

Public



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

December 5, 2008

**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 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

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,

Redacted Signature

James F. Horan, Acting Director  
Bureau of Adjudication

JFH:cah

Enclosure

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

COPY

-----X  
IN THE MATTER : DETERMINATION  
: :  
OF : AND  
: :  
DOMINGO CARLOS NUNEZ, M.D. : ORDER  
-----X

BPMC #08-231

A Notice of Hearing and Statement of Charges, both dated April 4, 2008, were served upon DOMINGO CARLOS NUNEZ, M.D., Respondent. ROBERT BRIBER, Chairperson, STEVEN M. LAPIDUS, M.D., and FERNANDO JARA, M.D., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. WILLIAM J. LYNCH, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer.

The Department of Health ("the Department") appeared by THOMAS CONWAY, General Counsel, by TERRENCE SHEEHAN, ESQ., of Counsel. The Respondent appeared by AARONSON RAPPAPORT FEINSTEIN & DEUTSCH, LLP, BARBARA A. RYAN, ESQ., of Counsel. Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Service: April 8, 2008  
Answer Filed: June 5, 2008  
Pre-Hearing Conference: July 16, 2008  
Hearing Dates: July 28, 2008  
September 9, 2008  
September 10, 2008  
Witnesses for Petitioner: Thomas H. Gouge, M.D.  
Witnesses for Respondent: Domingo Carlos Nunez, M.D.  
William Middlesworth, M.D.  
Receipt of Submissions: October 8, 2008  
Deliberation Held: October 21, 2008

STATEMENT OF CASE

The State Board for Professional Misconduct 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 [hereinafter "P.H.L."]).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. Domingo Carlos Nunez, M.D. ("Respondent") is charged with five specifications of professional misconduct, as defined in §6530 of the Education Law of the State of New York ("Education Law"). The charges relate to

Respondent's medical care of one patient. The charges include allegations of gross negligence, negligence on more than one occasion, and failure to maintain records. A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order as Appendix I.

The Department withdrew factual allegation A - A.7, but sought to add a new factual allegation to the Statement of Charges by way of a motion to conform the pleadings to the proof on the last hearing day. The motion was denied.

#### FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, the Hearing Committee hereby makes the following findings of fact:

1. Domingo Carlos Nunez, M.D., the Respondent, was authorized to

practice medicine in New York State on July 10, 1981, by the issuance of license number 146968 (Ex. 4).

2. Patient A underwent a colonoscopy which indicated that she had rectal cancer (T. 25-26; Ex. 3, pp. 83-89).

3. Patient A's primary care physician misread the colonoscopy report and mistakenly believed that Patient A had colon cancer (Ex. B). He referred Patient A to Respondent's practice for surgery at Lenox Hill Hospital (Ex. 3, p. 20).

4. On April 1, 2005, a CT scan ordered by Patient A's primary care physician was performed at Lenox Hill Hospital. The report containing the results of the CT scan indicates that the admitting diagnosis was malignant neoplasm of the rectosigmoid, but that the reason was colon cancer (Ex 2, p. 76).

5. Patient A scheduled a surgical consultation with Respondent; however, she went to the emergency room on April 4, 2005 with nausea and vomiting (T. 26, Ex. 2, pp. 12-13).

6. On the evening of April 4, 2005, Respondent's associate admitted Patient A to Lenox Hill Hospital to have surgery performed. The associate made an entry in the medical record indicating that Patient A had recently been diagnosed with colon cancer (Ex. 2, pp. 4, 17).

7. Patient A's primary care physician also made an entry in the medical record indicating that Patient A had ileocolic colon cancer

(T. 34-35, 94; Ex. 2, p. 14). In his consultation report, Patient A's primary care physician wrote that the patient had an apple core lesion of the cecum and that a biopsy indicated adenocarcinoma (Ex. 2, p. 59).

8. The CT scan report stated that there was increased soft tissue attenuation material seen in the region of the ileocecal valve and the proximal ascending colon, but it did not confirm the existence of a cecal carcinoma (Ex. 2, p. 76).

9. Patient A needed to be hospitalized, but there was no evidence of a need to perform emergent or urgent surgery (T. 28, 31-32, 55-56). Her symptoms suggested some degree of partial intestinal obstruction, but there was no evidence of intestinal obstruction, intestinal perforation or ascites (T. 28, 29; Ex 2, p. 76-77).

10. Patient A was diabetic with severe asthma and hypertension. A surgeon must perform surgery in an expeditiously controlled fashion when these medical conditions are present (T. 41-42).

11. Respondent first met Patient A preoperatively on the morning of April 5, 2008 (T. 43, 203-204; Ex. 2, p. 27).

12. The standard of care under the circumstances for Patient A was to perform a rectal exam (T. 38, 55).

13. No rectal examination was performed on Patient A (T. 38, 347).

14. On April 5, 2008 at 5:30 p.m., Respondent obtained Patient

A's consent to perform a right hemicolectomy (T. 56-57; Ex. 2, p.8).

15. Respondent did not read the colonoscopy or pathology reports (T. 74, 347; Ex. 5).

16. Performing the surgery without reading the colonoscopy report was a deviation from the standard of care (T. 47, 49-54, 272).

17. Respondent's misdiagnosis of Patient A as having colon cancer when he had not read the colonoscopy and pathology report was a departure from the standard of care (T. 84).

18. On April 6, 2005, Respondent removed the right side of Patient A's intestine and rejoined the intestine together. No tumor was present; the mass had been just stool (T. 76, 233-235).

19. Respondent then requested the colonoscopy report and performed a colonoscopy himself (T. 76-77, 236).

20. After obtaining consent from the Patient's spouse, Respondent proceeded with resection of the rectal lesion (Ex. 2, pp. 40-45; T. 77, 237-239).

21. The operation went from approximately 8:00 a.m. until 6:30 p.m. After the operation was completed, Patient A sustained a cardiopulmonary arrest and died after a long attempt at resuscitation (T. 78, 239-242; Ex 2, pp. 40-45).

22. As a result of Respondent's departures from accepted medical practice standards, Patient A initially underwent an unnecessary procedure before the correct procedure was performed.

The length of the operation contributed to Patient A's death (T. 78-79, 86-87).

23. The medical record that Respondent maintained for Patient A did not meet minimally accepted standards (T. 84, 87; Ex. 2).

#### CONCLUSIONS OF LAW

Respondent is charged with three specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" includes suggested definitions for gross negligence and negligence.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3<sup>rd</sup>

Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding. Id.

Gross Negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad," it is clear that articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence if it is established that the physician's errors represent a significant or serious deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3<sup>rd</sup> Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3<sup>rd</sup> Dept. 1995). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above.

All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee first considered the credibility of the various witnesses, and thus the weight to be accorded their testimony.

The Department presented testimony by Thomas H. Gouge, M.D. Dr. Gouge is board certified in general surgery. He did his residency at NYU Medical Center from 1970 to 1975 and has been on the staff and faculty there since that time. Dr. Gouge testified in a thoughtful and unbiased manner. The Hearing Committee found that Dr. Gouge's testimony was credible and gave it great weight.

Respondent offered the testimony of William Middlesworth, M.D. Dr. Middlesworth is the Director of the Pediatric Trauma Program and the Chair of the Quality Assurance Committee for the Department of Surgery at Columbia University College of Physicians & Surgeons. The Hearing Committee found that Dr. Middlesworth's testimony was credible, though it did not conflict in any significant manner with the testimony of the Department's expert witness.

Respondent testified himself. His testimony seemed somewhat evasive at times, yet he ultimately appeared truthful. His demeanor was serious and thoughtful. He acknowledged his mistake in Patient A's care and appeared contrite. The Hearing Committee found his testimony credible. Respondent admitted his fault in failing to

perform a rectal examination and failing to review Patient A's colonoscopy report before the surgery. The main issue, therefore, was whether Respondent's conduct constituted misconduct as alleged in the specifications of the Statement of Charges.

Respondent contended that his conduct did not constitute negligence on more than one occasion because his treatment of Patient A was limited to approximately a thirteen-hour period. The Hearing Committee agrees. Patient A was admitted to the hospital by another attending surgeon. Respondent's care of the patient was limited in its duration and to the manner in which he reviewed and conducted Patient A's preoperative history and physical review prior to performing a surgery.

Respondent also contended that any failure on his part did not rise to the level of gross negligence. Respondent urges that misinformation provided by both Patient A's internist and the admitting surgeon created the foundation for the mistaken diagnosis of colon cancer, and that he reasonably relied on their diagnosis in an urgent setting due to a possible bowel obstruction.

The Hearing Committee finds, however, that Respondent's single act of negligence occurring during this one event amounts to gross negligence on a particular occasion. While the misinformation Respondent received may have been a factor in the tragic outcome, the misinformation does not mitigate Respondent's negligence. There was

some urgency to the situation, but there was no emergency. As the surgeon, Respondent was ultimately responsible for ensuring that a complete and accurate patient history was obtained preoperatively. Respondent's decision to proceed with surgery when he had failed to review the colonoscopy report and no rectal examination had been performed was a significant deviation from acceptable medical standards which created the risk of grave consequence to Patient A. In sum, the Hearing Committee feels that Respondent is a fully competent physician who made an egregious mistake which had a tragic outcome.

Turning to the final three specifications in the Statement of Charges, Respondent argued that the specifications pertaining to his medical record of Patient A should not be sustained because he took a complete and accurate history "based on the information reasonably available him from his colleagues." The Hearing Committee, however, sustains the third and fourth specifications. The colonoscopy report and the results of a rectal examination were information reasonably available to the Respondent. Accordingly, the Hearing Committee finds that Respondent failed to maintain a record which accurately reflects the evaluation of the patient. The Committee did not sustain the fifth specification which appeared redundant of the third specification.

Factual Allegations

In accordance with these Conclusions of Law and based upon the Findings of Fact set forth above, the Hearing Committee makes the following determinations regarding the factual allegations contained in the Statement of Charges:

Paragraph A - A.1	Sustained (3-0)
Paragraph A - A.2	Sustained (3-0)
Paragraph A - A.3	Sustained (3-0)
Paragraph A - A.4	Sustained (3-0)
Paragraph A - A.5	Sustained (3-0)
Paragraph A - A.6	Sustained (3-0)
Paragraph A - A.7	Withdrawn
Paragraph A - A.8	Sustained (3-0)
Paragraph A - A.9	Sustained (3-0)

Specifications

The First Specification charged Respondent with practicing with gross negligence on a particular occasion, in violation of New York Education Law §6530(4). As discussed in detail above, the Hearing Committee found Respondent's treatment of Patients A constituted gross negligence. By a unanimous vote, the First Specification is **Sustained**.

The Second Specification charged Respondent with practicing with negligence on more than one occasion within the meaning of New York Education Law §6530(3). As discussed in detail above, the Hearing Committee determined that the Respondent was negligent in his

care of Patient A on only one occasion during her April 2005 hospitalization. As a result, the Second Specification is **Dismissed**.

The Third through Fifth Specifications charged Respondent with failing to maintain a record for Patient A which accurately reflects the care and treatment of the patient within the meaning of New York Education Law §6530(32). As discussed above, the Hearing Committee determined that Respondent's record fails to accurately reflect the evaluation of Patient A. As a result, the Third and Fourth Specifications are **Sustained**. The Fifth Specifications is **Not Sustained**.

#### DETERMINATION AS TO PENALTY

Petitioner recommended that, at the least, Respondent's license be suspended and the suspension stayed with a practice monitor requirement. Respondent asked that the charges be dismissed in their entirety.

The Hearing Committee agrees that a stayed suspension is an appropriate penalty under the circumstances. The record establishes that Respondent is a well-respected and trained surgeon, and the Respondent expressed sincere remorse for the tragic occurrence. He credibly testified that he would typically review a colonoscopy report before doing a surgery of this nature, and that his departures in this instance were an aberration from his normal practice. The

Hearing Committee felt confident that Respondent is a good doctor who had learned that even a single instance of proceeding to surgery without the necessary preoperative information can have dire consequences, and that he is unlikely to repeat his misconduct. The Hearing Committee sees no reason to require a practice monitor; however, the Committee does feel a period of probation is indicated. The Hearing Committee, therefore, imposes a fully stayed two-year suspension of Respondent's license during which Respondent shall be placed on probation. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The First, Third and Fourth Specifications of professional misconduct, as set forth in the Statement of Charges are SUSTAINED;
2. The Second and Fifth Specifications of professional misconduct, as set forth in the Statement of Charges are DISMISSED;
3. Respondent's license to practice medicine as a physician in New York State is hereby SUSPENDED FOR A PERIOD OF TWO YEARS; HOWEVER, THE SUSPENSION IS STAYED IN WHOLE;

4. Respondent is placed on PROBATION FOR TWO YEARS. The terms of probation are annexed and attached hereto;

5. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Schenectady, New York  
12/2, 2008

Redacted Signature

~~ROBERT BRIBER (CHAIR)~~

FERNANDO JARA, M.D.  
STEVEN LAPIDUS, M.D.

TO: Terrence Sheehan, Esq.  
Associate Counsel  
New York State 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

## Terms of Probation

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in

writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

7. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or violation of these terms, the Director of OPMC or the Board may initiate a violation of probation proceeding or any such other proceeding against Respondent as may be authorized pursuant to law.

# APPENDIX I

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

IN THE MATTER OF

OF

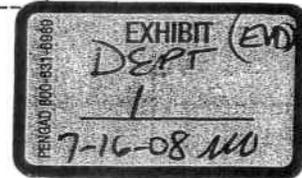
[REDACTED]

[REDACTED]

DOMINGO CARLOS NUNEZ, M.D.

NOTICE  
OF  
HEARING

TO: Domingo Carlos Nunez, M.D.  
c/o Barbara Ryan, Esq.  
Aaronson Rappaport Feinstein & Deutsch, LLP  
757 3<sup>rd</sup> Avenue  
New York, NY 10017-2013



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on **April 29, 2008**, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4<sup>th</sup> floor, New York, NY 10007, and at such other adjourned dates, times and places as the committee may direct. [REDACTED]

[REDACTED] WL 7/28/08

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please

note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. James F. Horan, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or

appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York  
April 4, 2008

Redacted Signature

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ROY NEMERSON  
Deputy Counsel  
Bureau of Professional  
Medical Conduct

Inquiries should be directed to: Terrence Sheehan, Associate Counsel  
Bureau of Professional Medical Conduct  
New York State Department of Health  
90 Church Street - 4<sup>th</sup> floor  
New York, NY 10007  
212-417-4450

IN THE MATTER  
OF  
DOMINGO CARLOS NUNEZ, M.D.

STATEMENT  
OF  
CHARGES

Domingo C. Nunez, M.D., the Respondent, was authorized to practice medicine in New York State in or about 1981, by the issuance of license number 146968 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. In or about April, 2005, Respondent treated Patient A (whose name is contained in the attached Appendix) at Lenox Hill Hospital, 100 East 77<sup>th</sup> Street, New York, NY 10021. Respondent's management and treatment of Patient A departed from accepted standards of medical practice in the following respects:
1. Respondent failed to take and record a complete and accurate Patient history in Patient A's chart at Lenox Hill Hospital, including an accurate description of the results of diagnostic testing, including a colonoscopy and its accompanying pathology report.
  2. Respondent misdiagnosed Patient A as having colon cancer.
  3. Respondent diagnosed Patient A's condition without having read the complete text of the diagnostic colonoscopy and associated pathology

report. The reports clearly describe, not colon cancer but rectal cancer.

4. Respondent inaccurately informed Patient A that she had colon cancer and inaccurately described to her the nature of the surgery she would have to undergo.
5. Respondent improperly obtained an informed consent from Patient A for a procedure which was not medically indicated.
6. Respondent failed to communicate directly with [REDACTED] DIEGO DIAZ, M.D., the referring physician, about the nature of the Patient's illness, her diagnostic work up and the reason for the referral.
- ~~7. Respondent, prior to performing surgery, failed to place in the Lenox Hill Hospital chart a copy of the out-patient colonoscopy and pathology reports.~~  
*Withdrawn 1/28/08 WL*
8. As a result of Respondent's departures from accepted medical practices, Patient A initially underwent an unnecessary procedure before the correct procedure was performed, resulting in a greatly extended period of surgery, finally resulting in her expiration intra-operatively.
9. Respondent failed to maintain a medical record for Patient A which accurately reflects the evaluations he provided, including accurate Patient history, diagnostic test results, diagnoses, recommended surgical procedures and treatment plans.

**SPECIFICATION OF CHARGES**

**FIRST TO FIFTH SPECIFICATION**

**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 following paragraphs:

1. A and A(1), A and A(2), A and A(3), A and A(4), A and A(6).

**SECOND 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 paragraphs:

2. A and A(1), A and A(2), A and A(3), A and A(4), A and A(6), A and A(7), (8).

**THIRD TO FIFTH SPECIFICATION**

**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 the following paragraphs:

3. A and A(1).
4. A and A(5).
5. A and A(9).

DATE: April 4, 2008  
New York, New York

Redacted Signature

\_\_\_\_\_  
ROY NEMERSON  
Deputy Counsel  
Bureau of Professional Medical Conduct