



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.  
Commissioner

Wendy E. Saunders  
Chief of Staff

March 26, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrance Sheehan, Esq.  
NYS Department of Health  
90 Church Street – 4<sup>th</sup> Floor  
New York, New York 10007

Domingo Carlos Nunez, M.D.  
Suite 2A  
132 E 76<sup>th</sup> Street  
New York, New York 10021

Barbara A. Ryan, Esq.  
Aaronson, Rappaport, Feinstein &  
Deutsch, LLP  
757 Third Avenue  
New York, New York 10017

**RE: In the Matter of Domingo Carlos Nunez, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 08-231) 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to deliver to the Board of Professional Medical Conduct your license to practice medicine **if said license has been revoked, annulled, suspended or surrendered**, together with the registration certificate.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,

Redacted Signature

(James F. Horan, Acting Director  
Bureau of Adjudication

JFH:cah

Enclosure

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

In the Matter of

Domingo Carlos Nunez, 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. 08-231

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

For the Department of Health (Petitioner): Terrence Sheehan, Esq.  
For the Respondent: Barbara A. Ryan, Esq.

Following a hearing below, a BPMC Committee found that the Respondent practiced medicine with gross negligence. The Committee voted to suspend the Respondent's license to practice medicine in New York (License) for two years, to stay the suspension and to place the Respondent's License on probation for two years. In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2009), the Respondent asks the ARB to nullify the Committee's Determination or to reduce the sanction to the lowest penalty provided by law. After reviewing the hearing record and the Committee's Determination, the ARB affirms the Committee's Determination in full.

Committee Determination on the Charges

The Committee conducted a hearing into charges that the Respondent, a surgeon, violated New York Education Law (EL) §§ 6530(3-4) & 6530(32)(McKinney 2009) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence, and,

- failing to maintain accurate patient records.

The charges related to the Respondent's care for one person (Patient A). The record refers to the Patient by an initial to protect patient privacy. Following the hearing, the Committee rendered the Determination now on review.

The Committee determined that the Respondent engaged in a single act of negligence, which rose to egregious proportions. The Committee also sustained the charge that the Respondent failed to maintain accurate patient records, but the Committee dismissed the charge that the Respondent practiced with negligence on more than one occasion.

The Committee found that the treating physician for Patient A misread a colonoscopy report on the Patient and diagnosed the Patient with colon cancer. Patient A underwent a CT scan on April 1, 2005. The CT scan report stated that there was increased soft tissue attenuation material in the region of the ileocecal valve and the proximal ascending colon, but the report gave no confirmation about the existence of a cecal carcinoma. On April 4, 2005, Patient A presented at Lenox Hill Hospital with nausea and vomiting. The Respondent's associate admitted Patient A for surgery and the associate made a medical record entry indicating a recent colon cancer diagnosis for Patient A. The Committee found that the Patient's condition suggested some degree of partial intestinal obstruction and a need for hospitalization, but found that no evidence pointed to the need for emergency surgery.

The record did show that Patient A suffered from diabetes, severe asthma and hypertension and the Committee found that a surgeon must perform surgery in an expeditiously controlled fashion with these medical conditions present. The Committee found that the standard of care required a rectal examination on Patient A. No rectal examination took place. The Respondent also failed to read the colonoscopy or pathology reports on Patient A. The Respondent requested consent from Patient A to perform a right hemicolectomy. The Committee found that the Respondent deviated from the standard of care by performing surgery without reading the colonoscopy report and by misdiagnosing the Patient with colon cancer without reading the colonoscopy report and the pathology report. The Respondent performed surgery on Patient A beginning at 8:00 a.m. on April 6, 2005. The surgery revealed that the mass contained

stool, but no tumor. The Respondent then read the colonoscopy report, performed a colonoscopy and obtained consent from the Patient's husband to do further surgery. The procedures lasted until 6:30 p.m. Following surgery, the Patient sustained a cardiopulmonary arrest and died.

The Committee concluded that the Patient underwent an unnecessary procedure initially, before the Respondent performed the correct procedure and that the length of the procedures contributed to the Patient's death. The Committee concluded further that the Respondent failed to maintain a medical record for the Patient that satisfied minimally accepted standards.

In making their findings, the Committee found testimony by the Petitioner's expert witness, Thomas H. Gouge, M.D., to be thoughtful, unbiased and credible. The Committee also found credible the testimony by the Respondent's expert, William Middlesworth, M.D. The Committee indicated, however, that they found no significant conflicts in the testimony by the two experts. The Committee found the Respondent's testimony evasive, but ultimately truthful. The Respondent admitted his fault in failing to perform a rectal examination and to review the Patient's colonoscopy report. The Respondent argued that his conduct fell short of gross negligence, on the grounds that he relied on misinformation and a mistaken diagnosis by other physicians. The Committee rejected that argument. The Committee noted that misinformation may have played a part in the tragic outcome, but the misinformation failed to mitigate the Respondent's negligence. The Committee found urgency, but no emergency in the case and the Committee found the Respondent ultimately responsible for obtaining a complete and accurate patient history preoperatively. The Committee found the Respondent's decision to proceed with surgery without a rectal examination and without reviewing the colonoscopy report amounted to a significant deviation from acceptable medical standards which created the risk of grave consequences to Patient A.

The Committee voted to suspend the Respondent's License for two years, to stay the suspension in full and to place the Respondent on probation for two years, under the terms that follow the Committee's Order. The Committee rejected the Petitioner's request that the probation terms include a practice monitor. The Committee found the Respondent a well respected and trained physician and the Committee found the facts in this case an aberration

from the Respondent's normal practice. The Committee did feel that the facts in the case indicated the need for a period of probation.

#### Review History and Issues

The Committee rendered their Determination on December 5, 2008. This proceeding commenced on December 18, 2008, when the ARB received the Respondent's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Respondent's brief and the Petitioner's reply brief. The record closed when the ARB received the reply brief on January 23, 2008.

The Respondent argues that his conduct amounted to only ordinary negligence on a single occasion and that the Committee's imposed a penalty with dire consequences that could result in the Respondent's dismissal from the Worker's Compensation Program, Medicaid and other insurance programs. The Respondent argued that other physicians contributed to the errors in this case and that it is arbitrary to single out one physician for discipline. The Respondent argued further that the Petitioner failed to prove that the Respondent's singular error amounted to gross negligence. The Respondent contended that the Committee erred in failing to consider properly the mitigating factors in the case.

The Petitioner argues that the ARB should reject attempts by the Respondent to dilute his responsibility due to the negligence by others. The Petitioner contends that misconduct by others should absolve no individual actor for misconduct and that the Respondent bears the ultimate and primary responsibility here. The Petitioner states that no basis exists to disturb the Committee's Determination.

### 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 (3<sup>rd</sup> 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 (3<sup>rd</sup> Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health. 222 A.D.2d 750, 634 N.Y.S.2d 856 (3<sup>rd</sup> 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 (3<sup>rd</sup> 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. The ARB affirms the Committee's Determination that the Respondent practiced with gross negligence and failed to maintain accurate records in providing care to Patient A. The ARB agrees with the Committee that the Respondent's conduct in this case amounted to an egregious failure to follow accepted care standards that resulted in grave consequences to Patient A. The ARB holds that the evidence before the Committee demonstrated that the Respondent practiced with gross negligence and that the Respondent failed to maintain an accurate patient record. The ARB rejects the Respondent's contention that the Committee failed to give proper consideration to mitigating factors in this case. The Committee clearly considered mitigating factors in staying the suspension in this case, in rejecting the request for a practice monitor and in limiting probation to two years. The ARB further rejects the Respondent's contention that errors by any others excused or decreased the responsibilities the Respondent bore in this case as the operating surgeon.

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 gross negligence and that the Respondent failed to maintain accurate patient records.
2. The ARB affirms the Committee's Determination to suspend the Respondent's License, to stay the suspension in full and to place the Respondent on probation for two years, under the terms that appear following the Committee's Order.

Thea Graves Pellman  
Datta G. Wagle, M.D.  
Linda Prescott Wilson  
Therese G. Lynch, M.D.  
Richard D. Milone, M.D.

In the Matter of Domingo Carlos Nunez, M.D.

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

Dated: March 13, 2009

Redacted Signature

Thea Graves Pellman

In the Matter of Domingo Carlos Nunez, M.D.

Linda Prescott Wilson, an ARB Member concurs in the Determination and Order in the Matter of Dr. Nunez.

Dated: 13 March, 2009

Redacted Signature

Linda Prescott Wilson

Linda Prescott Wilson

In the Matter of Domingo Carlos Nunez, M.D.

Richard D. Milone, an ARB Member concurs in the Determination and Order in the  
Matter of Dr. Nunez.

Dated: April 21, 2009

Redacted Signature

Richard D. Milone, M.D.

In the Matter of Domingo Carlos Nunez, M.D.

Richard D. Milone, an ARB Member concurs in the Determination

Richard D. Milone, M.D.

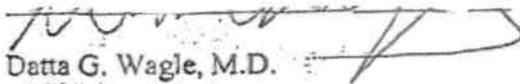
In the Matter of Domingo Carlos Nunez, M.D.

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

Matter of Dr. Nunez.

Dated: 3/13/ 2009

Redacted Signature

  
Datta G. Wagle, M.D.

In the Matter of Domingo Carlos Nunez, M.D.

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

  
Datta G. Wagle, M.D.

In the Matter of Domingo Carlos Nunez, M.D.

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

Dated: March 12, 2009

Redacted Signature

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Therese G. Lynch, M.D.

In the Matter of Domingo Carlos Nunez, M.D.

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

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Therese G. Lynch, M.D.