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

December 5, 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 Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah

Enclosure

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

COPY

In the Matter of

Petar Muncan, M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 00-233

Before ARB Members Grossman, Lynch, Pellman, Price and Briber
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): **Dianne Abeloff, Esq.**
For the Respondent: **Bill Vaslas, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent practiced medicine with gross negligence and negligence on more than one occasion in removing the wrong kidney from a patient. The Committee suspended the Respondent's License to practice medicine in New York (License), placed the Respondent on probation following the suspension and ordered that the Respondent perform community service. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney's Supp. 2000), the Petitioner asks the ARB to overturn the Committee's Determination, by sustaining a charge that the Respondent practiced fraudulently and by revoking the Respondent's License. The Respondent asks the ARB to sustain the Committee's Determination otherwise, but to modify the terms in the Respondent's probation. After reviewing the record and submissions by the parties, we modify the Committee's Determination and sustain a charge that the Respondent practiced fraudulently. We affirm the Committee's Determination to suspend the Respondent's License for four years, to stay the suspension for all but six months, to place the Respondent on probation for forty-two months, under the terms that appear at Appendix I to the Committee's Determination, and to order the Respondent to perform 300 hours community service.

Committee Determination on the Charges

The Petitioner's Statement of Charges alleged that the Respondent violated N. Y. Educ. Law §§ 6530(2-6) (McKinney Supp. 2000) by committing professional misconduct under the following specifications:

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

The charges related to the medical care that the Respondent, a surgeon, provided to one person, Patient A. The record refers to the Patient by letter to protect his privacy. The proceeding commenced by a Summary Order from the Commissioner of Health, pursuant to N.Y. Pub. Health Law § 230(12)(a). The Summary Order suspended the Respondent's License summarily, upon the Commissioner's Determination that the Respondent's practice constituted an imminent danger to the public health. A hearing on the charges and the Summary Order ensued before the BPMC Committee who rendered the Determination now on review. The ARB review addresses the Committee's Determination on the charges and penalty only, as the ARB lacks the authority to review Summary Orders [see Pub. Health Law § 230-c (1)].

The evidence before the Committee showed that the Respondent operated on Patient A on June 2, 1999. A May 14, 1999 CT scan had indicated a density in the Patient's left kidney suspicious for carcinoma. A May 20, 1999 MRI failed to rule out a mass in the left kidney. The Committee found that the Respondent should have reviewed the CT scan and MRI prior to

surgery and that the Respondent had both studies available to him prior to surgery. The Respondent failed to review the studies or to have the films in the operating room during surgery. At surgery the left kidney appeared normal. The Committee found that the Respondent should have attempted to visualize and palpate the kidney to identify the mass, or review imaging films if he found no mass. The Respondent failed to perform any of those procedures. The Committee also found that the Respondent failed to examine the kidney before sending the kidney to pathology. The Committee found that on June 2, 1999, the pathologist informed the Respondent that the kidney he removed contained no tumor. The Committee found that the Respondent made no attempt to review films or to take any other action to reconcile the inconsistency between that finding and the preoperative diagnosis. On September 24, 1999, a CT scan indicated a mass in Patient A's right kidney.

The Committee sustained charges that the Respondent's care for Patient A constituted practicing with negligence on more than one occasion and practicing with gross negligence. The Committee found the Respondent's failure to review all necessary tests preoperatively, intraoperatively and postoperatively constituted inexcusable behavior. The Committee dismissed charges that the Respondent committed fraud by attempting to conceal information that he had removed the wrong kidney. The Conclusion Section in the Committee's Determination [page 14] stated that the evidence indicated that the Respondent only learned that he had removed a healthy kidney months after the operation.

The Committee voted to suspend the Respondent's License for four years, to stay forty-two months of the suspension and to place the Respondent on probation during those forty-two months. The probation terms, that appear at Appendix I to the Committee's Determination, limit the Respondent to practice in a facility licensed under Public Health Law Article 28. The

Committee also ordered that the Respondent perform three hundred hours community service. The Committee 's Determination at page 15 listed several mitigating factors that resulted in the Committee's decision to reject revocation as a penalty. The factors included the Respondent's training and competence, the lack of a pattern of sub-standard practice and the mistakes by other physicians that contributed to the mistakes in care for Patient A. The Committee noted that the Radiologist, Dr. Badia, who prepared the report on the CT scan, identified the wrong kidney and that the Patient's treating physician, Dr. Appelbaum, failed to forward a number of studies to the Respondent for his consideration.

Review History and Issues

The Committee rendered their Determination on August 21, 2000. This proceeding commenced on August 29, 2000, when the ARB received the Petitioner's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and the Respondent's brief and response brief. The record closed when the ARB received the response brief on October 11, 2000.

The Petitioner asks that the ARB modify the Committee Determination on the charges by sustaining the charge that the Respondent committed fraud. The Petitioner alleges that the Committee erred in concluding that the Respondent had no knowledge that he removed the wrong kidney until months later. The Petitioner points out that the Committee found that the Respondent learned from the pathologist, on the same day as the surgery, that the Respondent had removed a kidney with no tumor. The Petitioner asks further that the ARB overturn the Committee Determination on penalty and revoke the Respondent's License. The Petitioner argues that the Committee found the Respondent inflexible. The Petitioner contends that the

Respondent's care for Patient A demonstrated a pattern of substandard care. The Respondent contends further that the Committee made no findings that the Respondent's errors would be amenable to remediation. The Petitioner contends that no educational program, therapy or retraining can remedy the Respondent's deficiencies. The Petitioner also argues that the errors by others should provide no mitigation in assessing the penalty against the Respondent.

The Respondent argues that the Committee imposed severe sanctions against the Respondent such as the actual License suspension. The Respondent points out that the six-month actual suspension and the time the Respondent served on suspension under the Summary Order will amount to almost a year on suspension for the Respondent. The Respondent asks that the ARB respect the Committee's intent to allow the Respondent to remain in practice and to consider a modification in the penalty, to restrict the Respondent to performing surgery only in an Article 28 facility, but to allow the Respondent to practice in a supervised and monitored office setting.

In reply to the Petitioner's brief, the Respondent argues that the Petitioner stated incorrectly that the Respondent failed to take responsibility for his actions. The Respondent argued that he has acknowledged his mistakes. As to the Respondent's allegation that the Respondent's care for Patient A amounted to a pattern of substandard care, the Respondent points out that the Committee found specifically that no pattern existed. The Respondent asks the ARB to consider also that the Committee dismissed 11 of 15 charges against the Respondent and to consider that in seeking to revoke the Respondent's License, the Petitioner relied on testimony from Dr. Appelbaum that the Committee found non-credible.

Determination

Prior to deliberations in this case, ARB Member Stanley Grossman indicated that he knows the Respondent's attorney, Mr. Vaslas. Dr. Grossman indicated that his acquaintance with Mr. Vaslas would have no effect on Dr. Grossman' ability to consider the case in a fair manner.

All ARB members participated in the case and reviewed the record and the parties' briefs. We modify the Committee's Determination by sustaining the charge that the Respondent practiced with fraud. We affirm the Committee's Determination to suspend the Respondent's License, to place the Respondent on probation and to order the Respondent to perform community service.

Fraud Charge: In order to sustain a charge that a licensee practiced medicine fraudulently, a hearing committee must find that:

1.) a licensee made a false representation, whether by words, conduct or by concealing that which the licensee should have disclosed,

2.) the licensee knew the representation was false, and

3.) the licensee intended to mislead through the false representation, Sherman v. Board of Regents, 24 A.D.2d 315, 266 N.Y.S.2d 39 (Third Dept. 1966), aff'd, 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967).

A committee may infer the licensee's knowledge and intent properly from facts that such committee finds, but the committee must state specifically the inferences it draws regarding knowledge and intent, Choudhry v. Sobol, 170 A.D.2d 893, 566 N.Y.S.2d 723 (Third Dept. 1991).

In dismissing the fraud charge, the Committee found that the evidence at hearing demonstrated that the Respondent was unaware that he removed the incorrect kidney until

months after the surgery. That conclusion at page 14 in the Committee's Determination contradicted the Committee's Finding of Fact (FF) 16 that found the pathologist informed the Respondent on June 2, 1999 that the Respondent had removed a tumor free kidney. The Committee also sustained factual allegation A6 from the Statement of Charges. Allegation A6 charged that the pathologist informed the Respondent about the tumor free kidney and the Respondent failed to take appropriate action on that information. The ARB concludes from FF 16 that the Respondent realized that he made a mistake as early as June 2, 1999 and we infer that the Respondent concealed that mistake rather than trying to correct the mistake.

Under our authority from Pub. Health Law § 230-c(4)(a), the ARB reviews whether a Committee has made a Determination consistent with their findings. The ARB may substitute our judgment for that of the Committee in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 AD 2d 940, 613 NYS 2d 759 (Third Dept. 1994). The ARB chooses to substitute our judgement for the Committee in this case. We find the Committee's Determination to dismiss the fraud charge inconsistent with the Committee's FF 16. We hold that the Respondent knew he made a mistake, concealed his mistake knowingly and failed to correct the mistake. Such conduct constituted practicing medicine fraudulently.

Penalty: Although others may bear responsibility for mistakes that occurred in caring for Patient A, the Respondent bears responsibility for his failures preoperatively, intraoperatively and postoperatively. We agree with the Committee that the Respondent's conduct merits six months actual time on suspension, in addition to the time on suspension the Respondent served under the Summary Order. We also agree with the Committee that the Respondent should serve forty-two months on probation, with supervision and monitoring, to assure that the Respondent has learned from his mistakes. We also agree that the Respondent should practice only in an

Article 28 facility during the probation period. We reject the Respondent's request for a modification in the probation. The Committee also ordered the Respondent to perform 300 hours community service. In deliberations, we questioned how community service would constitute an appropriate sanction for the negligence and gross negligence charges the Committee sustained. The ARB, however, has also sustained a fraud charge. We find that the 300 hours community service will constitute an appropriate sanction for the Respondent's fraudulent conduct.

In arguing for revocation, the Petitioner alleged that the Respondent's conduct amounted to a pattern of substandard care. The Committee found specifically that no such pattern appeared in this case and we agree with the Committee. The Petitioner also argued that the Committee made no findings that the Respondent was amenable to remediation. The Committee found specifically that the Respondent took responsibility for and showed remorse for his mistakes in the case. We agree again with the Committee. The Petitioner argued that no educational program, therapy or training could remedy the Respondent's bad judgement. The Committee's penalty, however, included no educational program, therapy or training. The ARB concludes that revocation would constitute an overly harsh penalty in this case.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB **AFFIRMS** the Committee's Determination that the Respondent practiced medicine with gross negligence and negligence on more than one occasion in caring for Patient A.
2. The ARB **MODIFIES** the Committee's Determination and **SUSTAINS** the charge that the Respondent practiced medicine fraudulently.
3. The ARB **AFFIRMS** the Committee's Determination to suspend the Respondent's License for four years, to stay the suspension for all but six months, to order the Respondent to serve 300 hours community service and to place the Respondent on probation for forty-two months, under the terms that appear at Appendix I to the Committee's Determination.

Robert M. Briber
Thea Graves Pellman
Winston S. Price, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Peter Muncan, M.D.

Winston S. Price, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Muncan.

Dated: 12/1/00, **2000**

Winston S. Price, M.D.

In the Matter of Peter Muncan, M.D.

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

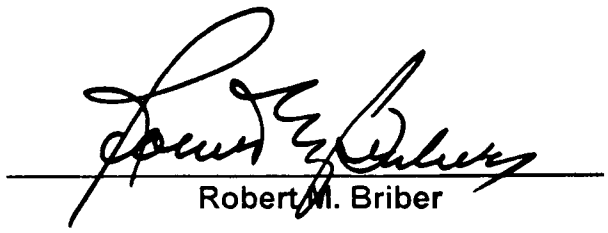
Dated: 12/1, **2000**

Thea Graves Pellman

In the Matter of Peter Muncan, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Muncan.

Dated: 11/30/2000



Robert M. Briber

In the Matter of Peter Muncan, M.D.

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

Dated: 11, **2000**

Therese G. Lynch, M.D.

In the Matter of Peter Muncan, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Muncan.

Dated: December 1, 2000

S L Grossman M.D

Stanley L Grossman, M.D.