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

November 14, 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 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah

Enclosure

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

COPY

In the Matter of

Leonard J. Burman, 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. 00-221

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

For the Department of Health (Petitioner): **Timothy J. Mahar, Esq.**
For the Respondent: **Daniel O'Brien, Jr., Esq.**

After a hearing below, a BPMC Committee determined that the Respondent committed professional misconduct by performing a procedure to sterilize a patient, without that patient's consent. The Committee voted to suspend the Respondent's License to practice medicine in New York State for six months. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney's Supp. 2000), both parties ask the ARB to overturn the Committee. The Respondent argues that the Committee erred in sustaining the charges in the case and asks the ARB to dismiss the charges. The Petitioner asks the ARB to sustain an additional charge against the Respondent and to revoke the Respondent's License. After considering the record and the review submissions by the parties, we affirm the Determination on the charges, except we affirm the additional specification charging that the Respondent's conduct evidenced moral unfitness in medical practice. We affirm the Determination to suspend the Respondent's License for six months. We modify the penalty to add the requirement that the Respondent complete a course in medical ethics.

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), 6530(4), 6530(6), 6530(20), 6530(26) & 6530(31-32) (McKinney Supp. 2000) by committing misconduct under the following specifications:

- practicing the profession fraudulently,
- practicing th .ofession with gross negligence,
- practicing the profession with gross incompetence,
- engaging in conduct that evidences moral unfitness,
- performing professional services without patient authorization,
- willfully abusing a patient physically, and,
- failing to maintain accurate patient records.

The charges [Petitioner Exhibit 1] alleged that the Respondent placed crushing clamps on a patient's fallopian tubes, during a cesarean delivery, in an attempt to sterilize the patient, without the patient's consent. The Respondent denied the charges [Respondent Exhibit F] and the matter proceeded to a hearing before the BPMC Committee which rendered the Determination now on review.

The Committee determined that the Respondent performed a repeat cesarean section on Patient A on July 22, 1999 at Newark Wayne Community Hospital (Hospital). The Committee found that the Respondent:

- attended a conference with the Hospital's social worker at which he learned that the Patient and her husband had lost custody over their children to the County Social Services Department [Finding of Fact (FF) 6];
- stated that the Patient should be sterilized because all the Patient's children were in foster care due to sexual abuse [FF 17];
- discussed a sterilization procedure with the Patient that the Patient refused [FF 7]; and,

- placed straight hemostat clamps on the Patient's fallopian tubes for approximately three minutes [FF 10].

The Committee also found that a straight hemostat is a crushing clamp and that its application to a fallopian tube would serve only in performing a sterilization procedure. The Committee found further that the Patient underwent a hysterosalpingogram (HSG) in an attempt to determine whether the fallopian tubes suffered an injury. The Committee found the HSG inconclusive, as the possibility for finding such damage ranged from zero to one hundred per cent. The Committee concluded that the Respondent committed a gross deviation from accepted medical care standards by applying the straight hemostats to the Patient's fallopian tubes without the Patient's consent for a sterilization procedure.

In reaching their Determination, the Committee found eyewitness testimony by David Hannan, M.D. and Operating Room Technician Jacquelyn Ward credible. Both witnesses testified to observing the Respondent apply the clamps to the Patient's fallopian tubes. The Committee rejected the Respondent's testimony that he had applied the clamps to round ligaments for traction. The Committee found the Respondent's statements about clamping the round ligaments inconsistent between the Respondent's statement in his operative report and his testimony at the hearing. The Committee noted that both the Petitioner's expert, James Steven Burkhart, M.D., and the Respondent's expert, Robert Silverman, M.D., testified that that they had never seen a cesarean section in which the surgeon used crushing clamps on round ligaments for traction. The Committee also rejected an opinion letter that the Respondent submitted from the American College of Obstetricians and Gynecologists (ACOG), because the letter failed to address the specific factual circumstances on July 22, 1999 [Committee Determination page 14].

The Committee voted to sustain charges that the Respondent practiced medicine fraudulently and with gross negligence, that he performed a procedure without patient consent, that he willfully abused a patient and that he failed to maintain accurate patient records. The Committee dismissed charges that the Respondent engaged in conduct that evidenced moral unfitness and practiced medicine with gross incompetence. The Committee voted to suspend the Respondent's New York Medical License for six months. The Committee concluded that the

suspension would punish the Respondent for his conduct and deter future misconduct by the Respondent or others. The Committee noted that the Respondent is a skilled surgeon, with no previous restrictions on his License and no prior misconduct.

Review History and Issues

The Committee rendered their Determination on August 4, 2000. This proceeding commenced on August 22, 2000, 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 response brief and the Respondent's brief and response brief. The record closed when the ARB received the Respondent's response brief on October 3, 2000.

The Petitioner's review brief argues that the Respondent's conduct also evidenced moral unfitness and the Petitioner asks the ARB to sustain that additional charge. The Petitioner argues further that the Respondent's conduct fails to merit the Committee's leniency in restricting the penalty to only license suspension for six months. The Petitioner asks the ARB to revoke the Respondent's License.

The Respondent alleges error by the Committee in rejecting the HSG results and the ACOG letter. The Respondent also contends that he gave no inconsistent statements. The Respondent argues that the Committee made findings inconsistent with the evidence. The Respondent notes that as soon as he learned about the accusations that he performed a sterilization without consent, he requested the HSG. The Respondent also alleges that the Committee erred in finding Dr. Hannan's testimony credible. The Respondent accuses Dr. Hannan of bias, due to a hostile relationship with the Respondent. The Respondent asks that the ARB dismiss the charges.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent committed misconduct in placing crushing clamps on Patient A's fallopian tubes after the Patient refused to consent to sterilization. We modify the Determination on the charges to sustain an additional charge. We reject the request that we revoke the Respondent's License. We affirm the Determination to suspend the Respondent's License for six months. We modify the Determination on penalty to also require that the Respondent complete a course in medical ethics.

Before discussing the reasons behind our Determination, we note that before deliberations in this case began, Dr. Grossman advised the ARB about his professional acquaintance with the Petitioner's witness Dr. Hannan. Dr. Grossman indicated that he knew Dr. Hannan through the Medical Society of the State of New York. Dr. Grossman stated that his acquaintance with Dr. Hannan would have no influence over Dr. Grossman's ability to review this case fairly. Neither the other ARB members nor the Administrative Officer for the ARB saw any conflict in Dr. Grossman continuing to serve on the case.

We affirm the Committee's judgement that the Respondent placed the clamps on the Patient's fallopian tubes. We agree with the Committee that the case turned upon a credibility determination between the Respondent's denials and the accusations by Dr. Hannan and Ms. Ward. As a reviewing body, the ARB owes deference to the Committee as the fact-finder in the Committee's Determination on credibility. We see no reason to overturn the Committee's judgement on credibility in this case.

The evidence showed that, before the operation, the Respondent attended a conference at which he learned that the Patient had lost custody over her children. The information the

Respondent learned at that conference may have clouded his judgement. At the time, the Respondent made a statement "Wouldn't it be a shame if the knife slipped" [Committee Determination pages 11-12]. The Respondent later made a written statement admitting that he remarked that the Patient should be sterilized [FF 17]. The Respondent discussed tubal ligation, or sterilization, with Patient A, but the Patient refused to consent [FF 7]. During the surgery, two witnesses saw the Respondent place crushing clamps on the Patient's fallopian tubes. The Respondent accused Dr. Hannan of bias, but the testimony by Ms. Ward corroborated Dr. Hannan's testimony and contradicted the Respondent's claim that he placed the clamps on round ligaments for traction. The Respondent also gave inconsistent statements about the clamping between his operative report and his hearing testimony. Further, both the Respondent's and the Petitioner's expert witnesses testified that they had never used, nor seen used, clamps on round ligaments for traction in non-hysterectomy settings. The Committee rejected an ACOG opinion letter that expressed a contrary opinion, because the letter failed to address the factual situation on July 22, 1999. The Committee found non-conclusive the HSG that the Patient underwent on September 23, 1999, because the possibility for finding evidence of damage from fallopian tube clamping ranged from zero to one hundred per cent.

Both expert witnesses agreed that clamping a patient's tubes intentionally without consent constitutes serious misconduct. We affirm the Committee's Determination that the conduct amounted to practicing fraudulently and with gross negligence, abusing a patient, performing a procedure without patient consent and failing to maintain accurate records. The Committee also concluded that the Respondent violated the Patient's trust by engaging in an immoral act - attempting a sterilization without consent, necessity or emergency. We hold that the Committee made a determination inconsistent with that conclusion by dismissing the charge that the

Respondent engaged in conduct that evidenced moral unfitness. The Committee found that a single immoral act failed to evidence moral unfitness. We disagree. Education Law § 6530(20) defines misconduct to include engaging in "conduct" that evidences moral unfitness. We see nothing in the statute that requires multiple immoral acts to evidence moral unfitness. We sustain the charge that the Respondent's conduct constituted misconduct under Education Law §6530(20).

We reject the Petitioner's request that we overturn the Committee and revoke the Respondent's License. The Committee's Determination discusses many mitigating factors in this case. The Respondent has engaged in practice for forty years without any prior discipline. He also exhibited a high standard of care and performed community service. The Committee also found the Respondent's behavior unlikely to recur. We agree with the Committee that revocation would constitute an overly harsh sanction in this case. We hold that the Committee acted appropriately in suspending the Respondent for six months, to give the Respondent the opportunity to reflect upon his misconduct. Such penalty will deter future misconduct. We modify the Committee's Determination to require that the Respondent complete a course on medical ethics within six months from the date the Determination becomes effective.

ORDER

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

1. The ARB **AFFIRMS** the Committee's Determination that the Respondent practiced medicine fraudulently and with gross negligence, abused a patient, performed a procedure without patient consent and failed to maintain accurate records.
2. The ARB **OVERTURNS** the Committee's Determination and we **SUSTAIN** the charge that the Respondent engaged in conduct that evidenced moral unfitness.
3. The ARB **AFFIRMS** the Committee's Determination to suspend the Respondent's License for six months.
4. The ARB **MODIFIES** the Committee's Determination to include the requirement that the Respondent complete a course in medical ethics within six months from the date this Determination becomes effective.

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 Leonard J. Burman, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Burman.

Dated: November 1, 2000

Robert M. Briber

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

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

Dated: Nov 9, **2000**

Thea Graves Pellman

Thea Graves Pellman

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

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

Dated: November 6, **2000**

Winston S. Price, M.D.

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

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

Dated: November 2, 2000

S. L. Grossman M.D.

Stanley L Grossman, M.D.

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

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

Dated: Oct. 31, **2000**

Therese G Lynch

Therese G. Lynch, M.D.