecessary surgery;
- no neurological basis appeared to explain the behavior,
- prior BPMC disciplinary action did little to improve the Respondent's practice; and,
- the Respondent demonstrated little insight into his problem and repeatedly blamed others rather than acknowledging his own flaws.

The Committee concluded 2-1, however, that mitigating circumstances warranted a lesser sanction. The Committee found mitigation because the Respondent limited his poor judgement to the operating room. The Committee's dissenting member found insufficient mitigating circumstances to warrant the lesser sanction.

The ARB agrees with the Committee's dissenting member that insufficient mitigation appears in this case and that the penalty the Committee's majority crafted will provide insufficient protection to the public. We conclude that poor judgement in the operating room provides no mitigation when the Respondent performs his practice in the operating room. The Respondent bore the responsibility to assure that he operated on the correct anatomical area. Even one surgery at the wrong site would constitute gross negligence, but after performing wrong site surgery the first time, the Respondent should have taken even greater precautions to avoid a similar error again. The Respondent failed to change his practice pattern and committed repeated errors in judgement. The Committee found that the Respondent lacked insight into his problem. The ARB concludes that the Respondent's refusal to accept responsibility for his errors leaves the Respondent at risk to commit errors again. We also find no protection for the public by limiting the Respondent to practice in an Article 28 facility, such as a general hospital. The Respondent committed the errors at issue in this case, at a general hospital, Adirondack Medical Center. The ARB also sees no reason to believe that the Respondent could practice any more safely caring for patients in general hospital departments such as an emergency room or intensive care unit, rather than in an operating room.

The Respondent asks that the ARB remand this case for clarification, if the ARB found the Committee failed to articulate sufficiently their reasons for imposing a sanction less severe than revocation. We see no reason for a remand in this case. The Committee majority explained the reasons for their penalty Determination quite clearly. The majority found mitigating circumstances. The ARB members disagreed unanimously with the majority. In reviewing a Committee's Determination, the ARB may substitute our judgement for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d

381 (3rd Dept. 1993); and in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994). The ARB elects to exercise our review authority in this case and substitute our judgement on the appropriate penalty in this case. We vote 5-0 to revoke the Respondent's License.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER**:

1. The ARB affirms the Committee Determination that the Respondent practiced with gross negligence and negligence on more than one occasion and performed unnecessary surgery.
2. The ARB affirms the Committee's Determination to dismiss the charges that the Respondent practiced fraudulently, engaged in conduct that evidenced moral unfitness and willfully filed false reports.
3. The ARB overturns the Penalty that the Committee imposed.
4. The ARB votes 5-0 to revoke the Respondent's License.

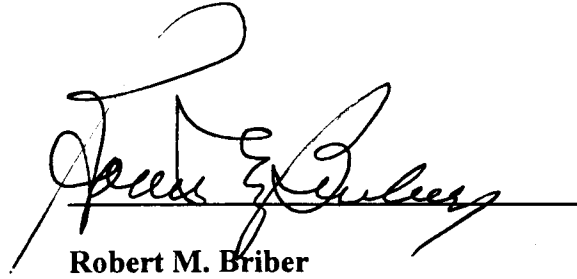
Robert M. Briber
Thea Graves Pellman
Winston S. Price, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Craig R. DuMond, M.D.

Robert M. Briber, an ARB Member concurs in the Determination and Order in the

Matter of Dr. Dumond.

Dated: Sept 17, 2002



Robert M. Briber

In the Matter of Craig R. DuMond, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Dumond.

Dated: 9/27, 2002

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Thea Graves Pellman

In the Matter of Craig R. DuMond, M.D.

Winston S. Price, M.D., an ARB Member concurs in the Determination and Order in the
Matter of Dr. Dumond.

Dated: Sept 26, 2002

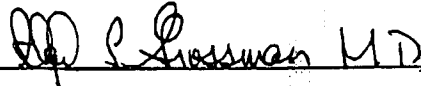
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Winston S. Price, M.D.

In the Matter of Craig R. DuMond, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Dumond.

Dated: September 27, 2002

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Stanley L Grossman, M.D.

In the Matter of Craig R. DuMond, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in
the Matter of Dr. Dumond.

Dated: Sept. 27, 2002

The image shows a handwritten signature in cursive script that reads "Therese G. Lynch M.D." The signature is written in black ink on a white background.

Therese G. Lynch, M.D.