



New York State Board for Professional Medical Conduct

433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Richard F. Duines, M.D.
Commissioner
NYS Department of Health
James W. Clyne, Jr.
Executive Deputy Commissioner
Keith W. Servis, Director
Office of Professional Medical Conduct

PUBLIC

Kendrick A. Sears, M.D.
Chair
Carmela Torrelli
Vice Chair
Katherine A. Hawkins, M.D., J.D.
Executive Secretary

May 12, 2010

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

David Walborn, M.D.

RE: License No. 183082

Dear Dr. Walborn:

Enclosed is a copy of Order BPMC #10-75 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect May 19, 2010.

If the penalty imposed by the Order is a fine, please write the check payable to the New York State Department of Health. Noting the BPMC Order number on your remittance will assist in proper crediting. Payments should be directed to the following address:

Bureau of Accounts Management
New York State Department of Health
Corning Tower, Room 1717
Empire State Plaza
Albany, New York 12237

Sincerely,

Katherine A. Hawkins, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

cc: J. Mark Gruber, Esq.
Roach, Brown, McCarthy & Gruber, P.C.
1920 Liberty Bldg., 420 Main Street
Buffalo, New York 14202-3616

IN THE MATTER
OF
DAVID M. WALBORN, M.D.

CONSENT
ORDER
BPMC # 10-75

Upon the application of (Respondent) DAVID M. WALBORN, M.D. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

- by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR
- upon facsimile transmission to Respondent or Respondent's attorney, whichever is first.

SO ORDERED.

DATE: 05/11/2010

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional Medical Conduct

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

IN THE MATTER
OF
DAVID M. WALBORN, M.D.

CONSENT
AGREEMENT
AND
ORDER

DAVID M. WALBORN, M.D., represents that all of the following statements are true:

That on or about July 17, 1990, I was licensed to practice as a physician in the State of New York, and issued License No. 183082 by the New York State Education Department.

My current address is _____, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with 13 specifications of professional misconduct.

A copy of the Statement of Charges, marked as Exhibit "A", is attached to and part of this Consent Agreement.

I do not contest the first specification as it applies to factual allegations B.1 and C.1, and deny the remainder of the charges, in full satisfaction of the charges against me, and agree to the following penalty:

Pursuant to N.Y. Pub. Health Law § 230-a(3), my license to practice medicine in New York State shall be limited to preclude any general surgery and/or any intervention that is needed beyond that which can be done under local anesthesia and to permit wound care practice only in a setting affiliated with an Article 28 facility.

Pursuant to N.Y. Pub. Health Law § 230-a(9), I shall be placed on probation for a period of thirty-six (36) months, subject to the terms set forth in attached Exhibit "B."

Pursuant to N.Y. Pub. Health Law §§ 230-a(7) and (9), I shall be subject to a fine in the amount of \$25,000.00, to be paid in full within eighteen (18) months of the effective date of this Order. Payments must be submitted to:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1717
Albany, New York 12237

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent remains a licensee in New York State; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning

Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed.

Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future by OPMC, this Consent Agreement and Order **shall** be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this

Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities, if any, redacted. As public documents, they may be posted on the Department's website.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 4/30/2010

DAVID M. WALBORN, M.D.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 4/30/2010

J. MARK GRUBER, ESQ.
Attorney for Respondent

DATE: 5-5-2010

LEE A. DAVIS
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 5/11/10

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

EXHIBIT "A"

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

**IN THE MATTER
OF
DAVID M. WALBORN, M.D.**

**STATEMENT
OF
CHARGES**

DAVID M. WALBORN, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 17, 1990, by the issuance of license number 183082 by the New York State Education Department. Respondent is currently registered to practice medicine with the New York State Education Department through March 31, 2012.

FACTUAL ALLEGATIONS

- A. Respondent provided medical care to Patient A (The patients are identified in the Appendix), a 68 year old man, at Kenmore Mercy Hospital in Kenmore, New York from June 29, 2005 until July 2, 2005 for an incisional hernia. Respondent's care and treatment of Patient A deviated from accepted standards of medical care in the following respects:
1. Respondent failed to return Patient A to surgery in a timely manner given Patient A's symptoms and condition, placing Patient A at risk of harm. And/or
 2. Respondent failed to maintain a medical record accurately reflecting the care and treatment he provided Patient A.
- B. Respondent provided medical care to Patient B, a 49 year old woman, at Kenmore Mercy Hospital in Kenmore, New York, from June 14, 2006 until June 27, 2006 for an incisional hernia. Respondent's care and treatment of Patient B deviated from accepted standards of medical care in the following

respects:

1. Respondent failed to return Patient B to surgery in a timely manner given Patient B's symptoms and condition, placing Patient B at risk of harm. And/or
 2. Respondent failed to maintain a medical record accurately reflecting the care and treatment he provided Patient B.
- C. Respondent provided medical care to Patient C, a 27 year old woman, at his office and Millard Fillmore Gates Suburban Hospital in Buffalo, New York from September 3, 2005 through March 7, 2006 for chronic cholecystitis by performing a cholecystectomy on September 23, 2005 and two subsequent revision surgeries. Respondent's care and treatment of Patient C deviated from accepted standards of medical care in the following respects:
1. Respondent failed to perform a cholangiogram during the initial surgery to identify the structures associated with the gall bladder to avoid damaging unintended structures during the surgery.
- D. Respondent provided medical care to Patient D, a 79 year old woman, at Millard Filmore Gates Circle Hospital in Buffalo, New York from July 25, 2005 until her transfer to Buffalo General Hospital on August 4, 2005 for cholelithiasis by performing a cholecystectomy and two subsequent surgeries to repair injuries to the right hepatic duct, right hepatic artery and a common bile duct leak. Respondent's care and treatment of Patient D deviated from accepted standards of medical care in the following respects:
1. Respondent failed to perform a cholangiogram during the initial surgery to identify the structures associated with the gall bladder to avoid damaging unintended structures during the surgery.
- E. Respondent provided medical care to Patient E, a 43 year old man at his office and Millard Fillmore Gates Suburban Hospital in Williamsville, New York from July 25, 1999 until his discharge on August 18, 1999 for acute

pancreatitis by performing a cholecystectomy and treatment for a common bile duct injury sustained during the cholecystectomy. Respondent's care and treatment of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent failed to accurately identify the the structure of the gall bladder and its ductal structure, or perform an intraoperative x-ray of the bile duct, resulting in damaging to the hepatic and common bile ducts. And/or
2. Respondent failed to maintain a medical record accurately reflecting the care and treatment he provided Patient E.

F. Respondent provided medical care to Patient F, a 50 year old man at his office and Kenmore Mercy Hospital in Kenmore, New York from April 25, 1997 until his discharge on April 6, 1997 for cholecystitis by performing a cholecystectomy and treatment for a common bile duct injury sustained during the cholecystectomy and reconstruction. Respondent's care and treatment of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent failed to perform a cholangiogram during the surgery to identify the ductal structures associated with the gall bladder to avoid damaging unintended structures during the surgery. And/or
2. Respondent employed an inappropriate repair technique of the bile duct. And/or
3. Respondent failed to maintain a medical record accurately reflecting the care and treatment he provided Patient F.

G. Respondent provided medical care to Patient G, a 69 year old woman at Kenmore Mercy Hospital in Kenmore, New York from March 21, 2007 until her discharge on March 30, 2007 for diverticulitis and cholecystitis by performing a sigmoid colon resection, cholecystectomy and a hernia repair with mesh discovered during surgery. Respondent's care and treatment of

Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent failed to return Patient G to surgery in a timely manner given Patient G's symptoms and condition, placing Patient G at risk of harm. And/or
2. Respondent inappropriately performed a hernia repair with mesh in a potentially contaminated operative field by performing the repair during the same procedure as the bowel resection, placing Patient G at risk of harm of infection. And/or
3. Respondent failed to maintain a medical record accurately reflecting the care and treatment he provided Patient G.

H. Respondent provided medical care to Patient H, a 42 year old man at Kenmore Mercy Hospital in Kenmore, New York from October 15, 2004 until his discharge on October 26, 2004 for acute cholecystitis by performing a cholecystectomy and subsequent repair of a bile duct injury on October 20, 2004. Respondent's care and treatment of Patient H deviated from accepted standards of medical care in the following respects:

1. Respondent failed to appropriately clip Patient H's cystic duct and artery during the initial surgery. And/or
2. Respondent failed to provide appropriate post-surgical coverage for Patient H between October 16 and 20, given his symptoms and condition. And/or
3. Respondent failed to maintain a medical record accurately reflecting the care and treatment he provided Patient H.

I. Respondent provided medical care to Patient I, a 53 year old man at Kenmore Mercy Hospital in Kenmore, New York on June 7, 2006 for outpatient hernia repair with mesh, and from June 10, 2006 until his discharge on June 22, 2006 for an exploratory laparotomy to resolve an obstructed bowel and an incidental appendectomy performed during the

laparotomy. Respondent's care and treatment of Patient I deviated from accepted standards of medical care in the following respects:

1. Respondent inappropriately performed an appendectomy during the laparotomy, potentially exposing the mesh material to enteric bacteria, placing Patient I at risk of harm of infection.
And/or
2. Respondent failed to maintain a medical record accurately reflecting the care and treatment he provided Patient I.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts set forth in paragraphs A and A.1, B and B.1, C and C.1, D and D.1, E and E.1 F and F.1, F and F.2, G and G.1, G and G.2, H and H.1, H and H.2, and/or I and I.1.

SECOND THROUGH SIXTH SPECIFICATIONS

GROSS NEGLIGENCE

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

2. The facts set forth in paragraphs A and A. 1.
3. The facts set forth in paragraphs B and B.1.
4. The facts set forth in paragraphs G and G.1.
5. The facts set forth in paragraphs G and G.2. And/or
6. The facts set forth in paragraphs I and I.1.

SEVENTH THROUGH THIRTEENTH SPECIFICATIONS
FAILURE TO MAINTAIN RECORDS

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

7. The facts set forth in paragraphs A and A2.
8. The facts set forth in paragraphs B and B.2.
9. The facts set forth in paragraphs E and E.2.
10. The facts set forth in paragraphs F and F.3.
11. The facts set forth in paragraphs G and G.3.
12. The facts set forth in paragraphs H and H. 3.
13. The facts set forth in paragraphs I and I.2.

DATE: *May 5*, 2010
Albany, New York

Peter Van Buren
Deputy Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

Terms of Probation

1. Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).
2. Respondent shall maintain active registration of Respondent's license (except during periods of actual suspension) with the New York State Education Department Division of Professional Licensing Services, and shall pay all registration fees.
3. Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299 with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required information.
4. Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.
5. Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].
6. The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

7. The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.
8. Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.
9. Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

PRACTICE MONITOR

10. Within thirty days of the Consent Order's effective date, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.
 - a. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.
 - b. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.
 - c. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.
 - d. Respondent shall maintain medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.
11. Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.

EXHIBIT "C"

Requirements for Closing a Medical Practice Following a Revocation, Surrender, Limitation or Suspension of a Medical License

1. Licensee shall immediately limit his practice of medicine in accordance with the terms and limitations of this Order.
2. Within 15 days of the Order's effective date, Licensee shall notify all patients of the limitation of Licensee's medical practice, and shall refer all previous patients from his private practice to another licensed practicing physician for continued care, as appropriate. Licensee shall notify, in writing, each health care plan with which the Licensee contracts or is employed, and each hospital where Licensee has privileges, that Licensee has ceased his private medical practice and will be limiting his practice to Article 28 Facilities. Within 45 days of the Order's effective date, Licensee shall provide OPMC with written documentation that all patients and hospitals have been so notified of the limitation of Licensee's medical practice.
3. Licensee shall make arrangements for the transfer and maintenance of all private practice patient medical records. Within 30 days of the Order's effective date, Licensee shall notify OPMC of these arrangements, including the name, address, and telephone number of an appropriate and acceptable contact person who shall have access to these records. Original records shall be retained for at least 6 years after the last date of service rendered to a patient or, in the case of a minor, for at least 6 years after the last date of service or 3 years after the patient reaches the age of majority, whichever time period is longer. Records shall be maintained in a safe and secure place that is reasonably accessible to former patients. The arrangements shall include provisions to ensure that the information in the record is kept confidential and is available only to authorized persons. When a patient or a patient's representative requests a copy of the patient's medical record, or requests that the original medical record be sent to another health care provider, a copy of the record shall be promptly provided or forwarded at a reasonable cost to the patient (not to exceed 75 cents per page.) Radiographic, sonographic and similar materials shall be provided at cost. A qualified person shall not be denied access to patient information solely because of an inability to pay.
4. Failure to comply with the above directives may result in a civil penalty or criminal penalties as may be authorized by governing law. Under N.Y. Educ. Law § 6512, it is a Class E Felony, punishable by imprisonment of up to 4 years, to practice the profession of medicine when a professional license has been suspended, revoked or annulled. Such punishment is in addition to the penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, which include fines of up to \$10,000 for each specification of charges of which the Licensee is found guilty, and may include revocation of a suspended license.