STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

Dennis P. Whalen
Executive Deputy Commissioner

August 4, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Leonard J. Burman, M.D.
10 Buckthorn Run
Victor, New York 14564

Timothy J. Mahar, Esq.
NYS Department of Health
Corning Tower Room 2429
Empire State Plaza
Albany, New York 12237

Dan O'Brien, Esq.
Woods Oviatt Gilman Struman & Clark
700 Crossroads Building
Two State Street
Rochester, New York 14614

RE: In the Matter of Leonard J. Burman, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-221) 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.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

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.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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.

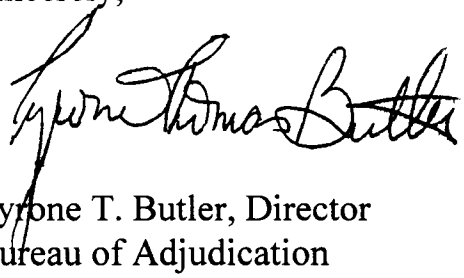
The notice of review served on the Administrative Review Board should be forwarded to:

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:nm
Enclosure

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

COPY

IN THE MATTER

OF

LEONARD J. BURMAN, M.D.

DETERMINATION
AND
ORDER

BPMC – 00 - 221

STEPHEN A. GETTINGER, M.D. (Chair), **WILLIAM K. MAJOR, M.D.**, and **NANCY J. MORRISON**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law of the State of New York.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer ("**ALJ**").

The Department of Health appeared by **TIMOTHY J. MAHAR, ESQ.**, Associate Counsel.

Respondent, **LEONARD J. BURMAN, M.D.**, appeared personally and was represented by **WOODS, OVIATT, GILMAN, STURMAN, L.L.P., DONALD W. O'BRIEN, JR., ESQ.**, of counsel.

Hearings were held, evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the full record, the Hearing Committee issues this Determination and Order pursuant to the Public Health Law and the Education Law of the State of New York.

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq. of the Public Health Law of the State of New York ["**P.H.L.**"]).

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Petitioner**" or "**Department**") pursuant to §230 of the P.H.L. LEONARD J. BURMAN, M.D., ("**Respondent**") is charged with seven (7) specifications of professional misconduct, as delineated in §6530 of the Education Law of the State of New York ("**Education Law**"). All seven (7) specifications arise out of one single incident.

Respondent is charged with: (a) professional misconduct by reason of having willfully abused a patient physically[1]; (b) professional misconduct by reason of practicing the profession of medicine fraudulently[2]; (c) professional misconduct by reason of having committed conduct in the practice of medicine which evidences moral unfitness to practice medicine[3]; (d) professional misconduct by reason of practicing the profession with gross negligence[4]; (e) professional misconduct by reason of practicing the profession with gross incompetence[5]; (f) professional misconduct by reason of having performed professional services which was not authorized by the patient[6]; and (g) professional misconduct by reason of failing to maintain a record for a patient which accurately reflected the evaluation and treatment of that patient[7].

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[1] Education Law § 6530(31) (Willful Abuse) and First Specification of Department's Exhibit # 1.
[2] Education Law § 6530(2) (Fraudulent Practice) and Second Specification of Department's Exhibit # 1.
[3] Education Law § 6530(20) (Moral Unfitness) and Third Specification of Department's Exhibit # 1.
[4] Education Law § 6530(4) (Gross Negligence) and Fourth Specification of Department's Exhibit # 1.
[5] Education Law § 6530(6) (Gross Incompetence) and Fifth Specification of Department's Exhibit # 1.
[6] Education Law § 6530(26) (Informed Consent) and Sixth Specification of Department's Exhibit # 1.
[7] Education Law § 6530(32) (Record Keeping) and Seventh Specification of Department's Exhibit # 1.

The charges brought by the Department concern the medical care, treatment and services provided by Respondent to one patient in the course of a cesarean section performed on July 22, 1999 (Patient A)[8]. The principal allegation is that Respondent, without the consent of the Patient, attempted to intentionally harm the patient by placing crushing clamps on each of the patient's fallopian tubes in an attempt to sterilize the patient (Department's Exhibit # 1).

Respondent admits to being licensed to practice medicine in New York; admits that he treated Patient A but denies that he ever applied a clamp to either of Patient A's fallopian tubes. Respondent denies each specification of misconduct (Respondent's Exhibit # F).

A copy of the Statement of Charges (Department's Exhibit # 1) is attached to this Determination and Order as Appendix I. A copy of the Answer to the Statement of Charges (Respondent's Exhibit # F) is attached to this Determination and Order as Appendix II.

The Hearing consisted of three (3) separate days. The Department called four (4) witnesses. Respondent called four (4) witnesses including himself.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	January 11, 2000
Date of Service of Notice of Hearing and Statement of Charges:	January 31, 2000
Answer to Statement of Charges:	February 18, 2000
Pre-Hearing Conferences Held:	February 15, 2000 and April 11, 2000
Hearings Held: - (First Hearing day):	April 11, 2000; April 25, 2000; and May 18, 2000

[8] Patient A is identified in an Appendix to the Statement of Charges.

Department's Proposed Findings of Fact, Conclusions of Law and Recommendation as to Penalty:	Received June 27, 2000
Respondent's Closing Argument, Post-Hearing Memorandum, Proposed Findings of Fact and Conclusions of Law:	Received June 27, 2000
Deliberations Held: - (Last Hearing day):	July 13, 2000

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. **Where there was conflicting evidence or testimony, the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence.** All Findings and Conclusions herein were unanimous. The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was licensed to practice medicine in New York State on August 6, 1991 by the issuance of license number 186519 by the New York State Education Department (Department's Exhibits # 1 and # 3); (Respondent's Exhibits # F and # J)[9].

2. Respondent is currently registered with the New York State Education Department to practice medicine (Department's Exhibits # 1 and # 3); (Respondent's Exhibits # F and # J).

[9] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit) or submitted by Dr. Leonard J. Burman (Respondent's Exhibit).

3. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d]); (Department's Exhibit # 2); [P.H.T-8-9] [10].

4. Respondent provided obstetrical care to Patient A from February 3, 1999 through August 2, 1999 at the Women's Health Center at Newark Wayne Community Hospital (ViaHealth of Wayne) (Department's Exhibits # 4 and # 4A).

5. On July 22, 1999, Respondent performed a repeat cesarean section on Patient A, then 22 years old, at ViaHealth of Wayne in Newark, New York (Department's Exhibits # 4 and # 4A); [T-28-29].

6. During a monthly conference with the hospital's social worker and prior to Patient A's cesarean section, Respondent was informed that Patient A's three other children had been removed from her custody and the custody of their father's by Child Protective Services of the County Social Services Department. Respondent was further informed that custody of the child to be delivered on July 22, 1999 would also be transferred to Child Protective Services following delivery [T-201-204].

7. Prior to the cesarean section, Respondent had discussed with Patient A performing a tubal ligation of her fallopian tubes, which is a sterilization procedure. Patient A refused [T-312, 330, 368].

8. At Patient A's cesarean section, the baby was delivered by Respondent through a low transverse incision in the uterus. The placenta was subsequently delivered, after which the fundus of the uterus was brought out of the abdominal cavity and placed on the patient's abdomen in accordance with Respondent's customary practice [T-31-32, 227-228, 331].

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[10] Numbers in brackets refer to Hearing transcript page numbers [T-]; to Pre-Hearing transcript page numbers [P.H.T-] or to Intra-Hearing transcript page numbers [I.H.T-]. The Hearing Committee did not review the Pre-Hearing or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

9. Respondent placed a suture in the left side of the incision line where there was bleeding. Respondent then placed a straight hemostat (a surgical clamp) on the patient's right fallopian tube and another straight hemostat on the left fallopian tube (Department's Exhibit # 17); [T-31-34, 229-230].

10. Both clamps remained on Patient A's fallopian tubes for approximately three minutes [T-34-35, 234].

11. The clamps were then removed from Patient A's fallopian tubes by Respondent [T-34, 234]. During the time the clamps were on the fallopian tubes no one touched them until they were removed by Respondent [T-34-35, 234].

12. A straight hemostat is a crushing clamp. Placing a straight hemostat on a fallopian tube would stop the flow of blood through the tissue at which point the tissue would be injured and there is the possibility that the tissue would no longer be capable of its normal function [T-107-108]. The extent of injury to the fallopian tubes depends on the length of time the clamp remains in place and the fallopian tube's ability to heal from the effects of the injury [T-107-108].

13. There is no medical indication for applying straight hemostats across a patient's fallopian tubes absent a plan to perform a tubal ligation (which would require patient consent) [T-107].

14. Patient A did not provide consent to any form of sterilization procedure (Department's Exhibits # 4 and # 4A); [T-312].

15. Respondent's intentional application of straight hemostats to Patient A's fallopian tubes was a gross deviation from accepted standards of medical care given that there was no consent for a sterilization procedure [T-112-114]. The identification of the fallopian tubes by an obstetrician should be absolute, as should the physician's ability to distinguish fallopian tubes from other anatomical structures [T-113-114].

16. The intentional application of straight hemostats across a patient's fallopian tubes violates standards of medical ethics which require that a patient not be physically harmed [T-112-113, 115-117].

17. In a written statement made to hospital administrators on August 2, 1999, 11 days following the cesarean section, Respondent stated, in part, the following:

> I admit that prior to the start of the surgical procedure, but not in the presence of the patient, I remarked that this woman [Patient A] should be sterilized because all her children are in foster care due to sexual abuse. I feel in hindsight this comment represents poor judgment on my part. (Department's Exhibit # 21); [T-328-329].

18. On September 23, 1999, Patient A underwent a hysterosalpingogram ("**HSG**") procedure (Department's Exhibits # 6 and # 15). The HSG was non-conclusive. The possibility of finding physical evidence on the HSG, of the type of injury indicated by the clamping of the patient's fallopian tubes, ranges from zero to one hundred percent [T-135-136].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact ("**FoF**") listed above. All conclusions as to the allegations contained in the Statement of Charges were by unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the January 11, 2000, Statement of Charges, are **SUSTAINED:**

First Paragraph [preamble - not numbered]		:[FoF 1-2].
Paragraph A.	(first two sentences)	:[FoF 4-5].
Paragraph A.	(last sentence)	:[FoF 1-18].

Paragraph: A.1. Respondent applied clamps to both of Patient A's fallopian tubes without medical indication during the cesarean section performed on July 22, 1999 :[FoF 5-17].

Paragraph: A.3. Respondent did not obtain Patient A's informed consent for a sterilization procedure :[FoF 5, 7, 9-14].

Paragraph: A.4. Respondent failed to maintain a complete and accurate medical record for Patient A :[FoF 5, 9-14].

The Hearing Committee unanimously concludes that the following Factual Allegation, from the January 11, 2000 Statement of Charges, is **NOT SUSTAINED:**

Paragraph: A.2. Respondent did not obtain Patient A's informed consent to apply clamps to one or both of her fallopian tubes. This allegation is not sustained because physicians do not generally obtain consent from patients for the application of any particular or specific surgical instrument.

Based on the above, the complete Findings of Fact, and the entire record, the Hearing Committee concludes that the following Specifications of Charges are **SUSTAINED:**

The FIRST, SECOND, FOURTH, SIXTH and SEVENTH SPECIFICATIONS (WILLFUL ABUSE, FRAUDULENT PRACTICE, GROSS NEGLIGENCE, INFORMED CONSENT and RECORD KEEPING).

Based on the above, the complete Findings of Fact, and the entire record, the Hearing Committee concludes that the following Specifications of Charges are **NOT SUSTAINED:**

The THIRD and FIFTH SPECIFICATIONS (MORAL UNFITNESS and GROSS INCOMPETENCE).

The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with seven (7) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a variety of forms or types of conduct which constitute professional misconduct.

The ALJ discussed with the Hearing Committee the types of medical misconduct alleged in this proceeding. These definitions were obtained from a memorandum entitled Definitions of Professional Misconduct under the New York Education Law ("**Misconduct Memo**")[11]. The Misconduct Memo sets forth some suggested definitions (relevant to this Hearing) of practicing the profession: (1) fraudulently; (2) with gross negligence; and (3) with gross incompetence.

During the course of its deliberations on these charges, the Hearing Committee consulted the relevant definitions contained in the Misconduct Memo.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. All findings by the Hearing Committee were established on their own merits and based on the evidence presented. If evidence or testimony was presented which was contradictory, the Hearing Committee made a determination as to which evidence was more believable based on its observations as to credibility, demeanor, likelihood of occurrence and reliability.

The Hearing Committee used ordinary English usage and understanding for all other terms, allegations and charges. Other issues raised are addressed where appropriate.

[11] A copy of the Misconduct Memo was available for Respondent [T-5].

With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility.

The Hearing Committee found David Hannan, M.D., a board certified family practitioner whose practice includes obstetrics, to be credible. Dr. Hannan's background, training and experience were reviewed and taken into consideration. Respondent's contention that Dr. Hannan has fabricated his account of the clamps as retribution for Respondent having placed him under a monitoring term in the case of a past patient some five years earlier or to discredit him as a codefendant in that past patient's malpractice action was not believed by the Hearing Committee. The Hearing Committee did not find that Dr. Hannan had a reason to falsify his accusation. The Hearing Committee believes that Dr. Hannan's momentary inability to respond to the actions of Respondent, during the cesarean section, was probably a result of his confusion, borne in part by a loyalty to a colleague with whom he had worked for years, and is understandable. Dr. Hannan's failure to say anything or react to the placements of the clamps may have resulted from his belief that the action was intentional.

Jacquelyn Ward's testimony was consistent with Dr. Hannan's testimony in all respects except as to whether Respondent asked for the clamps or she gave the clamps to Respondent. The Hearing Committee determines that Ms. Ward observed Respondent apply the clamps to Patient A's fallopian tubes after giving Respondent the clamps that he had requested. Ms. Ward's response that she is about 95% sure that the clamps were placed on Patient A's fallopian tubes is believed by the Hearing Committee. Ms. Ward has been an operating room technician for 23 years and has assisted at several hundred surgeries involving the fallopian tubes including ectopic pregnancies, tubal ligations, hysterectomies, as well as cesarean sections.

Ms. Ward had on other occasions observed the clamping of fallopian tubes during tubal ligations and the clamping of the round ligaments during hysterectomies. The Hearing Committee observes that Ms. Ward has no motivation in this matter to report anything other than what actually occurred to the best of her abilities. Ms. Ward's testimony was both credible and reliable.

Dr. James Steven Burkhart testified as the State's expert. Dr. Burkhart is Board Certified in Obstetrics and Gynecology and is involved in the instruction of residents. Dr. Burkhart was found to have good credentials and was credible. The same can be said about Dr. Robert Silverman who testified as Respondent's expert.

Dr. Silverman's expertise is in maternal-fetal medicine and he is Board Certified in Obstetrics and Gynecology and is also involved in the instruction of residents. Dr. Silverman's testimony was credible although his explanation of the status of the fallopian tubes as seen on the hysterosalpingogram ("**HSG**") was unconvincing. This case was more one of credibility of Respondent versus the credibility of the witnesses rather than a battle of expert opinions. It is significant that both experts agreed that they did not use nor teach the clamping of the round ligaments in the fashion that was asserted by Respondent.

Dr. Jack Nolen, who had left his position at Newark Wayne Community Hospital some two years prior to these events, was seen as testifying for Respondent as a friend who was trying to be supportive. The Hearing Committee did not give his testimony much weight.

Sharon Brown, the hospital social worker, testified that prior to the surgery, Respondent was advised that Social Services had taken custody of Patient A's three other children and that a court order had been obtained to transfer custody of the infant, which would be delivered on July 22, 1999, to Social Services. Prior to the delivery, Respondent attended a meeting with Ms. Brown and representatives of Social Services to discuss Patient A. At that time Respondent made a remark relating to the planned cesarean section for Patient A to the effect:

"Wouldn't it be a shame if the knife slipped".

While the Hearing Committee does not believe that this remark by Respondent proves the allegations of the Department, the remark nevertheless portrays an attitude towards this patient and her situation which could explain his conduct (and intent) during Patient A's July 22, 1999 cesarean section surgery.

Obviously Respondent had the greatest amount of interest in the results of these proceedings. Although Respondent appeared to be sincere in his testimony, the Hearing Committee found it to be self-serving and not credible. Leonard J. Burman is a board certified obstetrician/gynecologist who has practiced medicine for 42 years. He has been licensed as a physician in New York since August 6, 1991. Respondent's inconsistent statements as to when in the surgery the clamps were allegedly applied to the round ligaments, casted serious doubts as to the validity of his claims. Respondent disavowed during his testimony his prior written statements as to when in the surgery the clamps were applied. Respondent's credibility becomes suspect where he was required to contradict his own prior statements.

The testimony of W. Neil Stroman was seen as mostly irrelevant to the charges and was given very little consideration.

The September 23, 1999 HSG does not conclusively prove or refute whether the patient's fallopian tubes were clamped on July 22, 1999 or were not. There is no prior study for comparison, and the abnormality described appears only in the left tube and not in the area where the clamp was alleged to have been placed. After more than 8 weeks complete healing could have occurred. Since the HSG findings are non-conclusive the Hearing Committee gave the HSG very little evidentiary weight.

Using the above definitions and understanding, including the relevant portions of the remainder of the Misconduct Memo and the legal understanding set forth above, the Hearing Committee concludes by a unanimous vote that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State.

The Department of Health has met its burden of proof as to one (1) act of willful abuse; fraudulent practice; gross negligence; performing professional services without obtaining informed consent; and failing to maintain accurate records as charged in the January 11, 2000 Statement of Charges.

The Hearing Committee does not find that Respondent lacked the skill or knowledge of proper medical care as to Patients A and we do not sustain the charges of gross incompetence. Nor, as further discussed below, do we sustain the charge of moral unfitness.

The evidence establishing misconduct in this matter does not come from one source. This is not simply a case of Dr. Burman's word against that of Dr. Hannan. Dr. Hannan's evidence is corroborated by the testimony of the operating room technician, Jacquelyn Ward; by the fact that neither the State's expert nor Respondent's own expert has any experience with the surgical technique of clamping the round ligaments which Respondent claims he was employing and by the inconsistent explanations of Respondent. When this evidence is considered in its totality, it conclusively establishes that Respondent clamped the patient's fallopian tubes. Respondent's attempt to intentionally harm a patient is an anathema to the fundamental tenets of medical ethics.

Respondent's contention that he used straight hemostats on the round ligaments to obtain traction on the uterus must be reviewed first from the standpoint of the propriety and efficacy of such a technique, and then the credibility of Respondent's account must be considered given his conflicting statements as to when in the surgery he claims he used the clamps.

Neither Dr. Burkhart nor Dr. Silverman, the two experts in this case, who have between them performed or assisted at some 2500 cesarean sections has ever used crushing clamps on the round ligaments for traction (in non hysterectomy situations); neither one has ever seen any other practitioner use clamps in this way; and neither one has ever heard of other practitioners using clamps in this way.

In addition, Dr. Silverman conceded that he does not instruct residents to obtain traction by this method, has not seen clamps used in conjunction with manual traction, and has not seen this technique described in professional publications.

Dr. Burkhart and Dr. Silverman are both well-trained, experienced obstetricians who are responsible for the instruction of obstetrical residents at teaching institutions. They were not trained to use clamps in the manner Respondent states that he used them, nor do they train others to use this method.

Respondent produced no witnesses from any of his other surgeries to confirm the use of clamps on a patient's round ligaments, under similar circumstances as occurred with Patient A. Ms. Ward had assisted Respondent in at least 100 prior cesarean sections, while Dr. Hannan had assisted him at some 150 previous sections. Neither had ever seen Respondent apply clamps to the round ligaments for traction.

The letters from Dr. Zinberg of the American College of Obstetricians and Gynecologists ("**ACOG**") (Respondent's Exhibits # C and # D) did not address the specific factual circumstances of the July 22, 1999 events. Therefore these exhibits were give no evidentiary weight or significance.

Respondent's claim that he used clamps on the round ligaments is highly suspect because he changed his account as to when in the surgery the clamps were used for this alleged purpose.

The testimony of Dr. Hannan and Ms. Ward contradicts Respondent's account in two significant aspects. The first, obviously, is the placement of the clamps on the fallopian tubes, rather then the round ligaments. However, Dr. Hannan and Ms. Ward also testified that from the time the clamps were applied until the time they were removed by Respondent, no one touched them. Respondent was then required to explain who held the clamps to provide the traction.

In his written account of the surgery to the hospital in early August 1999, Respondent clearly states that the clamps were applied at the time the second suture line was placed to close the uterine incision (Department's Exhibit # 21 - second page, undated letter to Drs. Howard and Edwards states:)

> ... As you peruse this report [operative report] you will note a second layer of suture was placed in the lower uterus segment. Usually I close the uterus in one layer only. However, due to the defect in the uterus it became apparent a second suture line was necessary. It was at or about this time additional exposure was needed; therefore hemostats were placed on the round ligaments...

Respondent's statement indicates that following the placement of the first line of sutures he had to vary from his normal practice and place a second suture line for which he required additional exposure resulting in the use of the clamps. His statement is unequivocal that it was at this point in the surgery that he applied the clamps.

However, when he testified, Respondent stated that the clamps were placed and used at the time that he lysed bladder adhesions prior to the placement of the first suture line to close the uterine incision. Respondent concedes that his testimony that the round ligaments were clamped during the lysing of bladder adhesions is not consistent with his earlier written account. Respondent's attempt to place the blame on his wife or to an error in dictation for the August 1999 correspondence is not credible.

The Hearing Committee finds that the greater part of the credible evidence (more than a preponderance) establish that Respondent clamped Patient A's fallopian tubes. As reviewed above, the State's evidence is corroborated from different sources, while Respondent's account lacks independent corroboration and is inconsistent with Respondent's own prior written statements.

The medical experts agree that if an obstetrician were to intentionally clamp a patient's fallopian tubes without consent it would be a serious act of professional misconduct given the potential for injury to a vital organ of reproduction. There was no consent obtained for a sterilization procedure for Patient A. By intentionally clamping Patient A's fallopian tubes Respondent willfully abused Patient A physically (the First Specification is sustained) and failed to obtain her informed consent prior to undertaking a procedure which could potentially sterilize her (the Sixth Specification is sustained).

Respondent knew that he did not have permission to clamp Patient A's fallopian tubes, attempted to conceal his actions, both verbally and in writing (through the patient's medical record and his letters to the hospital), all with the intention of concealing his conduct to protect his own interests. By doing so Respondent has practiced the profession of medicine fraudulently (the Second Specification is sustained). Respondent's use of a medical procedure to promote his own interests (or to promote what he may have believed to be in the best interest of society) rather than the health interests of the patient constitutes the fraudulent practice of medicine.

Patient A placed her trust in Respondent, when she agreed to have him perform a cesarean section. Respondent then violated the patient's trust by committing what can only be categorized as an immoral act of attempting a sterilization without the consent of the patient or without a medical necessity or emergent situation.

What Respondent did was wrong and he knew it. The Hearing Committee determines that Respondent did commit an immoral act but we do not believe that this single immoral act evidences the moral unfitness to practice medicine (Third Specification is not sustained).

Respondent's application of the clamps to Patient A's fallopian tubes was not by mistake, was egregious in nature and constitutes grossly negligent conduct. Respondent unnecessarily subjected the patient to a risk of severe injury. Respondent's conduct was intentional and deliberate (the Fourth Specification is sustained).

The Hearing Committee does not believe that Respondent lacks the skill or knowledge necessary to perform a cesarean section. The Hearing Committee does not believe nor was there any evidence presented to prove that Respondent is grossly incompetent or even incompetent (the Fifth Specification is not sustained).

Finally, Respondent is charged with failing to maintain an adequate medical record. The medical record does not document the clamping of the fallopian tubes. Respondent failed to maintain a record that accurately reflected the care and treatment rendered to Patient A (the Seventh Specification is sustained).

DETERMINATION AS TO PENALTY

The Hearing Committee pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above determines, by a unanimous vote, that Respondent's license to practice medicine in the State of New York should be SUSPENDED for a period of SIX (6) MONTHS.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

The Hearing Committee believes that Respondent's conduct signifies a momentary loss of control and lapse in good judgment. Respondent was unable to confine his personal beliefs regarding the patient's social situation to opinion alone, but acted on his beliefs inappropriately.

The Hearing Committee believes that Respondent has been a good physician for the past 40 years. There is no credible evidence otherwise. As Dr. Hannan testified, Respondent is a very skilled surgeon who had always taken excellent care of his patients in the past. Respondent was readily available to help his colleagues, was there to supervise when necessary, and made special arrangements to help colleagues who were on hospital probation. Respondent exhibited a high standard of care. Respondent performed community service as the primary physician associated with the women's health clinic. Other than this one incident, Respondent's bedside manner and professionalism were not questioned. Although five (5) specifications of misconduct were sustained, the Hearing Committee was aware of the fact that all specifications arose out of one single event or incident. No pattern or recurring problem was shown to exist in Respondent.

Respondent has not had any previous restrictions on his license imposed by any state agency or hospital boards. Respondent has never been charged with unprofessional conduct by any state agency or hospital boards. Respondent has held a number of administrative and leadership positions with a number of hospitals around the country. Respondent had low complication rates and prevented problems by using his good diagnostic ability.

Given the above mitigating factors, the Hearing Committee does not believe that Respondent's license to practice medicine in New York should be revoked. The Hearing Committee has no doubt that Respondent's one time abhorrent behavior will never happen again. The deterrence and expenses of going through the State investigation and Hearing process insures that it will not happen again for this Respondent.

For the above reason, the Hearing Committee did not see any benefit to placing Respondent on probation for any period of time because there is nothing to monitor or observe.

The Hearing Committee believes that the swift sharp penalty of no practice for 6 months sends a clear message that Respondent is being punished for a bad act and he can't practice because of that bad act for a specific period. The Hearing Committee believes that during that six month period Respondent will reflect on his conduct and learn from his error. The Hearing Committee found no lack of knowledge or skills and therefore did not feel that CME or training was necessary.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines the above to be the appropriate sanction under the circumstances. The Hearing Committee concludes that the sanction of six months of suspension strikes the appropriate balance between the need to punish Respondent, deter future misconduct of Respondent or others, and protect the public.

All other issues, proposed findings and conclusions raised by both parties have been duly considered by the Hearing Committee, have been rejected and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The First, Second, Fourth, Sixth, and Seventh Specifications of professional misconduct contained within the Statement of Charges (Department's Exhibit # 1) as discussed herein are **SUSTAINED,** and

2. The Third and Fifth Specifications of professional misconduct contained within the Statement of Charges (Department's Exhibit # 1) as discussed herein are **NOT SUSTAINED,** and

3. Respondent's license to practice medicine in the State of New York is hereby **SUSPENDED FOR A SIX (6) MONTHS PERIOD**; and

4. This Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. section 230(10)(h).

DATED: **New York, New York**
July 31 **, 2000**

STEPHEN A. GETTINGER, M.D.
WILLIAM K. MAJOR, M.D.
MS. NANCY J. MORRISON

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APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
LEONARD J. BURMAN, M.D.	:	CHARGES

----------X

LEONARD J. BURMAN, M.D., the Respondent, was authorized to practice medicine in New York State on August 6, 1991, by the issuance of license number 186519 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine.

FACTUAL ALLEGATIONS

A. Respondent provided obstetrical care to Patient A (Patient A is identified by name in Appendix A) from on or about February 3, 1999 through August 2, 1999 at the Women's Health Center at Newark Wayne Community Hospital, Newark, New York and Newark Wayne Community Hospital. On July 22, 1999, Respondent performed a cesarean section on Patient A at Newark Wayne Community Hospital. Respondent's care and treatment of Patient A deviated from accepted standards of medical care and subjected the patient to a risk of significant injury in the following respects:

1. Respondent applied a clamp to one or both of Patient A's fallopian tubes without medical indication during the cesarean section performed on July 22, 1999.

2. ~~Respondent did not obtain Patient A's~~ informed consent

1999.

2. Respondent did not obtain Patient A's informed consent to apply clamps to one or both of her fallopian tubes.

3. Respondent did not obtain Patient A's informed consent for a sterilization procedure.

4. Respondent failed to maintain a complete and accurate medical record for Patient A.

SPECIFICATIONS

FIRST SPECIFICATION

WILLFUL ABUSE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(31) by reason of his having willfully abused a patient physically, in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1.

SECOND SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(2) by reason of his practicing the profession of medicine fraudulently or beyond its authorized scope, in that Petitioner charges the following:

2. The facts in Paragraphs A and A.1.

THIRD SPECIFICATION

MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(20) by reason of his having committed conduct in the practice of medicine which evidences moral unfitness to practice medicine, in that Petitioner charges the following:

3. The facts in Paragraphs A and A.1.

FOURTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) by reason of his having practiced the profession with gross negligence on a particular occasion, in that Petitioner charges the following:

4. The facts in Paragraphs A and A.1.

FIFTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) by reason of his practicing the profession of medicine with gross incompetence on a particular occasion, in that Petitioner charges the following:

5. The facts in Paragraphs A and A.1.

SIXTH SPECIFICATION

INFORMED CONSENT

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(26) by reason of his having performed

professional services which have not been duly authorized by the patient or her legal representative, in that Petitioner charges the following:

6. The facts in Paragraphs A and A.2 and/or A and A.3.

SEVENTH SPECIFICATION

RECORD KEEPING

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) by reason of his failing to maintain a record for his patient which accurately reflected the evaluation and treatment of the patient, in that Petitioner charges the following:

7. The facts in Paragraphs A and A.4.

DATED: January 11, 2000
Albany, New York

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

STATE OF NEW YORK
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

In the Matter of

Leonard J. Burman, M.D.

ANSWER TO STATEMENT OF CHARGES

Respondent **LEONARD J. BURMAN, M.D.,** by his attorneys, Woods, Oviatt, Gilman, Sturman & Clarke LLP, for his answer to the statement of charges herein, pursuant to Public Health Law § 230(10)(c), alleges as follows:

1. Admits the facts stated in the preamble to the Statement of Charges.

2. With respect to the allegations of paragraph "A", Respondent admits the first two sentences thereof, stating in sum and substance that he provided obstetrical services to [redacted] and performed a cesarean section on the dates specified; but Respondent otherwise denies the allegations contained in paragraph "A", and specifically denies that his care of [redacted] deviated from accepted standards of medical care and subjected her to a risk of significant injury.

3. Denies the allegations of paragraphs "A.1", "A.2", "A.3" and "A.4", and specifically denies that he ever applied a clamp to either of [redacted] fallopian tubes.

4. With respect to each and every one of the Seven Specifications, charging him with willful abuse, practicing the profession fraudulently, moral unfitness, gross negligence, gross incompetence, performing services without obtaining informed consent, and failing to maintain accurate records, Respondent denies each and every one

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of the charges of misconduct stated therein, and repeats and realleges his allegations in response to the allegations set forth in paragraphs "A", "A.1", "A.2", "A.3" and "A.4" as if more fully set forth herein.

Dated: February 18, 2000

WOODS, OVIATT, GILMAN,
STURMAN & CLARKE LLP

By: _____

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TO: NEW YORK STATE DEPARTMENT OF HEALTH
DIVISIO OF LEGAL AFFAIRS
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