STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 21, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Dianne Abeloff, Esq.
NYS Department of Health
5 Penn Plaza – Sixth Floor
New York, New York 10001

Bill Vaslas, Esq.
Amabile & Erman, P.C.
1000 South Avenue
Staten Island, New York 10314-3407

Petar Muncan, M.D.
160-40 81st Street
Howard Beach, New York 11414

RE: In the Matter of Petar Muncan, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-233) 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), 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.

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.

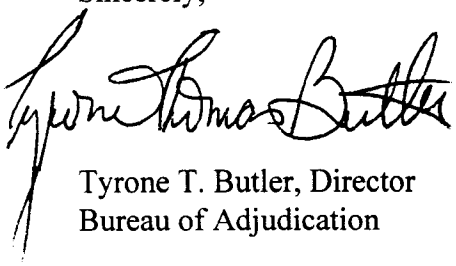
The notice of review served on the Administrative Review Board should be forwarded to:

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:nm

Enclosure

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

IN THE MATTER OF PETAR MUNCAN, M.D.	DETERMINATION AND ORDER

BPMC-00-233

A Commissioner's Order and Notice of Hearing, dated April, 2000 and a Statement of Charges, dated April 7, 2000, were served upon the Respondent, **PETAR MUNCAN, M.D.** **DATTA WAGLE, M.D.**, Chairperson, **RAMAN KAUL, M.D.** and **MR. KENNETH KOWALD**, 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. **JEFFREY ARMON, ESQ.**, served as Administrative Law Judge for the Hearing Committee.

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

PROCEDURAL HISTORY

Service of Commissioner's Order, Notice & Charges:	April 12, 2000
Department of Health Appeared by:	**HENRY M. GREENBERG**, Esq. General Counsel, NYS Dept. of Health
BY:	**DIANNE ABELOFF**, Esq. Associate Counsel
Respondent appeared by:	**BILL VASLAS & KAREN HAUSS**, Esqs. Amabile & Erman, P.C. 1000 South Avenue Staten Island, New York 10314-3407

Hearing Dates:	May 5, 19, June 5, 6, 12, 2000
Witnesses for Department of Health:	John J. Ippolito, M.D. Gabriel S. Levi, M.D. Jack Apelbaum, M.D.
Witnesses for Respondent:	Barry Rubin, M.D. Petar Muncan, M.D. (Respondent)
Record closed:	July 13, 2000
Deliberations held:	July 18, 2000

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they 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. All Hearing Committee findings were unanimous unless otherwise specified. A copy of the Statement of Charges (Ex. 1) is attached to this Determination and Order as Appendix II.

NOTE: Petitioner's Exhibits are designated by Numbers.
Respondent's Exhibits are designated by Letters.
T.= Transcript

1. The Respondent was authorized to practice medicine in New York State on August 11, 1993 by the issuance of license number 193243 by the New York State Education Department. (Ex. 2)

2. Patient A, an 80 year old male, presented at Respondent's office on May 19, 1999 after having been referred by the patient's primary physician with a diagnosis of possible renal cell carcinoma. (Ex. 3, pp. 5, 7; T. 609-10)

3. The patient brought with him a blood work report that indicated mild to severe anemia and a CT scan report, dated May 14, 1999, that noted an impression of a " 5 x 7 cm. lobulated heterogeneous density... arising from the lower pole of the left kidney. This area does not show enhancement following contrast administration and is slightly hypodense as compared to the surrounding renal parenchyma. This finding is suspicious for a primary renal cell carcinoma.". The CT examination was performed by Flatlands Medical Imaging and the report was prepared by a radiologist, James D. Badia, M.D., following his review of the scans.(Ex. 3, pp. 6, 47-9)

4. Respondent recorded the patient's history in the medical record, noted findings of no abdominal or suprapubic masses following a physical exam and indicated an impression of a plan to perform an MRI test to rule out a hemorrhagic cyst versus a column of Bertin. Respondent contacted Patient A's primary treating physician, Dr. Jack Apelbaum, for authorization for performance of the MRI. (Ex. 3, p.7; T. 619-624)

5. A hemorrhagic cyst is a cyst containing blood which is walled off by a very thin membrane. (T.49)

6. A column of Bertin is an anatomical portion of the kidney and is normal kidney. (T. 50-1)

7. Respondent obtained the films of the May 14, 1999 CT scan and those films were present in his office prior to the surgery performed on Patient A on June 2, 1999. (T. 642)

8. An MRI was performed on Patient A on May 20, 1999, at Doshi Diagnostic, an imaging company different than that which performed the CT scan on May 14, 1999. Respondent spoke

with the Doshi Diagnostic radiologist who indicated that the results from the MRI were not more conclusive than the CT scan results in ruling out renal cell carcinoma. Respondent noted in the patient's chart "preliminary report from Doshi, MRI positive for solid mass left, question mark, consistent with renal cell carcinoma. Plan: radical nephrectomy as per patient's wish". (Ex. 3, p. 7; T.632-6)

9. In an entry in the patient's record dated May 21, 1999, Respondent wrote that the patient had called and stated that the MRI had been performed. He recorded that the official report was pending and that the preliminary report indicated a questionable non-enhancing left renal mass. (Ex.3, p. 8; T.637)

10. In order to confirm or rule out a benign condition in a mass, Respondent would have had to review the CT scan and MRI films and the final MRI report. Those studies would have confirmed the location of the mass, assisted in determining the manner in which the surgical incision would be performed and described the extent of any vascular involvement. (T. 49-50, 54-5, 178, 643)

11. Respondent did not review the films of either the CT scan or MRI test or report at any time before his performance of a left radical nephrectomy on Patient A on June 2, 1999. He made no attempt to obtain the MRI films or report before the surgery. Respondent had an obligation to obtain the MRI films and report prior to the surgery if they had not been provided to him. (T.60-1, 331, 638, 641-2, 749, 762, 773-4, 785-6, 1020-2)

12. Respondent did not have the CT scan films and the MRI test films and final report with him in the operating room on June 2, 1999, when he performed the left nephrectomy on the

patient. (T. 638, 773-4, 785-6)

13. The failure to have such films and report present while performing the surgery was a deviation from accepted standards of practice. The surgeon is at a disadvantage if a problem is encountered or if there is uncertainty about the pathology during the procedure and the films and report are not present for review. (T. 62-4; 320-1)

14. Once the kidney was exposed during the surgery, the appropriate procedure for a urologist to follow would have been to attempt to visualize the tumor. If the kidney appeared normal, it should be gently felt in a further effort to identify the mass. If it still could not be located, a review of the imaging films would be appropriate to establish that the correct kidney was being examined. Respondent did not follow these procedures during Patient A's surgery. (T. 70-2; 189-190; 667, 774-5)

15. It was incumbent for Respondent to investigate why the kidney appeared normal in light of the preoperative CT scan report of a 5x7 cm. mass. Following removal of the kidney, Respondent should have sectioned it, with the permission of the pathologist, to determine whether the reported mass actually existed. Respondent did not examine the kidney before sending it to the Pathology Department. (T. 73-5; 670-1)

16. Respondent was informed by a pathologist later on June 2, 1999 that the kidney that had been removed was determined to be free of any tumor. The surgical pathology report contained in the patient's hospital record confirmed that the kidney was negative for tumor. Respondent did not review the CT films or take any other action to reconcile the inconsistency between this finding and the preoperative diagnosis. (Ex. 3, p.19; Ex. 4, pp. 176-9; T. 352-4; 379-80; 770-1; 792-3)

17. While hospitalized on June 7, 1999, Patient A complained of right flank pain. This was the patient's only complaint of right flank pain during the hospitalization. Patient A was treated with two tablets of Tylenol #3 and was reported to be pain free one hour later. He was discharged later that day. (Ex. 4, pp.125, 189-90)

18. At an office visit on June 11, 1999, Respondent recorded low hemoglobin and hematocrit levels in Patient A's chart following the performance of an urinalysis. Respondent ordered a blood test to monitor the patient's BUN and creatine levels. Results reported on June 24, 1999 indicated an elevated BUN of 45 and an elevated creatine level of 1.9. (Ex. 3, pp.20-1; 24)

19. Patient A's primary care physician was also monitoring the post-surgical BUN and creatine levels and performed monthly blood tests during that period. The patient's BUN level was reported at 27 and creatine level at 1.9 on July 21, 1999, at 31 and 1.6 on August 24,1999 and at 30 and 1.7, respectively, on September 14, 1999. These levels were slightly above the upper range of normal, remained stable without significant change during the three month post-surgical period and were improved from the June levels. The hemoglobin and hematocrit levels were found to be within the normal range in August and September, 1999.
(Ex. 3, p. 24; Ex. B, pp. 294-5, 299-300, 316-8; T. 697-9, 946-949)

20. Respondent met regularly with Patient A during the four months following the June 2, 1999 nephrectomy. Respondent consulted with a hematologist/oncologist during an office visit on July 7, 1999 in response to Patient A's complaints of shortness of breath, fatigue and weight loss with an intent for the patient to follow up with that physician. In addition, Patient A was seen by a pulmonary specialist and his primary care physician on several occasions during that period. (Ex. 3, B; T. 453-460, 700-4)

21. On or about July 13, 1999, Respondent spoke with Dr. Apelbaum, Patient A's primary care physician, and told him that the pathology report indicated a benign hypertrophy. (Ex. B, p. 79; T. 518-20, 772-3)

22. Patient A had a CT scan of the abdomen performed on September 24, 1999 which indicated an approximately 6 x 7 cm. mass in the lower pole of the right kidney. The results of this test were faxed to Respondent by Dr. Apelbaum about one week later on September 30, 1999. Respondent contacted Patient A for the purpose of scheduling an office visit to discuss the CT results and saw the patient about one week later on October 8, 1999. (Ex. 3, pp. 35-8, T. 719-27)

23. In an entry in the patient's chart dated October 8, 1999, Respondent recorded a finding that the recent CT scan had shown a new 6 x 7 cm. lesion in the right kidney. He further noted that options for nephrectomy with hemodialysis were given to the patient. (Ex. 3, p. 38; T. 728-31)

CONCLUSIONS OF LAW

The following Conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from an unanimous vote of the Hearing Committee.

The Hearing Committee concluded that, based on the above Findings of Fact, the following Factual Allegations set forth in the Department's Notice of Hearing and Statement of Charges (Ex. 1) should be **SUSTAINED**:

Paragraphs A. 2.; A.4.; A.5.; and A.6.

The Committee determined that all other Factual Allegations should **NOT** be **SUSTAINED** and should therefore be **DISMISSED**.

The Hearing Committee concluded that the following Specifications should be **SUSTAINED** based upon the Factual Allegations which were sustained:

First and Second Specifications as they relate to Paragraphs A. and A. 2., A. 4., A. 5., and A. 6. only.

The Hearing Committee concluded that other Specifications should **NOT BE SUSTAINED:**

DISCUSSION

Respondent was charged with multiple 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. The document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

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

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Committee relied on these definitions in considering certain of the Specifications of professional misconduct.

In the course of their deliberations, Committee members evaluated the credibility of the witnesses to assign the relative weight to accord to their testimony. Each expert was seen as an experienced urologist who was well-qualified to address the appropriate standards of their medical specialty. The testimony of Dr. Ippolito was viewed as straight-forward and objective and his opinions were given significant weight. Dr. Rubin's testimony was considered less detached because he had spoken extensively with Respondent about the case. The Committee was less concerned with Dr. Rubin's explanation of what Respondent's thought processes may have been than with a neutral opinion as to whether deviations from accepted medical standards had occurred. In general, when the testimony of the experts conflicted, greater weight was given to Dr. Ippolito's opinions.

The Committee believed Respondent was credible in the explanation of his actions. He was not seen to be arrogant and was sincerely remorseful about the errors in the treatment of Patient A. He was considered to be quite knowledable about the field of urology. In contrast, Dr. Apelbaum's entire testimony was questioned by the Committee and was determined to be beyond belief and not credible. As further discussed below, his statements were given no weight.

Sustained Allegations

Respondent admitted that he did not have the films and/or final report of the MRI of Patient A which was performed on May 20, 1999. He further testified that the films of the CT scan performed on May 14, 1999 were available to him, but that he did not review them prior to the nephrectomy. Factual Allegations A. 2. And A. 4. were sustained based on this testimony.

The Committee agreed with the testimony of Dr. Ippolito that Respondent had a duty to make a greater effort during the surgery to locate the mass that had been observed by the CT

scan. A tumor 5 x 7 cm. should have been large enough to either have been visualized or palpated. If it could not have been located following such steps, Respondent should have reviewed the CT films. He should not have assumed that whatever had been observed was part of a benign process. Similarly, once the left kidney was removed, Respondent should have examined it before sending it to the Pathology Department. He was too accepting of his impression that what had been observed on the CT scan films was not a carcinoma. Factual Allegation A. 5. was sustained.

The Committee members felt that Respondent had an even greater obligation to reconcile the pre-operative diagnosis and post-operative negative finding when he was advised by the pathologist that the removed organ was determined to be free of tumor. However, Respondent again failed to review the CT films or attempt to secure the MRI films or report. His contention that he requested that the pathologist undertake additional stainings of the removed specimen to test for the presence of a condition known as malakoplakia was denied by the pathologist and was not confirmed by any documentation in the hospital or patient's medical record. There was no evidence presented to indicate that the Respondent questioned in any manner the failure to locate the mass. Factual Allegation A. 6. was sustained.

Allegations Not Sustained

Factual Allegation A. 1. was easily disproved by a review of Respondent's record of the May 19, 1999 examination of Patient A. Clinical findings were documented and a referral was made for performance of a MRI, which all parties agreed was appropriate. He would have been unable to identify which kidney contained the mass or to document his clinical findings until he reviewed the films. Allegation A. 1. was not sustained.

The Committee did not sustain Factual Allegation A. 3. because it did not conclude that it was Respondent's responsibility to include the test reports in the hospital record. While Dr.

Ippolito testified that it was a deviation from accepted standards of practice to not include the reports in the hospital chart, he did not state that it was the responsibility of the surgeon to include them. Dr. Rubin testified that, under current practices, Respondent was not obligated to place such reports in the hospital chart.

The Committee determined that Respondent did not intent to mislead anyone by not specifically documenting that a tumor-free kidney had been removed. The pathology report clearly identified that fact and was found in both the Respondent's and the hospital's records. The Committee members reasoned that any alleged intent to mislead was belied by the presence of the pathology report in the charts. Factual Allegation A. 7. was not sustained.

The Department based the allegation that Respondent intentionally misled Patient A and Dr. Apelbaum by informing them that a benign tumor had been removed on a conversation betweeen Dr. Apelbaum and Respondent in July, 1999. Dr. Apelbaum testified that Respondent told him that he had removed a benign hypertrophy. The Committee distinguished that from a benign tumor. In addition, the Committee questioned the authenticity of Dr. Apelbaum's note in his chart for Patient A of that July 13, 1999 conversation. The overall testimony of Dr. Apelbaum was viewed as highly questionable and was accorded little weight by the Committee. It did not always conform with his written records and was seen as evasive and self-serving. Dr. Apelbaum stated that he had another conversation with Respondent on or about August 9, 1999 following the receipt of a report of a CT scan of Patient A's abdomen performed on or about August 3, 1999 which indicated an impression of a possible right renal mass. Respondent denied that this conversation took place and the Committee found Dr. Apelbaum's contention of this August, 1999 conversation to have no basis in fact. Allegation A. 8. was not sustained as it was based on testimony found to be without any credibility.

The Committee determined that the credible evidence presented at this proceeding did not demonstrate that Respondent was actually aware of the fact that he removed the incorrect kidney until approximately February, 2000 when he received and reviewed the MRI report prepared in

May, 1999. Whether he *should* have known of the error earlier than that is a separate issue. Respondent believed that the right renal mass was a new lesion when he wrote the October 8, 1999 note. He received no report before that date to indicate otherwise. As previously stated, Dr. Apelbaum's allegation of an August conversation in which he informed Respondent of such a right renal mass was determined to not be credible testimony. Allegation A. 9. was not sustained.

Patient A's first, and only, complaint of right flank pain occurred on the day of his hospital discharge. He was treated with Tylenol with codeine and was reported to be pain-free one hour later. The Committee saw nothing inappropriate with this course of action and did not sustain Factual Allegation A. 10. Respondent met regularly with the patient following the June 2, 1999 surgery. In addition, Patient A was seen by both his primary care physician and a number of specialists during the post-surgery period. Respondent appropriately referred the patient to these physicians for a variety of necessary tests and procedures. He was not made aware of the presence of the right renal mass until late September, 1999 and could not have addressed that situation sooner. Factual Allegation A. 11. was not sustained.

Results of blood work on June 11, 1999 for Patient A indicated elevated BUN and creatine levels and low hemoglobin and hematocrit levels. During the next three months, these levels were stable and somewhat improved. Dr. Apelbaum was monitoring the blood chemistries and was performing regular blood tests during the same time. The Committee concluded that Respondent properly monitored the slightly abnormal levels and noted that the hemoglobin and hematocrit levels were found to be normal in August and September, 1999. Allegation B. 12. was not sustained.

Allegation A. 13. was dismissed by the Committee out-of-hand. Respondent saw Patient one week after he became aware of the discovery of the right renal mass. The Committee believed this to be a timely response and believed this Allegation to be frivolous and to reduce the gravity of the more substantial Allegations.

The note of October 8, 1999 in the patient's record indicated that options for a

nephrectomy with hemodialysis were given the patient and found Respondent to be credible in his statement that such options included a partial nephrectomy. In any event, the Committee members believed a partial nephrectomy for a patient with only one remaining kidney to not have been a viable option for the patient to consider. Factual Allegation A. 14. was not sustained.

The Committee determined that the hospital chart maintained by Respondent was accurate to the best of his knowledge at the time. The evidence in the record was clear that he did not receive the MRI report until months after the surgery. Allegation A. 15. was not sustained.

SPECIFICATIONS OF MISCONDUCT

The Committee considered the four sustained Factual Allegations to constitue the practice of medicine with negligence on more than one occasion because they represented compound and continuing failures to meet accepted standards of care in the treatment of Patient A. Each of the four sustained charges related to Respondent's failure to review the CT films and failure to obtain and review the MRI test films and report. These failures by Respondent, pre-, intra- and post- operative, were considered so egregious and contrary to accepted standards that they were determined to constitute the practice of medicine with gross neglience. The failure to obtain and review all necessary test results before surgery was inexcusable. Respondent's only explanation, that he mistakenly thought he had reviewed the results, was an inadequate response. He shared the responsibility for obtaining the test results, if they were not provided by Dr. Apelbaum or others. The Committee felt Respondent was too inflexible in his belief that a benign process had been detected in the patient and that he should have more aggressively ruled out the possibility of a carcinoma. As a result of a failure to consider alternatives, he continued to hold to his pre-operative diagnosis even when presented with clear evidence that no mass had been located in the left kidney.

The Committee did not believe that Respondent practiced with incompetence. The members considered him knowledgeable in his specialty and believed his deviations to be errors of judgement and not a showing of an absence of skill. Respondent was well aware of the necessity to review relevant reports and films prior to surgery and the failures to perform such reviews were perceived as acts of negligence and not incompetence.

No charges relating to the alleged fraudulent practice of medicine were sustained. The preponderance of evidence clearly demonstrated that Respondent did not know that he removed a healthy kidney until months after the surgery. Results of the diagnostic tests performed in May and August, 1999 were shown to be unavailable to Respondent in a timely manner. The copies of these reports which were in Respondent's medical record indicate that these test results were sent to other concurrently treating physicians, but not to the Respondent. Dr. Apelbaum's testimony that he informed Respondent in early August, 1999 of the discovery of a right renal mass was deemed to be not credible. The lack of communication among the many physicians treating the patient at the time was appalling, but was not evidence of an intent by Respondent to mislead others as to Patient A's condition.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in New York should be suspended for four years from the effective date of this Determination and Order, forty-two (42) months of said suspension to be stayed, and that he be placed on probation in accordance with the Terms of Probation as set forth in Appendix I during said four year period. Included in the Terms of Probation are requirements that Respondent's practice be limited to a supervised practice setting and that he perform a substantial amount of community service. This determination was reached upon due consideration for the full spectrum of penalties available

pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee considered, and expressly rejected, the Department's request that Respondent's license be revoked. This decision was based on a number of factors. The Committee considered Respondent to be a well-trained and competent urologist. His serious errors in the treatment of one patient did not represent a pattern of sub-standard practice and the Committee members felt Respondent was young enough to learn from these mistakes and to take corrective actions. No allegations of fraud were sustained and the Committee was convinced that Respondent did not knowingly conceal the fact that the wrong kidney was removed. In addition, the Committee strongly believed that the questionable practices of other physicians and of the hospital itself exacerbated the poor care provided to the patient and should be considered in determining an appropriate penalty.

Dr. Badia was the radiologist who mistakenly identified the involved organ as the left kidney in the May 14, 1999 CT report. In a subsequent study of a chest X-ray and abdominal sonogram dated June 25, 1999 after the left nephrectomy was performed, Dr. Badia found no mass in the *right* kidney of Patient A and documented an impression of a normal right kidney and examination. The Committee was shocked by the failure to reconcile the two reports and the obvious errors in the June 25, 1999 study and urged that an investigation of the conduct of this radiologist relative to his impressions of the condition of Patient A be undertaken.

The Committee had similar concerns about the quality of care provided by Dr. Apelbaum. A number of studies of the patient, including the results of the MRI performed in May, 1999, were not forwarded to the Respondent for his consideration. Both parties shared the responsibility of ensuring that they each were made aware of the results. In addition, the Committee had serious doubts about the truthfulness of Dr. Apelbaum's testimony and the accuracy of his records. He testified that his treatment of Patient A was being invesigated by the OPMC, and the Committee supported a continuation of that investigation to determine whether

the care rendered met established standards of practice.

The Committee was also distressed to learn from the pathologist's testimony that there was no Tissue Committee or Surgical Review Committee in place at Maimonides Medical Center to review a case such as this with a significant discrepancy between pre-operative diagnosis and post-operative findings. The absence of an appropriate peer review process caused concern. Respondent also testified that the urological resident had not been involved in the preparation of the case and merely came at the time of the surgery and scrubbed. There was a consensus that a diligent assisting resident could have reduced the errors that occurred.

The Committee felt that the failures of other physicians and the hospital itself served to mitigate, to a limited extent, the Respondent's deviations from accepted practices. The penalty that was imposed was not a light one. It reflected the Committee's belief that the performance of the surgery without reviewing the CT scan and MRI reports and films was inexcusable as were subsequent failures to review those results when the reported mass was not found. Respondent has been suspended from practice since April, 2000 and this suspension will be extended for six additional months. He will be prohibited from practicing in an office setting for three and one-half years thereafter. The duty to conscientiously manage patient care would be expected to be impressed on Respondent during the period of supervised practice. The Committee believed that it would then be appropriate for him to resume his practice with no additional restrictions, if Respondent were to successfully fulfill these conditions of probation.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First and Second Specifications, as they relate to Paragraphs A. and A. 2., A. 4., A. 5., and A. 6. only as set forth in the Statement of Charges (Ex. 1) be **SUSTAINED;** and

2. All other Specification of Charges set forth in the Statement of Charges (Ex. 1) be **NOT SUSTAINED** and hereby be **DISMISSED**; and

3. The license of Respondent to practice medicine in New York State be hereby **SUSPENDED** for a period of four years from the effective date of this Order, three and one-half years of said period of suspension to be **STAYED**; and

4. Respondent shall be placed on **PROBATION** during the period of the stayed suspension of his license, and shall comply with all terms of probation as set forth in Appendix I, attached hereto and made a part of this Determination and Order.

5. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: Albany, New York
August 18th, **2000**

DATTA G. WAGLE, M.D. (CHAIR)

RAMAN KAUL, M.D.
KENNETH KOWALD

TO:

Dianne Abeloff, Esq.
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Petar Muncan, M.D.
160-40 81st Street
Howard Beach, New York 11414

Bill Vaslas, Esq.
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Staten Island, New York 10314-3407

APPENDIX I

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, 4th Floor, 433 River Street, 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 periodic written 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.

7. Respondent shall work only in an Article 28 licensed hospital setting ("supervised setting") where close practice oversight is available on a daily basis and where quality assurance and risk management protocols are in effect. Respondent shall not practice medicine until the supervised setting proposed by Respondent is approved, in writing, by the Director of OPMC.

8. Respondent shall propose an appropriate supervisor or administrator in all practice settings, who shall be subject to the written approval of the Director of OPMC. Respondent shall cause the supervisor or administrator to submit reports, as requested, regarding Respondent's overall quality of medical practice. Respondent shall provide the supervisor/administrator in all settings with the Order and terms of probation and shall cause the supervisor/administrator, in writing, to comply with OPMC schedules and requests for information.

9. Respondent shall submit semi-annually a signed Compliance Declaration to the Director of OPMC which truthfully attests whether Respondent has been in compliance with the practice supervision and supervised setting requirements.

10. Respondent shall perform five hundred (500) hours of community service. The service must be medical in nature, and delivered in a facility or with an organization equipped to provide medical services and serving a needy or medically underserved population. A written proposal for community service must be submitted to, and is subject to the written approval of the Director of OPMC. Community service performed prior to written approval shall not be credited toward compliance with this Order.

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

APPENDIX II

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

IN THE MATTER

OF

PETAR MUNCAN , M.D.

STATEMENT

OF

CHARGES

PETAR MUNCAN, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 11, 1993, by the issuance of license number 193243 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about May 19, 1999, Respondent examined Patient A at his office, 2519 Avenue U, Brooklyn, N.Y. 11229, for a possible renal mass. On or about June 2, 1999, Respondent admitted Patient A (the identity of Patient A is contained in the attached Appendix) to Maimonides Medical, Brooklyn, N.Y. On or about the date, Respondent performed a left radical nephrectomy. Respondent's conduct deviated from accepted medical standards, in that:

1. Respondent examined Patient A on or about May 19, 1999. Respondent failed to identify which kidney contained the mass, and or document in office record his clinical findings about the conditions of Patient A's kidneys.

2. Prior to surgery Respondent failed to review the MRI or the report of the MRI which he had ordered on or about May 19, 1999.

3. Respondent failed to incorporate Patient A's CT Scan report of May 14, 1999 and the MRI report of May 20, 1999 in Patient A's hospital record.

4. Respondent failed to have Patient A's CT scan and MRI in the operating room on June 2, 1999, when he performed the left nephrectomy.

5. On or about June 2, 1999, Respondent failed to perform an adequate intra-operative examination of Patient A's left kidney. After the kidney was removed, Respondent failed to perform an adequate examination of the kidney.

6. On or about June 2, 1999, the afternoon of the left nephrectomy, the pathologist informed Respondent that the left kidney was tumor free. Respondent still failed to reconcile the removal of a tumor- free kidney with the pre-operative diagnosis of a 5x7 cm lobulated heterogeneous mass and failed to take appropriate action based upon this information.

7. Respondent knowingly and with the intent to deceive failed to make a note in Patient A's hospital record that he had removed a tumor-free kidney.

8. Sometime subsequent to the surgery, Respondent in sum and substance informed Patient A and his primary treating physician

that the left kidney that Respondent had removed contained a benign tumor. Respondent knew that this was false, and engaged in the communication with the intent to deceive.

9. Respondent on or about October 8, 1999, wrote in his office record that the September 24, 1999 CT Scan of the Patient A's remaining kidney revealed a new 6x7 cm mass. Respondent knew that this statement was false, and engaged in the communication with the intent to deceive.

10. On or about June 7, 1999, Respondent inappropriately discharged Patient A from the hospital despite pain in his right flank.

11. Respondent failed to provide complete post-operative follow-up care for Patient A.

12. On or about June 11, 1999, Respondent recorded low hemoglobin and hematocrit for Patient A. On or about June 23, 1999, Respondent ordered a blood test. Patient A had an abnormally high BUN of 45 (normal = 5-26) and a creatinine level of 1.9 (normal= .5- 1.5). Respondent failed to follow-up, in a timely manner, the abnormal results of the blood tests.

13. On or about September 30, 1999, after receiving the report of Patient A's CT scan of September 24th, Respondent learned of the right renal mass. Respondent failed to immediately notify

Patient A of this mass.

14. On or about October 8, 1999, Respondent informed Patient A that he needed a total nephrectomy of the remaining (right) kidney with permanent hemodialysis. Respondent failed to offer a partial right nephrectomy to the patient, or other alternative treatment.

15. Respondent's hospital chart for Patient A failed to accurately reflect Patient A's medical condition.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 2000) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

1. Paragraph A and all its subparagraphs.

SECOND SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 2000) 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:

2. Paragraphs A, A1 through A 14 and/or A15.

THIRD SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 2000) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

3. Paragraph A and all of its subparagraphs.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 2000) 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, A1 through A 14, and/or A15.

FIFTH SPECIFICATION

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 2000) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

5. Paragraph A and all of its subparagraphs.

DATED: April 7, 2000
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct