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

October 22, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dr. Hector Gil De Rubio
61-10 Grand Central Parkway
Forest Hills, New York 11375

Howard S. Richman, Esq.
Goldsmith, Richman, Levinson
& Hartz, LLP
747 Third Avenue – 37th Floor
New York, New York 10017

Denise Lepicier, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

RE: In the Matter of Hector Gil De Rubio, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-323) 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.

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 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

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

IN THE MATTER OF

OF

HECTOR GIL DE RUBIO, M.D.

DETERMINATION

AND

ORDER

BPMC #02-323

COPY

GERALD M. BRODY, M.D., Chairperson, **DANIEL W. MORRISSEY, O.P.**, and **DAVID SIBULKIN, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **ELLEN B. SIMON, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this Determination.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced with negligence on more than one occasion, with gross negligence, with incompetence on more than one occasion, and with gross incompetence; by having failed to maintain records; by practicing fraudulently; by engaging in conduct that evidences moral unfitness to practice medicine; and by violating Section 2805-k of the Public Health Law. The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to and made a part of this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Statement of Charges Dated: September 14, 2001

Prehearing Conference:	November 8, 2001
Hearing Dates:	November 16, 2001 December 21, 2001 January 4, 2002 January 8, 2002 January 18, 2002 January 28, 2002 April 4, 2002
Deliberation Date:	May 7, 2002
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner Appeared By:	Donald P. Berens, Jr., Esq. General Counsel NYS Department of Health By: Denise Lepicier, Esq. Associate Counsel
Respondent Appeared By:	Goldsmith Richman Levinson & Harz, LLP 747 Third Avenue New York, New York 10017 By: Howard S. Richman, Esq.

WITNESSES

For the Department:	Respondent Carolyn Graham Patient B's mother Patient A's mother Mohamed Sharieff Hedva Shamir, M.D. Astrid Carl Daniel G. Murphy, M.D.
For the Respondent:	Respondent Mark C. Henry, M.D.

Affirmation of Members of the Hearing Committee

Gerald M. Brody, M.D., a duly appointed member of the State Board for Professional Medical Conduct and of its Hearing Committee designated to hear the matter of Hector Gil de Rubio, M.D., hereby affirms that he was absent from a brief part of the hearing session conducted on January 18, 2002. Dr. Brody affirms that he has read and considered the transcripts of the proceedings of, and the evidence received at, such whole or partial hearing days before deliberations of the Hearing Committee beginning on May 7, 2002

Daniel W. Morrissey, O.P., a duly appointed member of the State Board for Professional Medical Conduct and of its Hearing Committee designated to hear the matter of Hector Gil de Rubio, M.D., hereby affirms that he was absent from a brief part of the hearing session conducted on January 8, 2002. Father Morrissey affirms that he has read and considered the transcripts of the proceedings of, and the evidence received at, such whole or partial hearing days before deliberations of the Hearing Committee beginning on May 7, 2002.

FINDINGS OF FACT

Numbers in parentheses refer to transcript pages or exhibits and denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

GENERAL FINDINGS

1. **HECTOR GIL DE RUBIO, M.D.,** the Respondent, was authorized to practice medicine in New York State on May 11, 1988, by the issuance of license number 174379 by the New York State Education Department (uncontested; Ex 2).

Patient A

2. On or about December 22, 1998, Respondent treated Patient A, a sixteen-month-old male, at St. John's, Queens, Hospital (T 17; Ex 3, pp. 6, 8).

3. An adequate history in the context of an emergency room (hereinafter "ER") would include a statement of the chief complaint; a description of the patient in the context of the complaint; a description of critical risk factors including medications and/or other illnesses that could affect the complaint; a description of the mechanism of injury, i.e., how the injury occurred; and a notation of relevant positive and negative findings (T 466-

469).

4. It is important to record the mechanism of injury because it often makes a difference as to the extent of the injury, the workup required, and the treatment required (T 728).

5. An adequate ER physical would include vital signs, general appearance of the patient, apparent mental status, a review of systems via a quick primary survey with additional follow-up if necessary, and then a detailed system-by-system survey (T 469-473). Findings relevant to the complaint, both positive and negative, should be recorded (T 474-475).

6. It is important to record an adequate history and physical not only to help the physician focus his or her review of the patient but to preserve information for subsequent health-care professionals (T 469-470, 473).

7. It is important to document the care and treatment provided to a patient in the ER, including a procedure note or medications given or prescribed (T 475-476). When medications are given, it is important to document the medications, their dosage, their strength, and the timing of their administration (T 476).

8. Respondent's history of Patient A described in minimally acceptable detail the patient's head trauma and the presence of vomiting. What it omitted, however, was whether the child was sleepy or difficult to arouse and any history as to fever or gastrointestinal symptoms that might have accompanied the vomiting (Ex 3).

9. As to the physical examination, Respondent should have noted the presence or absence of dehydration (Exs 3, 8; T 491, 493). Respondent recorded a number of inconsistencies in his physical that he failed to explain. He described the baby's head examination as normal cephalic atraumatic but later described a forehead echymosis (T 494-495). Respondent also failed to do or note an abdominal examination, which would have been important in a baby who may be vomiting because of a gastroenteritis with fever (T 495). Neither did Respondent's record describe in adequate detail the circumstances of what happened after he administered Ketamine (Ex 3; T 495).

10. Respondent ordered a fluid challenge for Patient A, but no hydration had been noted on physical examination (Exs 3, 9; T 498-499, 519). Hydrating a child with this much fluid when the child has potential head trauma can aggravate brain swelling and is contraindicated until the head trauma is evaluated (T 499-501).

11. Respondent admitted that he administered 10 milligrams IV push of Ketamine to this patient (Ex 3, p. 9; T 21).

12. Informed consent is required when a physician administers conscious sedation in the ER. A physician must explain both the procedure and its risks and benefits, including the consequences of not performing the procedure and the alternatives to performing it (T 503-504).

13. There is in the record no consent form or note for the administration of Ketamine, or conscious sedation, to Patient A (T 504).

14. Respondent did not believe that he needed to obtain informed consent for the administration of Ketamine and did not inform the baby's mother of its risks and benefits or the risks of not consenting to its administration before he administered it to Patient A (T 48-51, 81-83, 376-377).

15. Ketamine is contraindicated in head trauma cases because it can increase intracranial pressure when such pressure already exists (T 506-507, 516).

16. When a physician is going to give conscious sedation of any type to a baby, he or she must ensure that the patient is connected to a pulse oximeter, to record oxygen saturation in the blood, and an EKG monitor, to record heart rate and blood pressure (T 511-512). The patient should be given oxygen and a crash cart should be available in case of respiratory or cardiac arrest (T 512). There should be available a separate, competent health-care provider whose sole role is to monitor the baby's respiratory and cardiac status and intracerebral pressure (T 512-513, 516).

17. Respondent had Patient A's mother carry her baby to the CAT scan room after he had administered conscious sedation; that was a deviation from the standard of care, because when a baby is being carried, his respiratory and cardiac status cannot easily be observed, particularly when the appropriate equipment is not attached to him (T 517-518, 631).

18. There is no evidence in the medical record or in the testimony of any of the witnesses in this matter, including that of Respondent, that Patient A was connected to the appropriate equipment before he was given Ketamine or even before he was in the CAT scan room (T 67-68, 260, 369, 407-408, 513-514).

19. Respondent admitted that Patient A should have been on a pulse oximeter when he was given Ketamine but was not (T 66-67).

20. Respondent admitted that Patient A should have been placed on oxygen when he was given Ketamine but was not (T 67-68).

21. Respondent admitted that one concern he had about Patient A was that he might have had a head contusion and that such a contusion could cause swelling and increased intracranial pressure (T 79-80).

22. Respondent admitted that vomiting can be a sign of elevated intracranial pressure and that a history of nausea and vomiting could be caused by intracranial pressure (T 70).

23. Respondent admitted that intracranial pressure was one of the contraindications for Ketamine and that vomiting with a history of head trauma can be a sign of elevated intracranial pressure (T 39, 69-71, 79-80).

24. Respondent did not believe that it is necessary to place a patient on a cardiac monitor when conscious sedation is administered (T 31, 66).

25. Respondent stated that the nurse, Carolyn Graham, was supposed to be bringing the pulse oximeter when he gave Patient A the Ketamine (T 31-32, 36).

26. Respondent did not ask Nurse Graham to bring a pulse oximeter, a cardiac monitor, an oxygen mask or ambu bag, or a pediatric crash cart before he administered Ketamine to the baby (T 31-32, 66-68, 257). Yet, Respondent admitted that he had taken a course in conscious sedation in order to become credentialed to use it in his practice (T 64-65).

27. Patient A's mother told Respondent that her baby was stiffening or twitching in her arms (T 371-372) and that he was not breathing when she put him down on the CAT scan table (T 372-373). She left to find her husband and bring him back to where their baby was (T 373).

28. The CAT scan technician, Mr. Mohamed Sharieff, arrived after Patient A's mother had gone (T 406). He testified that while he was with Respondent in the CAT scan room, he asked Respondent a few times whether he wanted to call a code, and Respondent repeatedly answered "No" (T 411).

29. When Respondent did ask the CAT scan technician to call the nurse, he still did not tell him to announce a code (T 410). Nurse Graham walked to the CAT scan room and walked back to the ER area for equipment, not knowing that the baby had already been sedated or that he was having any difficulties (T 259-261, 268, 271-272). When she returned and connected the pulse oximeter and monitor to the baby, a code finally was called (T 261-262, 273-274). Ms. Graham reported that at this point the baby was unresponsive, was not breathing, and had no audible heart sounds and no blood pressure (T 262, 273).

30. A child's heart is very strong, and in the absence of a congenital heart problem, a cardiac arrest is normally a secondary event precipitated by a respiratory problem (T 525). When a child's heart has stopped, it is an indication that there has already been either an asphyxiation, hypoxia, or hyperprofusion--something that prevented oxygen from getting into the body--and that the heart's stopping is secondary to this lack of oxygen (T 525). When a child's heart has stopped, it is almost axiomatic that the brain and heart have both been severely affected (T 525-526).

31. The initial blood gases after CPR reveal that Patient A was extremely acidotic, which is incompatible with life. The PCO_2 level was greatly elevated, indicating that Patient A was not properly ventilated. These values demonstrate that Patient A had been in anaerobic metabolism for a significant period of time (T 526-528).

32. In an attempt to correct the acidosis, Patient A was given 3 doses of bicarbonate within a period of 40 minutes--a significant administration of bicarbonate. Despite that,

and although Patient A was now being appropriately ventilated, his blood gases continued to register a significant acidosis, indicating that he was in anaerobic metabolism for a significant period of time (T 529-531).

33. When, in the CAT scan room, Patient A's mother told Respondent that her baby was not breathing [*see* Finding of Fact ("FF") 27 above], Respondent should have opened the child's airway and oxygenated him immediately (T 533-534). Failure to provide oxygen within the first few minutes of its deprivation can very quickly result in brain death (T 535). Delaying treatment in these circumstances is a significant deviation from the standard of care (T 536).

34. Respondent's final diagnostic findings failed to make any mention of his administration of Ketamine to this child, although there was an order for it (Ex 3). Respondent's final diagnostic findings do not adequately reflect Patient A's care and treatment and appropriate diagnoses (T 540-547, 625-628).

Patient B

35. Respondent treated Patient B, a sixteen-month-old boy, on or about Friday, December 31, 1999, at Huntington Hospital (Ex 6, pp. 4, 7; T 302).

36. Patient B's mother testified that her son, Patient B, cut his finger on a Christmas ornament and that the cut was bleeding so profusely that she could not put a Band-Aid on it (T 307-308).

37. Patient B's mother took her son to the Emergency Room at Huntington Hospital (T 307-308).

38. The boy's finger was bleeding in the waiting room and bled onto the floor of the ER (T 311-312, 332-334).

39. Respondent failed to record the mechanism of injury in either the chief complaint or the history of the present illness (Ex 6, p. 4; T 726-728, 801-802).

40. Respondent failed to adequately describe the size and appearance of Patient B's injury to his finger (T 729-730). The depth of the injury is not even noted (Ex 6, p. 4).

41. Respondent failed to examine or record the injured finger's appearance, pulses, or capillary status, so as to establish its neurovascular status (T 730-731).

42. Respondent failed to record the appearance or the status of Patient B's hand, or any other part of the child's extremity (T 731-732).

43. Respondent failed to record any sort of a procedure note to document exactly what he did for Patient B (T 732-734).

44. Respondent put a tourniquet on Patient B's finger and cleaned the wound. He told the patient's mother that the cut was little and that he did not need to stitch it. Respondent, applying a pressure dressing, put a yellow strip on the wound, put white gauze around the finger, taped the finger, and then removed the tourniquet (T 97-99,102, 309-310). Respondent gave Patient B's mother more of the same three things that he had used to dress the finger, instructed her to do just what he had done to dress the wound, and told her that she did not need to see a doctor to change the dressing. Respondent told Patient B's mother not to remove the dressing for two days (T 309-310; Ex 6, p. 4).

45. The dressing that Respondent applied covered the whole finger, although the very tip of the finger could be seen through the gauze (T 312-313).

46. Respondent admitted that he applied a pressure dressing and that he told Patient B's mother to leave the dressing alone for two days (Ex 6, p. 4; T 96, 103, 111). He admitted that more pressure is applied with a pressure dressing than with an ordinary one (T 114).

47. Patient B's mother was given discharge instructions to follow up with her pediatrician in a week (Ex 6, p. 5). A one-week follow-up for a child with a hand wound is too long because hands are at high risk for infection (T 743).

48. Respondent did not think that there was any contraindication to using a pressure dressing for two days because he believed that one would promote healing (T 102-106).

49. A pressure dressing is a temporary intervention to a bleeding limb or extremity to prevent the patient from losing a great deal of blood before definitive treatment is provided. The dressing is applied tightly but is not constricting, and the patient is told to elevate the bleeding part to decrease blood loss. Patients are never discharged with a pressure dressing. A pressure dressing is not a treatment (T 734-735, 737).

50. It is not appropriate to apply a pressure dressing for two days, particularly to a digit, because of the risk of the development of ischemia and necrosis and the compromise of the vasculature of the digit. If a pressure dressing is applied for more than four to six hours, signs of ischemia, or lack of oxygenation, will appear (T 737-740, 742).

51. Respondent stated, on more than one occasion, that he told Patient B's mother that he would not open the wound and explore it, or do anything else, like poke a needle into the wound, because there was nothing to suture or repair (T 98, 105, 109, 111).

52. Respondent testified that he would normally use a pressure dressing for minor oozing of a small laceration (T 107-108). Respondent later testified that the bleeding had already stopped when he treated Patient B, but since he did not want the finger to start bleeding again, or for the child to reinjure it, he applied a pressure dressing (T 112-113).

53. Patient B arrived at the ER on December 31, 1999, at 11:19 PM and was discharged on the same day at 11:39 or 11:40 PM (Ex 6, pp. 4, 5; T 737-738).

54. Patient B's mother took Patient B to his pediatrician, Bruce Gerberg, M.D., on Monday morning, January 3, 2000 (Ex 7, p. 15; T 313-314). Dr. Gerberg noted that the "tape and gauze wrap [was] removed" and that there was a "constriction effect on [the] finger with necrosis" (Ex 7, p. 15). The pediatrician described the wound as a 1-inch-deep by 2-inch-long laceration, although he probably meant centimeters instead of inches. He also recorded in his diagnosis that there was a "laceration of digit #2 with constriction" (Ex 7, p. 15). The pediatrician referred Patient B to a plastic surgeon, Jonathan Lebowitz, M.D. (Ex 7, p. 15; T 313-314, 746-748).

55. Patient B's mother took Patient B to the plastic surgeon as soon as she left her pediatrician's office on January 3, 2000 (T 314-315, 748; Ex 8, p. 14).

56. The plastic surgeon noted in his findings that there was "Partial amputation of the right hand/index finger, showing stellate, jagged, devitalized, crushed wound edges with missing tissue consisting of skin, subcutaneous tissues down to exposed bone at the distal tuft. With this, the radial digital nerve appeared to be lacerated. . . . due to being seen at a local hospital emergency room the date this injury occurred, December 31, 1999, the dressing that was applied acted as a tourniquet resulting in a ring-type skin injury at the base of the right index finger with compromise of the blood supply to the finger itself" (Ex 8, p. 14). Patient B's finger was not bleeding at this time (T 335-336, 748-750).

57. In the indications for the plastic surgery that he performed to try to repair the wound and the nerve dissection of Patient B's finger, Dr. Lebowitz noted "an injury to the surrounding skin and base of the right index finger . . . noted due to a previously applied dressing" (Ex 8, p. 15; T 750-751).

58. Dr. Lebowitz closed the initial injury and tried to repair the nerve damage. He also debrided the dead tissue (T 751-752; Ex 8).

59. Patient B's mother took Patient B back to the plastic surgeon on Tuesday, January 4, 2000, on Thursday, January 6, 2000, and on Friday, January 7, 2000 (T 315-316). Dr. Lebowitz informed Patient B's mother on January 7th that the tip of her son's finger was dead (T 316-317). The plastic surgeon noted an eschar, which is black dead tissue, at both the tip and the base of the finger (Ex 8, pp. 25, 26-27; T 752-754).

60. Patient B's mother sought a second opinion from a hand surgeon, Jerry Ellstein, M.D. (T 317; Ex 6, pp. 10, 14). Dr. Ellstein told Patient B's mother that much of the damage to the finger could not be reversed, but he suggested hyperbaric treatment to try to salvage whatever portion of the digit might be viable (T 317-318, 755-757; Ex 6, p. 11).

61. Following hyperbaric treatment at Nassau County Medical Center, Patient B had most of his finger amputated by the hand surgeon on January 22, 2000 (T 318-320, 759-760; Ex 6, pp. 63-64). The hand surgeon performed a second surgery to close the amputation on January 28, 2000 (T 320, 760-761; Ex 6, pp. 74-75).

Patient C

62. Respondent treated Patient C, a 51-year-old male, on or about September 24, 1998, at Maimonides Hospital Center (Ex 9, pp. 147-150; T 137-138).

63. Upon Patient C's arrival by ambulance on September 24th, he appeared to have an altered mental status, jaundice, ecchymosis of the right orbital region, a dislocated shoulder, and an ecchymotic right humerus, and he appeared to have ingested methadone (Ex 9, p. 147; T 140-141, 814-81).

64. Respondent evaluated and treated the patient (Ex 9); he performed a physical examination that noted the major physical findings with the exception of rib fractures (Ex 9, pp. 149-150), which were noted upon a subsequent examination by the hospitalist (Ex 9, p. 175).

65. Following Respondent's physical examination, the patient's condition deteriorated. Respondent was notified of that change but did not document it (T 151-152).

66. At 10:50 PM, Respondent determined to admit the patient to the brown team, which was a non-ICU, non-monitored-bed unit (Ex 9, p. 150; T 1247-1250).

67. Respondent testified that he signed Patient C over to ER physician White and PA Kolvo at 11 PM but didn't document it (T 156-158, 165-174).

68. Respondent initially asserted that he did not make a decision about which type of floor the patient was to go to and stated that he did not assign the patient to a regular medical ward (T 1059).

69. Respondent later testified that it was the brown team's obligation to assign the type of bed that the patient needed (T 1059-1061).

70. Patient C required at least a monitored bed (T 1061-1062, 1214-1215, 915-917).

71. It was Respondent's responsibility as the ER physician to determine the level of care to which the patient should be admitted (T 915-917, 1214-1215, 1280-1281).

Charge D

72. On or about February 12, 1999, Respondent's employment at the Catholic Medical Centers ("CMC") was terminated (Ex 13, pp. 108, 140).

73. Respondent argued at the hearing that he was never terminated from Catholic Medical Centers, but when asked where he worked, he testified that he worked at St. John's Hospital (T 14-15). Moreover, on the curriculum vitae ("c.v.") that he supplied to a number of hospitals after his termination from St. John's, and on his application forms,

Respondent lists his employer as St. John's Hospital, not CMC Physician Services, Inc. (Ex 14, pp. 13, 17; Ex 15, pp. 8, 13; Ex 16, p. 21).

74. On or about February 12, 1999, Respondent received a letter from Richard B. Birrer, M.D., Chairman of the Department of Emergency Medicine, informing Respondent that his employment with the Catholic Medical Centers was terminated effective January 31, 1999 (Ex 13, p. 140).

75. On or about August 25, 1999, there was delivered to Respondent a letter informing him that the Board of Trustees had terminated his employment on the Medical Staff at Catholic Medical Centers (Exs 13A, 13B).

76. On or about September 14, 1999, Respondent applied for medical staff privileges at Huntington Hospital. When asked on the application whether he had ever had his "membership [on] any hospital/medical staff" or "clinical privileges" revoked or involuntarily relinquished, Respondent replied that he had not (Ex 14, p. 14).

77. Respondent apparently told Pat Brink of Huntington Hospital, on or about November 22, 1999, that he had resigned from Catholic Medical Centers (Ex 14, p. 67).

78. While there is a letter from Respondent in the Catholic Medical Centers file dated October 16, 1998, "resigning [his] position as a full-time physician effective November 16, 1998," there is also a letter from Respondent, apparently written on November 30, 1998, rescinding the letter of resignation dated October 16; that resignation and reinstatement occurred before Respondent was terminated (Ex 13, pp. 110, 112-113).

79. On or about September 22, 1999, Respondent applied for medical staff privileges at Wyckoff Heights Medical Center, and when asked on the application whether he had ever had his "medical staff membership or employment status at any other hospital" or his "clinical privileges at any other hospital" revoked or "involuntarily relinquished," Respondent replied that he had not (Ex 15, pp. 10-12).

80. On or about April 3, 2000, Respondent applied for appointment/reappointment to the hospital medical staff of South Nassau Community Hospital, and when asked on the application whether he had ever had his "membership on any hospital medical staff or medical facility" or his "clinical privileges" revoked or relinquished, Respondent replied that he had not (Ex 16, p. 15).

81. Finally, on or about August 26, 2000, Respondent signed his New York State license reregistration application and admitted on the form that a "hospital or licensed facility [had] terminated [his] professional training, employment, or privileges, or [he had] voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence" (Ex 2, p. 22).

Charge E

85. On or about February 4, 2000, Respondent's employment with Huntington Hospital was terminated (Ex 14, pp. 2, 7-8).

86. Respondent admitted that he worked directly for Huntington Hospital and not for a professional corporation (T 121; Ex 17).

87. On or about April 3, 2000, Respondent applied for appointment/reappointment to the hospital medical staff of South Nassau Community Hospital, and when asked on the application whether he had ever had his "membership on any hospital medical staff or medical facility" or his "clinical privileges" revoked or relinquished, Respondent replied that he had not (Ex 16, p. 15).

88. Respondent failed to mention his affiliation with Huntington Hospital in his South Nassau Community Hospital application when asked for affiliations within the past ten years (Ex 16, p. 15).

89. At the hearing, Respondent contended that because he was in litigation with Huntington Hospital about his termination, he did not need to admit to the termination, and he asserted that he had never been notified that he had lost his privileges at that hospital (T 199-202).

90. On or about August 26, 2000, Respondent signed his New York license reregistration application and admitted on the form that a "hospital or licensed facility [had] terminated [his] professional training, employment, or privileges, or [he had] voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence (Ex 2, p. 22).

CONCLUSIONS

General Conclusions

The Hearing Committee is charged with reaching a present conclusion as to what happened in the past. Accordingly, the Committee must judge the credibility of the testimony it hears in order to determine the facts and reach the appropriate and necessary conclusions.

In the course of his testimony, Respondent often answered not a question that he was asked but, rather, the one he would like to have been asked, even interrupting his examiner to do so. For example, when asked about the circumstances of the termination of his employment by Wyckoff Heights Medical Center and Catholic Medical Centers, Respondent replied instead as to his clinical privileges (T 213-220; 224-225).

In addition, the record in this matter is full of inconsistencies between Respondent's testimony and related documentary evidence. For example, at the Hearing Committee's request, Respondent supplied a current curriculum vitae (Ex B) that represented that Respondent had been employed at Huntington Hospital through a professional corporation and not directly by the hospital. Yet, in response to one Committee member's question, Respondent admitted (T 121) that he had worked directly for the hospital and not for a P.C. That testimony is bolstered by the affidavit (Ex 17) of J. Ron Gaudreault, the hospital's Chief Executive Officer, that there was no P.C. at Huntington.

There are inconsistencies among Respondent's various applications in evidence as well. For example, although Respondent's employment by St. John's Hospital of the Catholic Medical Centers was terminated on February 12, 1999 (*see* FF 72) , he subsequently denied in applications to Huntington Hospital, Wyckoff Heights Medical Center, and South Nassau Community Hospital that his medical or hospital staff privileges or employment had been revoked. Yet, on his August 26, 2000 New York reregistration application, Respondent admitted that a hospital had terminated his privileges or employment (*see* FFs 72-76, 79-81).

Although in this matter no allegation was made that Respondent misrepresented on any application whether any medical malpractice suits were pending against him, during the hearing it came to the Committee's attention that on or about September 14, 1999, Respondent was served with a summons and complaint in such a proceeding brought against him by Patient A's parents. Yet, in applying for reappointment at South Nassau Community Hospital on April 3, 2000, when that lawsuit had not been resolved, Respondent represented that no such suit was then pending (Exs 16, 18).

The Hearing Committee concludes, therefore, that at least to the extent that Respondent's testimony is inconsistent with other, credible evidence, Respondent cannot be deemed to have testified truthfully during this hearing.

Conclusions as to Patient A

The Hearing Committee concludes that in his treatment of Patient A, Respondent caused the death of a healthy baby. The medical record and testimony show that until Respondent administered Ketamine by IV push, without using a pulse oximeter, administering oxygen, or taking other appropriate precautions, Patient A was a lively little boy.

The Committee observes, in particular, that in the beginning of his testimony, Respondent seemed not to understand that his care of Patient A was inadequate (e.g., T 30, lines 20-25; T 31-41). It was only after continued examination by the prosecutor for the Department and by the Committee that Respondent seemed to realize his shortcomings in treating the baby (e.g., T 62-64, line 12; T 66-68, line 3). Although at first Respondent blamed Patient A's death on the nurse, on the lack of pediatric

equipment in the ER—on everything except his own error—he ultimately acknowledged his responsibility. Yet Respondent never once expressed or otherwise indicated any remorse.

The Committee is struck by Respondent's arrogance and concludes that Respondent apparently believes that he does not have to follow the rules, that they do not apply to him. The Committee concludes as well that no amount of retraining is likely to change that attitude.

Conclusions as to Patient B

As to Patient B, the Hearing Committee notes that Respondent described the wound to the boy's finger as "a nick not even covering the epidermis" (T 98) and as "superficial" (T 105), yet after cleaning the wound and applying bacitracin, he applied a pressure dressing that he told the boy's mother not to remove for two days (T 98-99). Subsequent treating physicians' descriptions of the finger as nearly amputated differ so much from Respondent's notes that the Committee concludes that Respondent could not possibly have appreciated the wound's severity and that he ignored the inappropriateness of his applying the pressure dressing.

The Committee also observes that Respondent presented no expert opinion as to his treatment of Patient B, which suggests that he could find no one to testify that his care was acceptable.

Conclusions as to Patient C

The Hearing Committee concludes that Respondent performed an adequate physical examination of Patient C but failed to follow up appropriately in the patient's care.

On his examination of Patient C on the night of his admission to the hospital, Respondent did not note that, in addition to his other problems, the patient had broken ribs (Ex 9), but, having last seen the patient only two days earlier, Respondent was aware of his general condition. Respondent had, in fact, tried unsuccesfully to have Patient C admitted to the hospital at that earlier visit to the ER (Ex 9, pp. 535-550). Yet, when Patient C later returned to the ER with significant, adverse changes in his mental status and vital signs, Respondent admitted him only to the brown team, or a general medical floor, and not to a monitored-bed unit.

Respondent tried to justify that admission by testifying that since at the end of his shift the results of some of the tests on Patient C were still outstanding, it was the brown team's obligation, once they had those results, to determine the patient's appropriate level of care. He later contradicted himself by testifying (T 1060-1062) that he had recommended to the brown team that Patient C have at least a critical care bed. The chief of the Emergency Department at the hospital testified that it was the treating ER physician's responsibility to determine the level of care to which a patient should be

admitted (T 1280-1281).

The Committee concludes that Respondent made no such recommendation and that, in view of the severity of Patient C's illness, Respondent should himself have ensured that Patient C was assigned to at least a monitored bed before he left the hospital for the night.

Conclusions as to Charge D

The Hearing Committee concludes that Respondent's employment at St. John's Hospital of the Catholic Medical Centers was terminated by a letter dated February 12, 1999, and that Respondent misrepresented that termination in applying for medical staff privileges at Huntington Hospital and Wyckoff Heights Medical Center and in applying for reappointment to the medical staff of South Nassau Community Hospital.

To justify his representation in those applications, Respondent contended that he had been employed by a professional corporation and not by Catholic Medical Centers directly. Yet he listed St. John's Hospital as his employer on the c.v. that he supplied at the Committee's request and on his applications for privileges or reappointment. To further justify his contention, Respondent testified that he never received any notice from Catholic Medical Centers that his hospital privileges had been terminated.

The Hearing Committee finds Respondent's arguments disingenuous. During the hearing, there was some question whether Respondent actually received the CMC notice of termination. Astrid Carl, the Credentials Coordinator at Catholic Medical Centers at the time relevant to this matter, testified (T 668-718, 1111-1130) that she herself prepared a green return receipt card and mailed it to Respondent's home with the February 1999 letter from Dr. Richard Birrer informing Respondent of his termination by CMC (*see* FF 74). Because the signed original such receipt was not in evidence when Ms. Carl first testified, the Committee asked that, if possible, she produce it. She later appeared once more, with what she testified was the original, but it did not initially resolve the question of notice because the date of receipt indicated on the card was August 25, 1999, some six months after the date of the letter to which it purported to correspond. In addition, Respondent testified that the signature on the green card was not his.

In the course of her testimony about the matter, the Hearing Committee found Ms. Carl to be a consistent and credible witness. On both occasions, she struggled to listen carefully to questions and to answer them precisely and directly. She readily acknowledged that there were procedural problems in the CMC office at the time in question, and she explained them as directly and thoroughly as she could.

In view of its doubts about Respondent's credibility and its confidence in the integrity of Ms. Carl's testimony, the Hearing Committee concludes that Respondent deliberately misrepresented his termination by CMC in his applications to Huntington Hospital,

Wyckoff Heights Medical Center, and South Nassau Community Hospital.

Conclusions as to Charge E

As with Catholic Medical Centers, Respondent initially contended that he had been employed by a professional corporation and not by Huntington Hospital directly, so that he could deny in his reappointment application to South Nassau Community Hospital that his privileges on any hospital medical staff had been revoked even after his employment at Huntington Hospital had been terminated. Respondent further suggested that because he was in litigation with Huntington over the termination, he could deny the termination on that application. He also contended that he had never been notified that he'd lost his privileges at Huntington.

Yet, Respondent ultimately admitted, and an affidavit by the hospital's CEO confirmed, that there was no professional corporation at Huntington Hospital.

The Hearing Committee concludes that when in April 2000 Respondent applied for reappointment to South Nassau Community's medical staff, he knew that his employment at Huntington Hospital had been terminated just two months before, and he deliberately misrepresented that fact on his application.

The Committee also notes that when, in August 2000, Respondent applied to reregister for his New York license, he admitted that a hospital had terminated his employment or privileges (*see* FF 81). It therefore appears to the Committee that as to the hospitals and medical centers that he applied to, Respondent considered his termination insignificant, a nuisance, and that it was only as to his state reregistration that he thought a misrepresentation could compromise him.

In view of his repeated and deliberate misrepresentations of his credentials, the Hearing Committee concludes that Respondent has engaged in conduct that evidences his moral unfitness to practice the profession of medicine.

VOTE OF THE HEARING COMMITTEE

In consideration of the foregoing, the Hearing Committee concludes as to the specifications and votes unanimously as follows:

FIRST SPECIFICATION
Negligence on more than one occasion
SUSTAINED except as to C.1

SECOND AND THIRD SPECIFICATIONS
Gross negligence

SUSTAINED

FOURTH SPECIFICATION
Incompetence on more than one occasion
SUSTAINED except as to C.1

FIFTH SPECIFICATION
Gross incompetence
SUSTAINED except as to C.1

SIXTH THROUGH EIGHTH SPECIFICATIONS
Failure to maintain records
SUSTAINED except as to C.1

NINTH AND TENTH SPECIFICATIONS
Fraudulent practice
SUSTAINED

ELEVENTH AND TWELFTH SPECIFICATIONS
Moral unfitness
SUSTAINED

THIRTEENTH SPECIFICATION
Violation of PHL Section 2805-K
SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE

The Hearing Committee has considered not only the entire record in this matter but as well its overall impression of the Respondent through his testimony and demeanor during seven days of hearing. In view of all the foregoing and after seriously considering all possible sanctions, the Committee determines that Respondent's license to practice medicine shall be revoked.

This penalty represents the Determination of the Hearing Committee, as does its unanimous vote on the charges and specifications.

ORDER

Based upon the foregoing, it is hereby ordered that:

Respondent's license to practice medicine in the state of New York is hereby **REVOKED.**

Dated: Tuckahoe, New York
October 18, 2002

GERALD M. BRODY, M.D.
Chairperson
DANIEL W. MORRISSEY, O.P.
DAVID SIBULKIN, M.D.

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

IN THE MATTER OF HECTOR GIL DE RUBIO, M.D.	NOTICE OF HEARING

TO: HECTOR GIL DE RUBIO, M.D.
61-20 Grand Central Parkway
Forest Hills, N.Y. 11375

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 November 7, 2001, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, New York, New York, 10001, and at such other adjourned dates, times and places as the committee may direct.

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 appea 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. TYRONE BUTLER, 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 (McKinney Supp. 2001) 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
September 14, 2001

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Denise Lepicier
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza
New York, New York 10001
Tel.: (212) 268-6806

SECURITY NOTICE TO THE LICENSEE

The proceeding will be held in a secure building with restricted access. Only individuals whose names are on a list of authorized visitors for the day will be admitted to the building

No individual's name will be placed on the list of authorized visitors unless written notice of that individual's name is provided by the licensee or the licensee's attorney to one of the Department offices listed below.

The written notice may be sent via facsimile transmission, or any form of mail, but must be received by the Department **no less than two days prior to the date** of the proceeding. The notice must be on the letterhead of the licensee or the licensee's attorney, must be signed by the licensee or the licensee's attorney, and must include the following information:

Licensee's Name_____Date of Proceeding_____

Name of person to be admitted_____

Status of person to be admitted_____
(Licensee, Attorney, Member of Law Firm, Witness, etc.)

_____
Signature (of licensee or licensee's attorney)

This written notice must be sent to either:

New York State Health Department
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor South
Troy, NY 12180
Fax: 518-402-0751

Denise Lepicier
Associate Counsel
Bureau of Professional Medical Conduct
5 Penn Plaza
New York, New York 10001
Fax: 212-268-6735

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

IN THE MATTER

OF

HECTOR GIL DE RUBIO, M.D.

STATEMENT

OF

CHARGES

HECTOR GIL DE RUBIO, M.D., the Respondent, was authorized to practice medicine in New York State on or about May 11, 1988, by the issuance of license number 174379 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about December 22, 1998, Respondent treated Patient A, a sixteen month old male, at St. John's, Queens, Hospital.

1. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, and/or treatment;
2. Respondent failed to obtain appropriate consent for the administration of Ketamine;
3. Respondent failed to appropriately care for, evaluate, diagnose, treat, and/or manage Patient A's complaints and/or conditions.

B. On or about December 31, 1999, Respondent treated Patient B, a sixteen month old male, at Huntington Hospital.

1. Respondent failed to take or record an adequate history;
2. Respondent failed to perform or record an adequate physical examination;
3. Respondent failed to record notes which adequately and/or accurately reflect the patient's complaints, care, treatment and/or

follow up care;

4. Respondent failed to appropriately care for, evaluate, diagnose, treat, and/or manage Patient B's complaints and/or conditions;

5. Respondent failed to provide appropriate advice concerning follow up care.

C. On or about September 24, 1998, Respondent treated Patient C, a fifty-one year old male, at Maimonides Medical Center.

1. Respondent failed to perform or record an adequate physical examination;

2. Respondent failed to record notes which adequately and/or accurately reflected the patient's complaints, care and/or treatment;

3. Respondent failed to appropriately care for, evaluate, diagnose, treat, and/or manage Patient C's complaints and/or conditions.

D. On or about February 12, 1999, Respondent's employment at St. John's Queens Hospital of the Catholic Medical Center was terminated.

1. On or about September 14, 1999, Respondent applied for medical staff privileges at Huntington Hospital and when asked on the application whether he had ever had his membership on any hospital/medical staff revoked or involuntarily relinquished, Respondent knowingly and intentionally, with the intent to deceive, replied that he had not;

2. On or about September 22, 1999, Respondent applied for medical staff privileges at Wyckoff Heights Medical Center, and when asked on the application whether he had ever had his medical staff membership or employment status on any hospital medical staff revoked or relinquished, Respondent knowingly and intentionally, with the intent to deceive replied that he had not;

3. On or about April 3, 2000, Respondent applied for reappointment to the hospital medical staff of South Nassau Community Hospital and when asked on the application whether he had ever had his membership, privileges, prerogatives, rights, status, or affiliation on any hospital medical staff revoked or relinquished, Respondent knowingly and intentionally, with the intent to deceive replied that he had not.

E. On or about February 4, 2000, Respondent's employment at Huntington Hospital was terminated.

1. On or about April 3, 2000, Respondent applied for reappointment to the hospital medical staff of South Nassau Community Hospital and when asked on the application whether he had ever had his membership, privileges, prerogatives, rights, status, or affiliation on any hospital medical staff revoked or relinquished, Respondent knowingly and intentionally, with the intent to deceive, replied that he had not.

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. Paragraphs A and A1, A2, and/or A3; and/or B and B1, B2, B3, B4, and/or B5; and/or C and C1, C2, and/or C3.

SECOND THROUGH THIRD 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. Paragraphs A and A1 through A3;
3. Paragraphs B and B1 through B5.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

4. Paragraphs A and A1, A2, and/or A3; and/or B and B1, B2, B3, B4, and/or B5; and/or C and C1, C2, and/or C3.

FIFTH SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

5. Paragraphs A and A1, A2, and/or A3; and/or B and B1, B2, B3, B4, and/or B5; and/or C and C1, C2, and/or C3.

SIXTH THROUGH EIGHTH 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:

6. Paragraphs A and A1, and/or A2;

7. Paragraphs B and B1, B2, and/or B3;

8. Paragraphs C and C1 and/or C2.

NINTH THROUGH TENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

9. Paragraphs D and D1, D2, and/or D3;

10. Paragraphs E and E1.

ELEVENTH THROUGH TWELFTH SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

11. Paragraphs D and D1, D2, and/or D3;

12. Paragraphs E and E1.

THIRTEENTH SPECIFICATION

VIOLATION OF PHL SECTION 2805-K

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(14) by violating Public Health Law Section 2805-k, as alleged in the facts of:

13. Paragraphs D and D1, D2, and/or D3;

14. Paragraphs E and E1.

DATED: September 14, 2001
New York, New York

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct