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

March 7, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy Runge, M.D.
19 Stetson Avenue
Plattsburgh, New York 12901

Cindy M. Fascia, Esq.
NYS Department of Health
ESP- Corning Tower, Room 2509
Albany, New York 12237-0032

Carolyn Shearer, Esq.
Bond, Schoeneck & King, PLLC
111 Washington Avenue
Albany, New York 12110-2211

RE: In the Matter of Timothy Runge, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 05-271) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

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

In the Matter of

Timothy Runge, 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. 05-271

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

For the Department of Health (Petitioner): **Cindy M. Fascia, Esq.**
For the Respondent: **Carolyn Shearer, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent practiced with negligence on more than one occasion and with gross negligence and the Committee voted to suspend the Respondent's license to practice medicine in New York State (License), stay the suspension and place the Respondent on probation for two years, with a practice monitor and certain practice restrictions. In this proceeding pursuant to N.Y. Pub. Health Law (PHL) § 230-c (4)(a)(McKinney Supp. 2006), the Petitioner asks the ARB to modify that Determination to make additional findings of misconduct, to order a supervisor for the Respondent's practice and to increase the period for probation. After reviewing the hearing record and the review submissions by the parties, the ARB rejects the Petitioner's request to make additional findings and to increase the penalty. On our own motion, we overturn the findings that the Respondent practiced with gross negligence in treating two patients, we remove the suspension/stayed suspension against the Respondent's License, we censure and reprimand the Respondent, we reduce the probation to six months and we remove one condition from the probation.

Committee Determination on the Charges

The Committee conducted a hearing in this matter on charges that the Respondent violated N. Y. Educ. Law (EL) §§ 6530(3-5) (McKinney Supp. 2006) in committing professional misconduct by practicing medicine with:

- negligence on more than one occasion,
- gross negligence, and,
- incompetence on more than one occasion.

The charges related to the care that the Respondent rendered to nine persons (Patients A to I) in the Emergency Department at Champlain Valley Physician's Hospital (CVPH) during dates in 2001 to 2003. The record refers to patients by initials to protect patient privacy. A six-day hearing followed and the Committee then rendered the Determination now on review.

The Committee dismissed the incompetence charges and dismissed all charges relating to Patients D and E. The Committee determined that the Respondent practiced with negligence by failing to:

- order adequate fluid resuscitation, to detect a pelvic fracture and detect, diagnose or document a widened mediastinum on the x-ray for Patient A;
- assess and admit Patient B to CVPH;
- admit Patient C to CVPH or rule out myocardial infarction for the Patient;
- order adequate intravenous fluids for Patient F;
- order the administration of Albuterol for Patient H; and,
- detect an enlarged heart in Patient I and drain fluid from around the Patient's heart.

The Committee also found the Respondent negligent for:

- underestimating Patient B's blood loss;
- discharging Patient G from the Emergency Department without adequately evaluating chest pain;
- failing to respond to respiratory distress in Patient H; and,
- missing a low voltage reading on the EKG for Patient I.

The Committee determined that the care for Patients B and I also amounted to gross negligence.

The Committee found that the Respondent's practice in the Emergency Department focused on the best case rather than the worst-case scenario for Patients. The Committee found that the Respondent possessed a sufficient medical knowledge base, but determined that the Respondent's decision making required more review. The Committee voted to suspend the Respondent's License for two years, stay the suspension and to place the Respondent on probation for two years under the terms that appear as Appendix II to the Committee's Determination. The probation provides for a practice monitor for the entire two years, restricts the Respondent from working alone in the Emergency Department for the first year on probation and requires the Respondent to spend one hour per week, for the first six months on probation, reading x-rays and films at CVPH in the presence of a radiologist.

Review History and Issues

The Committee rendered their Determination on November 22, 2005. This proceeding commenced on December 8, 2005, when the ARB received the Respondent'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 reply brief. The record closed when the ARB received the reply brief on January 30, 2006. The Administrative Officer for the ARB granted the Respondent a one-week extension in the time to file the reply, over the Petitioner's objection.

The Petitioner asks that the ARB sustain additional charges and increase the penalty against the Respondent. The Petitioner asks that the ARB sustain an additional Factual Allegation A.4 that charged that the Respondent failed to order the timely transfer of Patient A. The Petitioner also asks that the ARB sustain the charge that the Respondent's care for Patient A constituted practicing with gross negligence. The Petitioner alleges that the Committee intended to require that the Respondent practice with a Supervisor, because the Committee placed a monitor on the Respondent's practice and forbade the Respondent to practice without another

physician present in the Emergency Department for the first year under the probation. The Petitioner asks that the ARB place a Supervisor over the Respondent's practice. The Petitioner also requests that the ARB extend the probation period beyond two years. In reply, the Respondent contends that any increase in the penalty would be grossly disproportionate to the misconduct in these cases.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment 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); 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); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. We reject the Petitioner's request that we sustain additional charges or increase the penalty that the Committee imposed. On our own motion, we modify the penalty that the Committee imposed.

The ARB concludes that the record demonstrates that the Respondent practiced with negligence on more than one occasion in treating Patients A, B, C, E, G, H and I. We disagree with the Committee that the Respondent's care for Patients B and I rose to egregious proportions and we overturn the Committee's Determination that the Respondent practiced with gross negligence. We also find no reason to find gross negligence in the care for Patient A and we decline to sustain Factual Allegation A4. In addition to the Respondent's negligence in the cases at issue, we also note systemic problems at CVPH contributed to care deficiencies, such as the failure to provide 24-hour coverage by radiologists, inadequate specialty back-up and the failure

to provide more than one physician to cover the Emergency Department for a three-hour period daily.

As to penalty, the ARB agrees with the Committee that the Respondent should spend time on probation with a practice monitor under the conditions in Appendix II to the Committee's Determination. We disagree with the Committee that the Respondent should serve two years on probation and we reject the Petitioner's request for an extension in probation beyond two years. We limit the Respondent's term on probation to six months. We note that most of the cases at issue date from 2002, with nothing more recent than 2003. The Respondent may have already corrected many of the problems with his practice. The six months on probation, with a monitor, will provide a sufficient time period to determine if any problems linger. We overturn the Committee's Determination to suspend the Respondent's License and to stay the suspension. In place of the stayed suspension, the ARB votes to Censure and Reprimand the Respondent.

The Committee's Probation Terms, at Paragraph 9, prohibited the Respondent from practicing in the Emergency Department without another physician present, during the first year of the probation. The ARB deletes that term from the probation terms. We conclude that CVPH, rather than the Respondent, should bear the responsibility for assuring proper coverage in the Emergency Department. We reject the Petitioner's argument that Paragraph 9 in the Probation Terms meant that the Committee really meant to impose a Supervisor on the Respondent's practice. The ARB agrees with the statement from the Respondent's reply brief, that if the Committee had meant to impose a practice supervisor, the Committee would have said that in the Determination.

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 with negligence on more than one occasion, but we overturn the Committee's Determination that the Respondent practiced with gross negligence.
2. The ARB overturns the Committee's Determination to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation for two years.
3. The ARB votes to censure and reprimand the Respondent and to place the Respondent on probation for six months, under the terms that appear at Appendix II to the Committee's Determination, except that the ARB deletes Paragraph 9 from the Probation Terms.

Robert M. Briber
Thea Graves Pellman
Datta G. Wagle, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Timothy Runge, M.D.

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

Dated: February 14, 2006

Robert M. Briber

In the Matter of Timothy Runge, M.D.

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

Dated: Feb. 22, **2006**

Thea Graves Pellman

In the Matter of Timothy Runge, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Runge.

Dated: 2/15/ **2006**

Datta G. Wagle, M.D.

In the Matter of Timothy Runge, M.D.

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

Dated: February 14, **2006**

Stanley L Grossman M.D.

Stanley L Grossman, M.D.

In the Matter of Timothy Runge, M.D.

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

Dated: Feb. 14, 2006

Therese G. Lynch M.D

Therese G. Lynch, M.D.