THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

Robert Mucciolo, Physician
171 Peachtree Lane
Roslyn Heights, New York 11577

November 15, 1991

Re: License No. 148353

Dear Dr. Mucciolo:

Enclosed please find the order of the Deputy Commissioner for the Professions No. 12011. This Order goes into effect five (5) days after the date of this letter.

**If the penalty imposed by the Order in your case is a revocation, surrender, or an actual suspension (suspension which is not wholly stayed) of your license,** you must deliver your license and registration to this Department within ten (10) days after the date of this letter. Your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department. In the event you are also served with this Order by personal service, the effective date of the Order is the date of personal service.

**If the penalty imposed by the Order in your case is a revocation or a surrender of your license,** you may, pursuant to Rule 24.7 (b) of the Rules of the Board of Regents, a copy of which is attached, apply for restoration of your license after one year has elapsed from the effective date of the Order and the penalty; but said application is not granted automatically.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By: Gustave Martine

GUSTAVE MARTINE
Supervisor

DJK/GM/er

**CERTIFIED MAIL - RRR**

cc: John T. Evans, Esq.
Belair & Evans
61 Broadway
New York, New York 10006

REPORT OF THE
REGENTS REVIEW COMMITTEE

ROBERT MUCCIOLO

CALENDAR NO. 12011

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

**ROBERT MUCCIOLO** **No. 12011**

who is currently licensed to practice
as a physician in the State of New York.

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**REPORT OF THE REGENTS REVIEW COMMITTEE**

ROBERT MUCCIOLO, hereinafter referred to as respondent, was licensed to practice as a physician in the State of New York by the New York State Education Department.

The instant disciplinary proceeding was properly commenced. A copy of the September 17, 1990 statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A". That exhibit shows that the charges have been amended in part and withdrawn in part.

Between October 17, 1990 and January 11, 1991 a hearing was held in four sessions before a hearing committee of the State Board for Professional Medical Conduct. On February 7, 1991, the hearing committee found and concluded that respondent was not guilty of each of the specifications of the charges and recommended that the

charges be dismissed. A copy of the hearing committee report, without attachments, is annexed hereto, made a part hereof, and marked as Exhibit "B".

On April 23, 1991, the Commissioner of Health, by designee, recommended to the Board of Regents that the findings and conclusions of the hearing committee be accepted except that additional findings be made as specified in his recommendation, the conclusions be rendered that respondent is guilty of the fourth specification of negligence on more than one occasion based on the facts alleged in paragraphs A, A.1, A.2, B, and B.2, and respondent's license be suspended for two years and the suspension be stayed provided respondent consult with a board certified urologist approved by the Office of Professional Medical Conduct in every case involving a urologic procedure. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On August 22, 1991, respondent appeared before us and was represented by his attorney, John T. Evans, Esq. Marcia Kaplan, Esq., presented oral argument on behalf of the Department of Health.

The materials originally forwarded to us by the Commissioner of Health did not include the pre-hearing conference transcripts. Therefore, a special request was made on our behalf on April 30, 1991 for the pre-hearing conference transcripts to be sent to us.

By letter dated May 22, 1991, the Health Department advised us that the pre-hearing conference transcripts would not be released until the parties had an opportunity to present objections and the Board of Regents issues a written order. Thereafter, both parties informed us that they had no objection to the release of these transcripts.

The originally scheduled review for June 11, 1991 was adjourned because this matter was not ready to be heard due to the absence of a complete record. The June 11, 1991 Regents Review Committee issued 6 Rulings to assure that the complete record would be received. On June 21, 1991, we received the requested transcripts sent by the Administrative Officer on June 20, 1991, almost two months after a special request was made for the unsent pre-hearing transcripts to be released.

The pre-hearing conference transcripts, which are part of the record in this matter, were, according to the Administrative Officer, not received by the Commissioner of Health prior to the issuance of the recommendation by the Commissioner of Health. The record available for review at the time of the issuance of said recommendation reflected the holding of two pre-hearing conferences. The Commissioner of Health could have chosen, as we did, to request a copy of the transcripts kept within the Department of Health. We note that, although we notified both parties of our request to obtain the materials originally not

forwarded to us by the Commissioner of Health, neither party addressed this issue of the Commissioner of Health not having reviewed these transcripts. Therefore, we do not pass upon this issue. Were the parties to ask us to pass upon this issue, we would conclude that there was no failure by the Commissioner of Health to fulfill his statutory duties with regard to this disciplinary matter or to accord respondent due process. See, Matter of Smith, Cal. No. 11657; Matter of Briggs, Cal. No. 11695; and Matter of Hah, Cal. No. 11953. Cf., DiMarsico v. Ambach, 48 N.Y.2d 576 (1979).

We have considered the record in this matter as transferred by the designee of the Commissioner of Health and the Administrative Officer, including all briefs, letters, and comments submitted by both parties before and after our meeting.

Petitioner's written recommendation as to the measure of discipline to be imposed, should respondent be found guilty, was two year suspension to be stayed provided respondent consult with a Board certified urologist, during the period of stayed suspension, in every case involving a urologic procedure.

Respondent's written recommendation was dismiss all charges.

We first assess whether respondent has committed unprofessional conduct and/or fraud regarding his record-keeping practices in the case of Patient A. These charges relate to respondent knowingly failing to enter in the hospital record for

one patient certain descriptions, an explanation, and a statement. Then, we will assess whether respondent has committed the charges involving negligence in the cases of Patients A and B. The charges upon which the Commissioner of Health recommended that respondent be found guilty relate to respondent performing immediate surgery on one patient without sufficient indication, using excessive force during that surgery, thereby avulsing the left ureter by ripping it away from the bladder, and using excessive force in surgery on another patient, thereby perforating the urethra, four layers of tissue, and the rectal wall.

**RECORD-KEEPING**

The fifth specification alleges respondent committed unprofessional conduct for record-keeping violations. Both this specification and the separate first specification, the latter alleging respondent practiced the profession fraudulently, are based on the same paragraphs of the charges involving Patient A.

It is undisputed that respondent, the surgeon for Patient A, did not prepare any operative report for the laparotomy he performed. Respondent's own expert testified, at the hearing, that there clearly "needed to be a dictated, very precise operative note of what transpired ... that is standard operational procedure." Transcript page 426 (hereafter T. ___). We agree with the findings of the hearing committee and the Health Commissioner's designee that a dictated operative note for this operation is not contained

in Patient A's medical chart and that a reasonably prudent physician knows that it is his responsibility to enter an operative report into the record containing information which describes accurately and appropriately the nature of his treatment of the patient. (Findings 22 and 23). However, we disagree with the conclusions of the hearing committee and the designee that respondent is not guilty of the fifth specification as to paragraph A.3 (cystoscopy and uteroscopy) and paragraphs A.4(a), (b), (c), and (d) (laparotomy).

In its objections to the hearing committee report, petitioner contended that the conclusion that respondent kept records which accurately reflect his care and treatment of Patient A "flies in the face" of the above findings of fact and the evidence, including the testimony of respondent's own expert. Medical records which do not meet the meaningful information standard are in violation of the applicable unprofessional conduct rule, 8 N.Y.C.R.R. §29.2(a)(3). Schwarz v. Board of Regents of University of State of New York, 89 A.D.2d 711 (3rd Dept. 1982). In our unanimous opinion, respondent's record-keeping practices in this case fall far short of this standard.

Critical details of what occurred during the operative procedure are lacking in the inaccurate and inadequate medical records prepared by respondent for Patient A. The expert witness for each party attempted to fill in gaps in Patient A's records by

piecing together disparate notes by various care providers. The deficiencies in respondent's record-keeping practices as to Patient A left petitioner's expert unsure of his understanding and impressions about the events and circumstances surrounding Patient A. While respondent's expert believed that specific information was "apparent" from the pathology report and the handwritten operative note, he acknowledged that there is "not ... as great a detail as one would want in a dictated, formal operative note". T. 373. Because there is much that is either confused or not apparent in Patient A's medical records, we agree with the thrust of the testimony of petitioner's expert that further and more detailed information should have been recorded by respondent.

The hearing committee report and Health Commissioner recommendation neither find nor show that relevant specific information was recorded by respondent. They made no finding as to the existence of any operative note for the cystoscopy and uteroscopy referred to in paragraph A.3 of the charges. Accordingly, they did not demonstrate the adequacy or meaningfulness of the information in such report. With respect to paragraph A.4, hearing committee finding 19 shows there is an operative note for the laparotomy in the record which contained some brief information. However, that information did not include the specific quality of information referred to in the charges which we sustain. The hearing committee and Health Commissioner's

designee did not identify the specific information missing from that operative note* and did not address whether such missing information should have been recorded.

Significantly, the hearing committee report does not recognize that respondent admitted that his operative note for the cystoscopy and uteroscopy was inaccurate regarding his observation of mucosa. According to respondent's expert, if respondent had observed just the mucosa, as he reported, the whole scenario would not have occurred. T. 406.

In his summation, respondent's attorney acknowledged that the absence of an operative report for the laparotomy was an oversight by respondent and that he was not arguing that there should not have been a dictated operative note or that the existing note was adequate or complete. He contended, however, that respondent was not guilty as to the charged record-keeping violations because respondent did not intend to misrepresent or conceal his actions. Similarly, respondent's expert witness testified that while there was a "filing procedural type of a problem" with respondent's records, T. 427, there was no attempt by respondent to "cover up".

We agree that respondent did not "intentionally misrepresent

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*Said operative note was not prepared by respondent and was, as respondent's expert testified, merely a "handwritten preliminary operative note". T. 367.

or conceal the facts of the procedures that he performed on Patient A." Hearing committee report page 8 (hereafter report ____). However, the absence of fraud does not preclude a finding of a record-keeping violation. Scienter, which is needed to establish fraud, is not an element of unprofessional conduct within the meaning of 8 N.Y.C.R.R. §29.2(a)(3). Amarnick v. Sobol, 569 N.Y.S.2d 780 (3rd Dept. 1991). In considering the fifth specification separately from the different and distinct definition of professional misconduct alleged in the first specification, we cannot agree with the hearing committee and the designee that respondent's "records do accurately reflect" the care and treatment of Patient A. Report, supra.

Contrary to respondent's defense, respondent's testimony shows he was aware of information as to the operations and the attendant complications which he knew he did not record. Had respondent entered available meaningful information in the hospital record, there would not be the uncertainty and dispute, which has resulted, as to what occurred during the operations and as to when, how, where, and why the events occurred.

We also reject respondent's defense that it was the hospital's responsibility to inform respondent that he failed to prepare an operative note for the laparotomy. He did not discharge his responsibilities to prepare and assure the entry into the medical records of meaningful information. Respondent's conduct may not

be excused by his delegating tasks to a resident, waiting for a reminder from the hospital, or relying on resort to pathology and notes prepared by others.

The purpose behind the requirement that a proper record be kept for each patient is in part to ensure that meaningful information is recorded in case the patient should transfer to another professional or the treating practitioner should become unavailable. Schwarz v. Board of Regents of University of State of New York, 89 A.D.2d 711 (3rd Dept. 1982). Respondent's records beyond certain general and preliminary information do not reveal pertinent information needed for subsequent practitioners to evaluate Patient A and evaluate the treatment provided by respondent. These deficient medical records are unacceptable, especially since, as respondent's expert testified, the uteroscopy procedure performed by respondent can lead to the Patient's development of problems after the surgery is completed.

Accordingly, respondent is, in our unanimous opinion, guilty of the knowing failures charged in paragraphs A.3, A.4(a), A.4(b), A.4(c), and A.4(d) of the fifth specification (as specifically charged herein although knowingly is not a necessary element of the rule alleged to be violated) and is not guilty of both paragraph A.4(e) of the fifth specification and of the entire first specification.

**NEGLIGENCE ON MORE THAN ONE OCCASION**

With respect to the fourth specification of negligence on more than one occasion, we have considered the differences of opinion between the expert witness for each party. The hearing committee heard the testimony of the two eminent experts and professional colleagues, observed their demeanor, and carefully evaluated their credibility and the patient records. Based upon the entire record, we agree with the findings and conclusions of the hearing committee as to the fourth specification.

Initially, respondent's contention that the medical qualifications and competence of the Health Commissioner's designee should be weighed in comparison to those of the hearing committee must be rejected. In evaluating the entire record, we have fully considered the decision of both the hearing committee and designee.

The hearing committee concluded that respondent was not guilty of negligence as to paragraph A.1 because the performance of a cystoscopy and uteroscopy on Patient A was an appropriate procedure to relieve the pain, vomiting, and obstruction from the underlying stone disease (report 8). Based on the clinical picture presented by Patient A and the various factors alluded to by both witnesses, respondent's performance of these procedures did not constitute a deviation from the standards for medical practice in effect at that time. (See, findings 3, 4, 5, 6, and 11). The record shows that the success rate for the two approaches of intervening with a

uteroscopy versus not intervening and observing whether the kidney stone passes are both substantial. The fact that other or better choices could have been made in caring for Patient A does not establish negligence. Further, the risks to Patient A, had she chosen to attempt to let the stone pass by itself, also have to be considered and weighed.

The conclusions of the hearing committee that respondent is not guilty of negligence are supported by the record. In contrast, the designee, as shown in his proposed finding (e) and conclusion on page 2, was affected by his consideration of the extent of respondent's experience in performing these procedures. However, the charge against respondent involving the absence of sufficient indication of infection, renal damage, or long-standing obstruction are not based upon any charge of alleged incompetence and are without regard to respondent's experience under the circumstances herein. Our focus, regarding these negligence issues, is on whether respondent's care of Patients A and B comported with the applicable accepted standards of other physicians.

The remaining negligence charges sustained by the Health Commissioner's designee concern respondent's alleged use of excessive force during the procedures on Patient A (paragraph A.2) and Patient B (paragraph B.2). The designee found that respondent used excessive force: in passing the ureteroscope in the case of

Patient A, which had "disastrous results leading ultimately to the loss of a kidney" (findings f and g); and with the whip and follower during the cystoscopy in the case of Patient B and "perforated Patient B's urethra, multiple layers of tissue between the urethra and the rectal wall" (finding j). On the other hand, the hearing committee concluded, and we agree, that respondent exercised ordinary care in his care and treatment of Patients A and B. Under the circumstances, including the extent of medical records for Patient A available to be reviewed by petitioner's expert, petitioner has not proven negligence by a preponderance of the evidence.

Regarding Patient B, the hearing committee found, and the designee accepted, the findings that the stricture of the urethra encountered by respondent changes the nature of a cystoscopy into a difficult one where the accepted practice is to try and dilate the stricture (findings 31 and 32). The hearing committee also found, and the designee agreed, that some element of force must be used to negotiate the scarring when the texture of the stricture is firm (finding 35). In our unanimous opinion, petitioner has not proven negligence by a preponderance of the evidence that respondent's use of force was excessive under the circumstances.

Accordingly, in view of the foregoing analysis, and our agreement with both the hearing committee and designee that respondent is not guilty of negligence as to paragraphs A.3,

A.4(a), A.4(b), A.4(c), A.4(d), A.4(e), and B.1 and is not guilty of any gross negligence charge, respondent is not guilty of negligence on more than one occasion and of gross negligence.

We unanimously recommend the following to the Board of Regents:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted; and the recommendation of the Commissioner of Health as to his additional findings of fact not be accepted;
2. The following additional findings of fact be accepted:

   17(a) An operative note signed by respondent for the May 14, 1987 cystoscopy and ureteroscopy performed by respondent on Patient A provides the general post-operative diagnosis of avulsion of left ureter. Said note indicates that the mucosa from the ureter was easily identified on the distal tip of the ureteroscope. (Exhibit 3A p. 59; T. 84, 393)

   17(b) The portion of said note regarding the mucosa from the ureter was, as respondent admitted, not accurate. In fact,

respondent identified ureter and not mucosa wrapped around the tip of the ureteroscope. (T. 95, 96, 174-180, 206, 207, 363, 393, 394, 404-406, 617, 618, 636, 640)

17(c) The cystoscopy and uteroscopy operative note indicates that the ureteroscope was passed with no unusual difficulty. This is also not accurate. (Exhibit 3A p. 59; T. 73-79, 83, 95, 96, 174-180, 617, 618, 640-642, 654)

17(d) An x-ray taken during the procedures shows that the ureteroscope had passed approximately an inch above the point where the ureter curves to go into the kidney and become the renal pelvis. He knew that he was past the point where he should have visualized the stone. During the ureteroscopy procedure, respondent was "in trouble". (T. 73-79, 87, 174-180, 206, 207, 617, 618, 640-642, 654)

17(e) Respondent observed the ureter when he was looking on the outside of the ureteroscope. During the ureteroscopy, it was

respondent's impression that there was an avulsion of the ureter and he could see by touching the ureter that indeed it was on the tip of the uteroscope. (T. 617, 618, 640-642)

17(f) A handwritten progress note indicates that there had been an avulsion of the ureter and that there was a plan to do a laparotomy for repair of the avulsion. (Exhibit 3A p. 19)

17(g) The operative note, the progress note, and the remainder of the hospital record fail to describe the nature or cause of the avulsion of the left ureter and the damage to the bladder. (T. 86-89, 92, 99, 122, 203, 426)

17(h) Respondent knowingly failed to enter in the hospital record for Patient A a description of the nature or cause of the avulsion of the left ureter and a description of the damage to the bladder. (T. 86-89, 99, 122, 174-180, 203, 426)

17(i) A reasonably prudent physician knows that it is his responsibility to enter into the

record an operative report which reflects accurately and appropriately the nature of his treatment of the patient during an operative procedure. (T. 86-89, 99, 179, 180, 203)

17(j) A reasonably prudent physician who had performed the cystoscopy and uteroscopy and who recognized that there was a complication during the operation would have entered meaningful information in the hospital record describing the nature or cause of the avulsion and of the damage to the bladder. (T. 86-89, 97, 174-180, 203, 351, 358)

17(k) It is important for the surgeon and for other subsequent treating physicians to have as accurate and specific a description in the record as possible of the nature or cause of the avulsion and the resulting damage so that information is available in the event of any subsequent problem or procedure, whether related or new. (T. 86-89, 99, 174-180, 203, 351, 358)

17(l) Subsequent treating physicians would not

be able to tell precisely what occurred from reading respondent's entries in the hospital record. The hospital record does not accurately and appropriately reflect respondent's treatment of Patient A during the ureteroscopy. (T. 86-89, 99, 174-180, 203, 351, 358, 404-406, 426)

18(a) Due to the avulsion, respondent performed on Patient A an exploratory laparotomy, left nephrostomy, and bladder repair. (Exhibit 3A p. 58; T. 137, 660)

18(b) Respondent failed to prepare <u>any</u> dictated operative note for the exploratory laparotomy, left nephrostomy, and bladder repair, and no dictated operative note was prepared by anyone for this procedure. (T. 89-91, 128, 129, 207, 369, 623, 624, 626)

18(c) Respondent did write a progress note on May 21, 1987. That progress note is not an appropriate substitute for a formal operative note and does not provide sufficient information about the operation. (Exhibit 3A; T. 35, 36, 187, 373)

18(d) A written operative note in the patient's medical record, written by someone other than respondent, simply provides the diagnosis of status avulsion of left ureter during uteroscopy procedure. (Exhibit 3A p. 58; T. 92, 138, 367, 623, 657)

18(e) The progress note, other person's operative note, and the remainder of the hospital record fail to describe the condition of the bladder and the ureter, explain why 24 cm. of ureter was removed, describe the procedure used to correct the torn ureter, state the fact that the stone was removed, and describe the method used to remove the stone. (Exhibit 3A p. 35, 36; T. 89-91, 94, 99, 128-130, 134, 175, 176, 179, 199, 207)

18(f) Respondent knowingly failed to enter in the hospital record for Patient A a description of the condition of the bladder and the ureter, an explanation of why 24 cm. of ureter was removed, a description of the procedure used to correct the torn ureter, and a statement of the fact that the stone

was removed and describing the method used to remove the stone. (T. 89-91, 94, 99, 128-130, 134, 175, 176, 179, 207, 615-618, 620, 641, 642, 654, 658, 659)

18(g) A reasonably prudent physician who had performed the exploratory laparotomy, left nephrostomy, and bladder repair would have entered information in the hospital record describing the condition of the bladder and the ureter, explaining why 24 cm. of ureter was removed, describing the procedure used to correct the torn ureter, and describing the fact that the stone was removed and the method used to remove the stone. (T. 89-91, 99, 358, 426)

18(h) The meager notes in the hospital record for Patient A are confusing and lacking in critical information and they do not help the surgeon and other subsequent treating physicians to be meaningfully informed about the procedures and surgery performed on Patient A by respondent on May 14, 1987. The hospital record for Patient A does not clearly and accurately reveal what

respondent knew to have occurred during each procedure he performed. (T. 90-92, 96, 99, 128-130, 134, 176-180, 184, 187, 194, 197, 198, 200, 201, 204, 205, 207)

18(i) It was respondent's responsibility to assure that an operative note was dictated or written, accurate, and appropriate. (T. 90-92, 94, 99, 140, 426, 427, 668)

18(j) In any event, in a case where there is a serious complication, such as this avulsion, a reasonably prudent surgeon would not delegate writing the note to a resident, but would write a very detailed note himself. (T. 99, 184, 202, 203, 426, 427, 660, 661, 668)

3. The conclusions of the hearing committee and Commissioner of Health be modified;

4. By a preponderance of the evidence, respondent is guilty of the fifth specification to the extent of paragraphs A.3, A.4(a), A.4(b), A.4(c), and A.4(d) for unprofessional conduct regarding record keeping violations involving respondent's knowing (as specifically charged herein although knowingly is not a necessary element of the rule alleged to be violated)

failures to describe, explain, and state in the records specific meaningful information relating to the cystoscopy, ureteroscopy and laparotomy operative procedures performed by respondent, and is not guilty of the remaining paragraphs and specifications; and

5. The measure of discipline recommended by the hearing committee and by the Commissioner of Health not be accepted, and respondent's license to practice as a physician in the State of New York be suspended for one year upon the fifth specification of the charges of which respondent has been found guilty, as aforesaid, that execution of said suspension be stayed, and that respondent be placed on probation for one year under the terms set forth in the exhibit annexed hereto, made a part hereof, and marked as Exhibit "D", which include provision for a random review of respondent's record-keeping.

Respectfully submitted,

EMLYN I. GRIFFITH

JANE M. BOLIN

PATRICK J. PICARIELLO

Chairperson

Dated: 10/31/91

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

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| IN THE MATTER | : | STATEMENT |
| OF | : | OF |
| ROBERT MUCCIOLO, M.D. | : | CHARGES |

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ROBERT MUCCIOLO, M.D., the Respondent, was authorized to practice medicine in New York State on October 30, 1981 by the issuance of license number 148353 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991.

FACTUAL ALLEGATIONS

A. On or about May 13, 1987, at approximately 10:26 a.m., Patient A, a 60 year old female, presented to the emergency room at Lutheran Medical Center, 150 55th Street, Brooklyn, New York, complaining of colicky left flank pain since the previous evening at 11 p.m. (The identity of Patient A is disclosed in the attached Appendix). She had a temperature of 99 degrees and her pulse rate was 76 beats per minute. The physical examination in the emergency room revealed no abdominal pain. A KUB x-ray showed a 5 mm. calcified density along the course of the ureter. Patient A was admitted to the hospital.

EXHIBIT "A"

The following day, May 14th, at approximately 8 a.m, the Respondent performed a urologic consultation on Patient A. He ordered an IVP, IV hydration, antibiotics, and straining of the urine. At or about noon, the IVP was done; it showed a probable 5mm ureteral stone at the L-3 level with obstruction above and with leakage of dye from the kidney. At this time, Patient A's white blood count was not elevated and fever was not noted. At approximately 3 p.m., Respondent performed a cystoscopy and ureteroscopy. While performing the cystoscopy and ureteroscopy, Respondent avulsed the left ureter. In order to repair the avulsion, Respondent thereafter performed an exploratory laparotomy, a left nephrostomy and repair of Patient A's bladder.

1. On or about May 14, 1987, Respondent performed immediate surgery, a cystoscopy and ureteroscopy, on Patient A without sufficient indication of infection, renal damage or long-standing obstruction.

2. Respondent performed the cystoscopy and ureteroscopy of Patient A's left ureter on May 14th with excessive force, avulsing the left

ureter by ripping it away from the bladder or the distal part of the ureter, resulting in the removal of 24 cm. of ureter.

3. Respondent knowingly failed to enter in the hospital record for Patient A descriptions of the nature or cause of the avulsion of the left ureter and/or the damage to the bladder, despite noting "avulsion of the ureter" as the post-operative diagnosis in the hospital record operative note for the cystoscopy and ureteroscopy he performed on May 14th.

4. Respondent knowingly failed to enter in the hospital record an operative note appropriately describing the exploratory laparotomy and left nephrostomy on May 14th, as follows:

   a. Respondent failed to describe the condition of the bladder and the ureter.

   b. Respondent failed to explain why 24 cm. of ureter was removed.

c. Respondent failed to describe the procedure used to correct the torn ureter.

d. Respondent failed to state the fact that the stone was removed and failed to describe the method used to remove the stone.

e. Respondent failed to describe the method used to insert the left nephrostomy tube.

B. On or about July 21, 1987, Patient B, a 64 year old male, was admitted to Lutheran Medical Center, 150 55th Street, Brooklyn, New York, with complaints of nocturia, urinary hesitancy, occasional discomfort urinating, poor stream, and microscopic hematuria. (The identity of Patient B is disclosed in the attached Appendix). Patient B's admitting diagnosis was benign prostatic hyperplasia, a large growth in the prostate. Patient B had a history of gonorrhea in the past. His BUN and creatinine were normal. A sonogram of the kidneys showed kidneys of normal size and position with no evidence of hydronephrosis. There was no evidence of infection. The following day, July 22, 1987, Respondent performed a cystoscopy.

1. Respondent performed immediate surgery on Patient B, i.e. a cystoscopy, without an adequate work-up including less invasive procedures. Such procedures include the following: an IVP with evacuation film; urethral catherterization; a sonogram of the bladder; a voiding urogram; and/or watching the patient urinate.

2. Respondent performed a cystosopy with excessive force, thereby perforating Patient B's urethra, four layers of tissue, and the rectal wall.

3. Respondent knowingly failed to enter in the hospital record an operative note appropriately describing the cystoscopy, as follows:

   a. Respondent failed to describe the attempted cystoscopy procedure.

   b. Respondent failed to detail the instruments used for cystoscopy or dilatation.

c. Respondent failed to explain how he ascertained that the perforation had occurred.

SPECIFICATION OF CHARGES

FIRST ~~THROUGH SECOND~~ SPECIFICATIONS

PRACTICING FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges:

1. The facts in paragraphs A, A.3, A.4(a), A.4(b), A.4(c), A.4(d), and/or A.4(e).

2. The facts in paragraphs B, B.3(a), ~~B.3(b)~~, and/or B.3(c).

2nd 3rd

~~THIRD~~ THROUGH ~~FOURTH~~ SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges:

2. 3. The facts in paragraphs A, A.1., A.2, A.3, A.4(a), and/or A.4(b).

3 4. The facts in paragraph B, B.1., B.2, B.3(a), B.3(b), and/or B.3(c).

Fourth

~~FIFTH~~ SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6509(2)(McKinney 1985), in that Petitioner charges Respondent with having committed at least two of the following:

4 5. The facts in paragraphs A, A.1, A.2, A.3, A.4(a), A.4(b), A.4(c), A.4(d), A.4(e), B, B.1, ~~B.2, B.3(a), B.3(b),~~ and/or B.2. ~~B.3(c).~~

~~SIXTH THORUGH SEVENTH~~ SPECIFICATIONS

FAILING TO MAINTAIN ACCURATE RECORDS

Respondent is charged with unprofessional conduct under N.Y. Educ. Law Section 6509(9)(McKinney 1985), in that he failed to maintain records for patients A and B which accurately reflect his evaluation and treatment of these patient within the meaning of 8 N.Y.C.R.R. 29.2(a)(3)(1987), in that Petitioner charges:

5 6. The facts in paragraph A, A.3, A.4(a), A.4(b), A.4(c), A.4(d), and/or A.4(e).

~~7. The facts in paragraph B, B.3(a), B.3(b), and/or B.3(c).~~

DATED: September 17, 1990
New York, New York

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct

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

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| IN THE MATTER | : | REPORT OF |
| OF | : | THE HEARING |
| ROBERT MUCCIOLO, M.D. | : | COMMITTEE |

TO: The Honorable David Axelrod, M.D.
Commissioner of Health, State of New York

Mr. Kenneth Kowald, Chairperson, Alexander M. DeLaGarza, M.D. and Robert J. Peartree, M.D. 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 Section 230(10)(e) of the Public Health Law. Tyrone T. Butler, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

## SUMMARY OF PROCEEDINGS

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| Service of Notice of Hearing and Statement of Charges: | September 17, 1990 |
| Prehearing conference: | October 9, 1990 |
| Hearing Dates: | October 17, 1990 |
| | November 20, 1990 |
| | December 18, 1990 |
| | January 11, 1991 |

EXHIBIT "B"

Deliberations were held on: January 29, 1991

Place of hearing: 8 East 40th Street
New York, New York

Department of Health
appeared by: Peter J. Millock, Esq.,
General Counsel by
Marcia Kaplan, Esq.
Office of Professional
Medical Conduct
8 East 40th Street
New York, New York

Respondent appeared by: Belair, Klein & Evans
61 Broadway
New York, New York
John T. Evans, Esq.
of Counsel

Witnesses for Department of
Health:

John Coleman, M.D. - Expert Witness

Witnesses for Respondent:

Robert Mucciolo, M.D. - Respondent

Edwin Darracott Vaughan, M.D. - Expert Witness

Petitioner (Department) filed
Proposed Findings of Fact,
Conclusions of Law and Written
Summations on: January 25, 1991

Respondent filed Proposed
Findings of Fact, Conclusions
of Law and Written Summations on: January 25, 1991

On September 17, 1990, the Respondent was served with the Notice of Hearing and Statement of Charges. The Department of Health and the Respondent presented their entire cases and the record was closed on January 11, 1991. On January 29, 1991 the Hearing Committee held deliberations.

## SUMMARY OF CHARGES

In the Statement of Charges (Dept's. Ex. 1 - copy attached), the Respondent, Robert Mucciolo , M.D. was charged with professional misconduct pursuant to Education Law §6509. The specific charges were: practicing the profession fraudulently [Education Law §6509(2)] (First specification), practicing the profession with gross negligence [Education Law §6509(2)] (Second and Third specifications), practicing the profession with negligence on more than one occasion [Education Law §6509(2)] (Fourth specification), and failing to maintain accurate records [Education Law §6509(9), 8 N.Y.C.R.R. 29.2(a)(3)] (Fifth specification).

## FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. The Pre-hearing transcript was not made available to the Hearing Committee at the time of deliberations.

1. Robert Mucciolo, M.D., Respondent, was authorized to engage in the practice of medicine in the State of New York on October 30, 1981, by the issuance of license # 148353, by the State Education Department. (Ex.2)

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1989 through December 31, 1991. (Ex.2)

PATIENT - A

3. On May 13, 1987, Patient A, a 60 year old female presented to the emergency room at Lutheran Medical Center, Brooklyn New York, with complaints of severe pain in her left flank, nausea and vomiting. (Ex. 3A, T. - 29-30, 584-585).

4. X-rays showed an approximately .5 centimeter calcified kidney stone along the course of the ureter at approximately the level of L-3. Patient A was admitted to the hospital. (Exs. 3A, 5K, 5L, 5M, T. - 30-32, 49-52)

5. On May 14, 1987, at approximately 8:00 a.m., Dr. Mucciolo, the Respondent, performed a urological consultation on Patient A. He ordered IV hydration, prophylactic antibiotics and straining of the urine. An IVP was ordered. (Ex. 3A, T. - 33)

6. On or about noon May 14, 1987, an IVP was performed showing a renal stone at the L-3 level with a blockage of the left ureter and extravasation of urine from the kidney. (Exs. 3A, 5A, 5C, 5D, 5E, 5N, 5O, T. - 39-40, 346)

7. A consultation concerning the results of the IVP was conducted among the Respondent; Dr. Caffaro, the admitting doctor and Dr. Nussbacher, the radiologist. (Ex. 3A, T. - 34, 37, 589, 593, 666)

8. Further consultations were held with Dr. Caffaro, Patient A and her daughter. The results of the IVP were explained to the patient and her daughter and various options with regard to treatment of the stone were discussed. Among the options presented to the patient were to wait and see if the stone passed or to attempt to remove the stone by ureteroscopy. The patient consented to ureteroscopy. At approximately 3:00 p.m. on May 14, 1987, the Respondent performed a cystoscopy and ureteroscopy on Patient A. (Ex. 3A, T. - 64, 182, 590, 593, 662-663)

9. At noon on May 14, 1987, Patient A's vital signs were stable, her white blood count was not elevated and she was afebrile. (Ex. 3A, T. 39-40)

10. Prior to the cystoscopy and ureteroscopy, on May 13, 1987, in the emergency room, Patient A's BUN was 27 and her creatinine was 1.3. The next morning, on May 14, 1987, at 6:00 a.m., her BUN was 24 and her creatinine was 1.6. (Ex. 3A, T. - 42-43)

11. A microscopic urinalysis done in the emergency room on May 13, 1987, at 11:13 a.m. showed one to two white blood cells, a full field of red cells and the presence of a moderate number of bacteria. (Ex. 3A, T. - 44-45)

12. The white blood cell count on May 13, 1987, was 9.2. The next morning it was 9.3. (Ex. 3A, T. - 47-48)

13. A cystoscopy is a procedure in which a hollow stainless steel tube is passed through the urethra into the bladder. A lens is passed through the tube; there are working portholes and water running through the tube. A light source illuminates the bladder. The urologist can then pass catheters, guide wires and other instruments through the cystoscope. (T. - 65, 67-68)

back and there are two guide wires still in their position in the ureter. (Exs. 5G, 5J, T. - 76-77, 615-616)

18. Upon removal of the ureteroscope a portion of the ureter was noted to be near the tip of the ureteroscope. The ureteroscopic procedure was terminated and Patient A was transferred to the operating room. An exploratory laparotomy and bladder exploration were performed by the Respondent with the assistance of Dr. Vincent Verderami and two residents Dr. Raju and Dr. Elihu. (Ex. 3A, T. 618-619)

19. An operative note lists the operation as bladder exploration and nephrostomy. The operative note further describes that an oblique incision in the lower left quadrant was performed and describes the procedure to close the wound. The estimated blood loss is listed. Specimens removed during the course of the operation are listed in the operative note and a diagnosis of status post avulsion of the left ureter during ureteroscopy procedure was noted. (Ex. 3A)

20. During the course of the laparotomy the ureter was found to be torn at both the distal and proximal ends. 24 centimeters of ureter was removed with a renal stone were submitted to pathology. (Ex. 3A, T. - 619-620)

21. The pathology report indicates that the specimen was received in two parts: A) the stone, and B) the left ureter, measuring 24 x .05 centimeters. (Ex. 3A, T. 132, 617-620)

22. A dictated operative note for the laparotomy and nephrostomy is not contained in Patient A's medical chart. (Ex. 3A)

23. A reasonably prudent physician knows that it is his responsibility to enter an operative report into the record containing information which describes accurately and

14. A ureteroscopy is a procedure in which a ureteroscope is passed into the bladder, into and up the ureter to the intramural tunnel where the ureter runs through the bladder wall, and then is advanced up the ureter to reach the location of interest. A ureteroscope is a rigid instrument between two and four feet long, its diameter ranges from about 12 millimeters down to about 7.5 millimeters. It has a narrow channel to allow the urologist to see. The ureteroscope has the same idea of light and water flowing through as does the cystoscope. (T. - 65-69)

15 The Respondent began the cystoscopy by passing the cystoscope into the bladder. He then located the opening of the left ureter into the bladder. He was using a portable X-ray machine that allowed him to follow the progress and the final location of the guide wire. During the course of the procedure two guide wires were placed in the ureter up to the kidney. The purpose of the guide wires was to allow the Respondent to guide the scope in the ureter. (Exs. 3A, 5F, 5G, T. - 71-73, 165-166, 356)

16. The Respondent used a balloon catheter to dilate the ureter where it passes through the bladder wall, then he removed the balloon catheter. He then passed the ureteroscope into the bladder, through the intramural portion of the ureter and up the ureter. He proceeded up the ureter using the guide wires to the level of the third and fourth lumbar vertebrae. He continued to follow the guide wires with the ureteroscope up to the level of the kidney. The guide wires remained in place throughout the course of the ureteroscopy procedure. (Exs. 3A, 5G, 5H, T. - 73-76, 166, 352, 389)

17. When the stone was not visualized by the ureteroscope at the level of the kidney the Respondent commenced to withdraw the ureteroscope. An X-ray shows that the scope has been pulled

appropriately the nature of his treatment of the patient during an operative procedure. (T. - 86-89)

CONCLUSIONS - PATIENT A

The Committee finds that the Respondent did not , in fact, dictate a detailed operative report for the laparotomy performed on Patient A. However, a review of the hospital records demonstrate numerous handwritten notes describing the cystoscopy, ureteroscopy, with its attendant complications, and the laparotomy.

The Committee concludes, therefore, that the fact that the Respondent made these entries does not indicate a knowing failure, by the Respondent, to intentionally misrepresent or conceal the facts of the procedures that he performed on Patient A. We also conclude that the aforementioned records do accurately reflect the Respondent's care and treatment of Patient A.

We conclude that the Respondent did not practice fraudulently or fail to maintain records accurately reflecting his evaluation and treatment of Patient A as charged by the Department. A reasonable examination of the hospital charts reveals the Respondent's diagnosis and all of the operative procedures performed, by him, on Patient A.

The Committee finds that in his care and treatment of Patient A, the Respondent exercised ordinary care. The performance of a cystoscopy and ureteroscopy on Patient A on May 14, 1987, was an appropriate procedure to relieve the pain, vomiting and the obstruction from the underlying stone disease.

The risks of ureteroscopy include many serious complications. It is conceded, and we agree, that the chances of the stone passing on its own were at least 50%, surgical intervention, therefore, surgical intervention was a reasonable

alternative and did not constitute gross negligence by the Respondent. The state's witness testified (T. 117) that:"...Ureteroscopy is an appropriate way to do it [remove the stone] realizing the increased risks...". The record reflects that the Respondent in consultation, with the patient's internist, discussed with Patient A and her family the pathology and the procedure to be performed.

The Committee concludes, based upon the credible evidence in the record, that the Respondent's care and treatment of Patient A did not constitute a deviation from reasonable and prudent medical practice and does not demonstrate simple negligence on this occasion.

ATIENT B

24. On July 17, 1987, Patient B, a 64 year old man presented to Dr. Mucciolo's office with complaints of frequency, urgency, poor stream and hematuria. The office records indicate that Patient B had been referred from a prior medical clinic for an evaluation by a urologist with regard to complaints of bladder outlet obstruction, frequency, urgency and poor stream. Physical examination revealed a hard, symmetrical and non tender prostate. The patient was observed to urinate. A prior history of gonorrhea and perirectal abscess was noted. (Ex. 7, T. - 215, 220-221, 256, 514, 518)

25. There was a discussion with Patient B and a family member concerning his symptoms and the Respondent's diagnosis. An initial diagnosis of benign prostatic hypertrophy was made. A course of treatment was discussed with Patient B including the performance of cystoscopy. Following a discussion of the cystoscopy and possible TURP the patient consented to undergo the procedure. (Ex. 6, 7, T. - 221, 223, 514, 516, 518)

26. Patient B was admitted to Lutheran Medical Center, Brooklyn, New York, on July 21, 1987, with complaints of nocturia, urinary hesitancy, occasional discomfort urinating, poor stream and microscopic hematuria. (Ex. 6)

27. Upon admission Patient B had the necessary laboratory workup leading to a TUR (Transureteral Resection). (T. - 519)

28. Patient B was examined by an internist, Dr. Cammerano, on July 22, 1987, who medically cleared him for surgery. (Ex. 6)

29. Cystoscopy and possible TURP began at, approximately, 1:00 p.m., July 22, 1987, there being that there were no contraindications for the cystoscopy procedure. (Ex. 6, T. - 435)

30. A cystoscopy is a diagnostic test in which the instrument is passed into the urethra to allow investigation of the lower urinary tract including the urethra, prostate and bladder. (T. - 225)

31. During the course of the cystoscopy, a stricture of the urethra was encountered. The presence of a stricture changes a simple cystoscopy into a difficult cystoscopy. The surgeon has to be careful when doing a cystoscopy, and he has to be more careful when he finds a stricture. (Ex. 6, T. - 241-243, 322-324)

32. When strictures are encountered the accepted practice is to try and dilate the stricture. This can be accomplished with filliforms, followers and sounds. (T. - 441-442)

33. During the course of the cystoscopy procedure, on Patient B, the urethra was perforated and the rectum was also perforated with either a filliform, follower or sound. (Ex. 6, T. - 447)

34. The distance between the urethra and the rectum at the bulbar urethra is less than one centimeter. (T. - 448-449)

35. When the texture of a stricture is firm the surgeon must use some element of force to negotiate the scarring. (T. - 478)

36. In his attempted negotiation of the stricture, the Respondent perforated the urethral-rectal septum. The perforation of the rectum was promptly recognized and corrected. (Ex. 6)

CONCLUSIONS - PATIENT B

The Committee finds that although the Respondent performed surgery on Patient B on July 22, 1987, approximately five days after his first examination of this patient, Patient B had been referred by another physician for urological evaluation. We find that Patient B had an appropriate pre-operative evaluation. The State's expert witness stated (T. - 269) that in his opinion the indications for cystoscopy on Patient B were appropriate.

Therefore, we conclude that the Respondent acted prudently and reasonably in recommending and performing a cystoscopy on Patient B, on July 22, 1987.

The State charges the Respondent with the use of excessive force resulting in the perforation of the urethral-rectal septum of Patient B. However, the evidence indicates that necessary force is mandated in a cystoscopy when a urethral stricture is encountered. The presence of a stricture changes a simple cystoscopy into a difficult cystoscopy. The perforation of the urethra is a well recognized complication of the procedure (T. - 455). Therefore, the Committee finds that the Respondent did not act with gross negligence or simple negligence in his care and treatment of Patient B.

## CONCLUSIONS - GENERAL

In light of the above discussion of the Committee's: Findings of Fact and Conclusions, re: Patients A and B, we conclude that the Respondent, Robert Mucciolo, M.D., did not act with either gross negligence or simple negligence in his care and treatment of Patients A and B. In addition, the Committee concludes that the Respondent did not practice the profession fraudulently or fail to maintain accurate records of his care and treatment of Patient A.

## RECOMMENDATIONS

The Committee recommends that the charges as noted in the Statement of Charges (Ex. 1) be dismissed.

DATED: New York, N.Y.
February 7, 1991

Respectfully submitted

Mr. Kenneth Kowald
Chairperson
Alexander M. DeLaGarza, M.D.
Robert J. Peartree, M.D.

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

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IN THE MATTER :

OF :

ROBERT MUCCIOLO, M.D. :

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COMMISSIONER'S

RECOMMENDATION

TO: Board of Regents
New York State Education Department
State Education Building
Albany, New York

A hearing in the above-entitled proceeding was held on October 17, 1990, November 20, 1990, December 18, 1990 and January 11, 1991. Respondent, Robert Mucciolo, M.D. appeared by John T. Evans, Esq. The evidence in support of the charges against the Respondent was presented by Marcia Kaplan, Esq., Office of Professional Medical Conduct.

NOW, on reading and filing the transcript of the hearing, the exhibits and other evidence, and the findings, conclusions and recommendation of the Committee,

I hereby make the following recommendation to the Board of Regents:

A. The Findings of Fact and Conclusions of the Committee should be accepted in full except as follows:

Patient A

In addition to the Findings of Fact of the Committee I make the following findings:

a. The calcified kidney stone found in Patient A [illegible] by x-ray was a small stone (Tr. [illegible]

EXHIBIT [illegible]

b. Patient A was in no acute danger of a life-threatening event on May 14, 1987. Patient A was suffering no systemic reaction or other evidence of infection on May 14, 1987 (Pet. 3A, pp. 18, 51; Tr. 35-36).

c. The extravasation of the diagnostic dye administered to Patient A is not unusual and is not an indication for immediate action (Tr. 97-98, 113-118, 347).

d. Uteroscopy is a complicated procedure (Tr. 68-69, 117, 349).

e. Respondent had a limited experience with uteroscopy having performed only 12 or 13 such procedures previously including those procedures done while he was a resident (Tr. 598-599).

f. Respondent used excessive force in passing the uteroscope (Exh. 3A, p. 114; Tr. 83, 93, 96-97, 99, 121-122, 174, 178-179, 205, 207).

g. Respondent's uteroscopy involving Patient A had disastrous results leading ultimately to the loss of a kidney.

h. The reasonable regimen in the case of Patient A would be hydration and waiting to determine the movement of the stone (Tr. 60, 62, 157-60).

In lieu of the Conclusions of the Committee, I conclude that Respondent failed to exercise ordinary care in the treatment of Patient A and would sustain the Forth Specification as based on the facts alleged in Paragraphs A, A.1 and A.2 of the Statement of Charges. Respondent failed to proceed conservatively. He used a difficult procedure for which he was minimally trained. He used excessive force in passing the uteroscope. In sum, he exercise poor judgment and substandard skill.

Patient B

In addition to the Findings of Fact of the Committee, I make the following findings:

i. Patient B's history of gonorrhea is significant in that people who have had gonorrhea are more likely to develop scarring

or strictures of the urethra than the normal patient (Tr. 223, 226-228), 458).

j. Respondent used excessive force with the whip and follower during the cystoscopy and perforated Patient B's urethra, multiple layers of tissue between the urethra and the bladder and the rectal wall (Pet. 6, pp. 12, 49; Tr. 243-244, 250-252)

In lieu of the Conclusions of the Committee, I conclude that Respondent failed to exercise ordinary care in the treatment of Patient B and would sustain the Fourth Specification as based on the facts alleged in Paragraphs B and B.2 of the Statement of Charges. Respondent again demonstrated poor judgement and substandard skills in the management of Patient B's stricture.

B. The Recommendation of the Committee should be rejected and, in lieu thereof, Respondent's license to practice medicine should be suspended for two years and that suspension stayed provided that, during the period of stayed suspension, Respondent consult with a board certified urologist approved by the Office of Professional Medical Conduct in every case involving a urologic procedure.

C. The Board of Regents should issue an order adopting and incorporating the Findings of Fact and Conclusions and further adopting as its determination the Recommendation described above.

The entire record of the within proceeding is transmitted with this Recommendation.

DATED: Albany, New York
April 23, 1991

Alfred Gellhorn

ALFRED GELLHORN, M.D.
Director of Medical Affairs
New York State Department of Health

EXHIBIT "D"

TERMS OF PROBATION
OF THE REGENTS REVIEW COMMITTEE

ROBERT MUCCIOLO

CALENDAR NO. 12011

1. That respondent shall make quarterly visits to an employee of and selected by the Office of Professional Medical Conduct of the New York State Department of Health, unless said employee agrees otherwise as to said visits, for the purpose of determining whether respondent is in compliance with the following:

   a. That respondent, during the period of probation, shall be in compliance with the standards of conduct prescribed by the law governing respondent's profession;

   b. That respondent shall submit written notification to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Albany, NY 12234 of any employment and/or practice, respondent's residence, telephone number, or mailing address, and of any change in respondent's employment, practice, residence, telephone number, or mailing address within or without the State of New York;

   c. That respondent shall submit written proof from the Division of Professional Licensing Services (DPLS), New York State Education Department (NYSED), that respondent has paid all registration fees due and owing to the NYSED and respondent shall cooperate with and submit whatever papers are requested by DPLS in regard to said registration fees, said proof from DPLS to be submitted by respondent to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, no later than the first three months of the period of probation; and

   d. That respondent shall submit written proof to the New York State Department of Health, addressed to the Director, Office of Professional Medical Conduct, as aforesaid, that 1) respondent is currently registered with the NYSED, unless respondent submits written proof to the New York State Department of Health, that respondent has

advised DPLS, NYSED, that respondent is not engaging in the practice of respondent's profession in the State of New York and does not desire to register, and that 2) respondent has paid any fines which may have previously been imposed upon respondent by the Board of Regents; said proof of the above to be submitted no later than the first two months of the period of probation;

2. That respondent shall be subject to random selections of respondent's patient records, office records, and hospital charts to review respondent's professional performance;

3. If the Director of the Office of Professional Medical Conduct determines that respondent may have violated probation, the Department of Health may initiate a violation of probation proceeding and/or such other proceedings pursuant to the Public Health Law, Education Law, and/or Rules of the Board of Regents.

**ORDER OF THE DEPUTY COMMISSIONER FOR THE PROFESSIONS OF THE STATE OF NEW YORK**

**ROBERT MUCCIOLO**

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**CALENDAR NO. 12011**

The University of the State of New York

IN THE MATTER

OF

**ROBERT MUCCIOLO**
(Physician)

**DUPLICATE ORIGINAL VOTE AND ORDER NO. 12011**

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 12011, and in accordance with the provisions of Title VIII of the Education Law, it was

**VOTED (November 15, 1991):** That, in the matter of ROBERT MUCCIOLO, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Commissioner of Health as to those findings of fact be accepted; and the recommendation of the Commissioner of Health as to his additional findings of fact not be accepted;
2. The following additional findings of fact be accepted:

   17(a) An operative note signed by respondent for the May 14, 1987 cystoscopy and ureteroscopy performed by respondent on Patient A provides the general post-operative diagnosis of avulsion of left ureter. Said note indicates that the mucosa from the ureter was easily identified on the distal tip of the ureteroscope. (Exhibit 3A p. 59; T. 84, 393)

17(b) The portion of said note regarding the mucosa from the ureter was, as respondent admitted, not accurate. In fact, respondent identified ureter and not mucosa wrapped around the tip of the ureteroscope. (T. 95, 96, 174-180, 206, 207, 363, 393, 394, 404-406, 617, 618, 636, 640)

17(c) The cystoscopy and uteroscopy operative note indicates that the ureteroscope was passed with no unusual difficulty. This is also not accurate. (Exhibit 3A p. 59; T. 73-79, 83, 95, 96, 174-180, 617, 618, 640-642, 654)

17(d) An x-ray taken during the procedures shows that the ureteroscope had passed approximately an inch above the point where the ureter curves to go into the kidney and become the renal pelvis. He knew that he was past the point where he should have visualized the stone. During the ureteroscopy procedure, respondent was "in trouble". (T. 73-79, 87, 174-180, 206, 207, 617, 618, 640-642, 654)

17(e) Respondent observed the ureter when he was looking on the outside of the ureteroscope. During the ureteroscopy, it was respondent's impression that there was an avulsion of the ureter and he could see by touching the ureter that indeed it was on the tip of the uteroscope. (T. 617, 618, 640-642)

17(f) A handwritten progress note indicates that there had been an avulsion of the ureter and that there was a plan to do a laparotomy for repair of the avulsion. (Exhibit 3A p. 19)

17(g) The operative note, the progress note, and the remainder of the hospital record fail to describe the nature or cause of the avulsion of the left ureter and the damage to the bladder. (T. 86-89, 92, 99, 122, 203, 426)

17(h) Respondent knowingly failed to enter in the hospital record for Patient A a description of the nature or cause of the avulsion of the left ureter and a description of the damage to the bladder. (T. 86-89, 99, 122, 174-180, 203, 426)

17(i) A reasonably prudent physician knows that it is his responsibility to enter into the record an operative report which reflects accurately and appropriately the nature of his treatment of the patient during an operative procedure. (T. 86-89, 99, 179, 180, 203)

17(j) A reasonably prudent physician who had performed the cystoscopy and uteroscopy and who recognized that there was a complication during the operation would have entered meaningful information in the hospital record describing the nature or cause of the avulsion and of the damage to the bladder. (T. 86-89, 97, 174-180, 203, 351, 358)

17(k) It is important for the surgeon and for other subsequent treating physicians to have as accurate and specific a description in the record as possible of the nature or cause of the avulsion and the resulting damage so that information is available in the event of any subsequent problem or procedure, whether related or new. (T. 86-89, 99, 174-180, 203, 351, 358)

17(l) Subsequent treating physicians would not be able to tell precisely what occurred from reading respondent's entries in the hospital record. The hospital record does not accurately and appropriately reflect respondent's treatment of Patient A during the ureteroscopy. (T. 86-89, 99, 174-180, 203, 351, 358, 404-406, 426)

18(a) Due to the avulsion, respondent performed on Patient A an exploratory laparotomy, left nephrostomy, and bladder repair. (Exhibit 3A p. 58; T. 137, 660)

18(b) Respondent failed to prepare <u>any</u> dictated operative note for the exploratory laparotomy, left nephrostomy, and bladder repair, and no dictated operative note was prepared by anyone for this procedure. (T. 89-91, 128, 129, 207, 369, 623, 624, 626)

18(c) Respondent did write a progress note on May 21, 1987. That progress note is not an appropriate substitute for a formal operative note and does not provide

sufficient information about the operation. (Exhibit 3A; T. 35, 36, 187, 373)

18(d) A written operative note in the patient's medical record, written by someone other than respondent, simply provides the diagnosis of status avulsion of left ureter during uteroscopy procedure. (Exhibit 3A p. 58; T. 92, 138, 367, 623, 657)

18(e) The progress note, other person's operative note, and the remainder of the hospital record fail to describe the condition of the bladder and the ureter, explain why 24 cm. of ureter was removed, describe the procedure used to correct the torn ureter, state the fact that the stone was removed, and describe the method used to remove the stone. (Exhibit 3A p. 35, 36; T. 89-91, 94, 99, 128-130, 134, 175, 176, 179, 199, 207)

18(f) Respondent knowingly failed to enter in the hospital record for Patient A a description of the condition of the bladder and the ureter, an explanation of why 24 cm. of ureter was removed, a description of the procedure used to correct the torn ureter, and a statement of the fact that the stone was removed and describing the method used to remove the stone. (T. 89-91, 94, 99, 128-130, 134, 175, 176, 179, 207, 615-618, 620, 641, 642, 654, 658, 659)

18(g) A reasonably prudent physician who had performed the exploratory laparotomy, left

nephrostomy, and bladder repair would have entered information in the hospital record describing the condition of the bladder and the ureter, explaining why 24 cm. of ureter was removed, describing the procedure used to correct the torn ureter, and describing the fact that the stone was removed and the method used to remove the stone. (T. 89-91, 99, 358, 426)

18(h) The meager notes in the hospital record for Patient A are confusing and lacking in critical information and they do not help the surgeon and other subsequent treating physicians to be meaningfully informed about the procedures and surgery performed on Patient A by respondent on May 14, 1987. The hospital record for Patient A does not clearly and accurately reveal what respondent knew to have occurred during each procedure he performed. (T. 90-92, 96, 99, 128-130, 134, 176-180, 184, 187, 194, 197, 198, 200, 201, 204, 205, 207)

18(i) It was respondent's responsibility to assure that an operative note was dictated or written, accurate, and appropriate. (T. 90-92, 94, 99, 140, 426, 427, 668)

18(j) In any event, in a case where there is a serious complication, such as this avulsion, a reasonably prudent surgeon would not delegate writing the note to a resident, but would write a very detailed note himself. (T. 99, 184, 202, 203, 426, 427, 660, 661, 668)

3. The conclusions of the hearing committee and Commissioner of Health be modified;

4. By a preponderance of the evidence, respondent is guilty of the fifth specification to the extent of paragraphs A.3, A.4(a), A.4(b), A.4(c), and A.4(d) for unprofessional conduct regarding record keeping violations involving respondent's knowing (as specifically charged herein although knowingly is not a necessary element of the rule alleged to be violated) failures to describe, explain, and state in the records specific meaningful information relating to the cystoscopy, ureteroscopy and laparotomy operative procedures performed by respondent, and is not guilty of the remaining paragraphs and specifications; and

5. The measure of discipline recommended by the hearing committee and by the Commissioner of Health not be accepted, and respondent's license to practice as a physician in the State of New York be suspended for one year upon the fifth specification of the charges of which respondent has been found guilty, as aforesaid, that execution of said suspension be stayed, and that respondent be placed on probation for one year in accordance with the terms prescribed by the Regents Review Committee, which include provision for a random review of respondent's record-keeping;

and that the Deputy Commissioner for the Professions be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

**and it is**

**ORDERED**: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted and **SO ORDERED**, and it is further

**ORDERED** that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Henry A. Fernandez, Deputy Commissioner for the Professions of the State of New York, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand, at the City of Albany, this 15th day of NOVEMBER, 1991.

Deputy Commissioner for the Professions