STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

July 22, 2008

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Terrence Sheehan, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Diego Diaz, M.D.
Redacted Address

Anthony Z. Scher, Esq.
Wood & Scher
222 Bloomingdale Road – Suite 311
White Plains, New York 10605

RE: In the Matter of Diego A. Diaz, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 08-128) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

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

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER	:	DETERMINATION
	:	
OF	:	AND
	:	
DIEGO A. DIAZ, M.D.	:	ORDER
		BPMC #08-128

COPY

A Notice of Hearing and Statement of Charges, both dated April 4, 2008, were served upon **DIEGO A. DIAZ, M.D.**, Respondent. **FRANK E. IAQUINTA, M.D.**, Chairperson, **PAUL F. TWIST, D.O.**, and **CONSTANCE DIAMOND, D.A.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **WILLIAM J. LYNCH, ESQ., ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer.

The Department of Health ("the Department") appeared by THOMAS CONWAY, General Counsel, by **TERRENCE SHEEHAN, ESQ.**, of Counsel. The Respondent appeared by WOOD & SCHER, ESQS., **ANTHONY Z. SCHER, ESQ.**, of Counsel. Evidence was received and witnesses sworn and heard, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Date of Service:	April 8, 2008
Answer Filed:	April 15, 2008
Pre-Hearing Conference:	April 21, 2008
Hearing Date:	April 29, 2008
Witnesses for Petitioner:	John Pellicone, M.D.
Witnesses for Respondent:	Diego A. Diaz, M.D. Angelo Acquista, M.D. Nevber Cemaletin, M.D. Stephen Joseph Huot, M.D.
Receipt of Submissions:	May 29, 2008
Deliberation Held:	June 16, 2008

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter "P.H.L."]).

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

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

FINDINGS OF FACT

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

1. Diego A. Diaz, M.D., the Respondent, was authorized to practice medicine in New York State on July 9, 1998, by the issuance of license number 211166 (Ex. 5).

2. Patient A was a relative of Respondent's medical partner (T. 126, 134-135, 152).

3. At his medical partner's request, Respondent began treating Patient A's asthma in approximately 2002. Eventually, he became her primary care physician (T. 126-127).

4. On March 22 2005, Patient A had a colonoscopy performed which revealed that she had an apple core lesion in the proximal rectum. A biopsy showed that the mass was adenocarcinoma (Ex. 2, pp. 83-87; T. 128-131).

5. Late in the afternoon on Friday, March 31, 2005, Patient A went to Respondent's office for an appointment and brought copies of the colonoscopy and pathology reports with her (Ex. 2, pp. 84-87; T. 128-131). Copies of these reports had been faxed to Respondent's office and were already in Patient A's medical file (T. 130).

6. The top page of the colonoscopy report, as the document was handed to Respondent by Patient A, included a schematic diagram of the colon (T. 134, 182-183; Ex. 2, p. 84).

7. The schematic diagram includes a black circle in the area of the cecum (T. 80-81; Ex. 2, p. 84).

8. Respondent assumed the black circle was the location of the cancer (T. 135).

9. Typewritten immediately below the schematic diagram were the words:

> 1. There is a 3 to 4 cm, nonobstructive apple core lesio (sic)
>
> 2. caput cecum (Ex. 2, p. 84).

10. Respondent misread these lines as diagnosing a cecal carcinoma (T. 134-137, 145).

11. Respondent failed to completely read the colonoscopy report and the pathology report which both indicate that Patient A had a rectal carcinoma (T. 137, 149-150, 153; Ex. 2, pp. 84-88).

12. The black circle on the schematic in the colonoscopy report did not represent the location of the cancer; it represented an anatomical landmark, the ileocecal valve (Ex. 2, p. 84).

13. On March 31, 2005, based on his mistaken assumption that Patient A had a cecal carcinoma, Respondent referred Patient A to a surgeon, Domingo Nunez, M.D., for treatment of colon cancer and obtained insurance approval for a CT scan (T. 137-138).

14. In his March 31, 2005 office note, Respondent wrote "CT scan" in error when he intended to write "colonoscopy" (Ex. 2, p. 20; T. 33).

15. Respondent inaccurately wrote in Patient A's medical chart on March 31, 2005, that the "biopsy was consistent with adenocarcinoma of the colon" (Ex. 2, p. 20; T. 33).

16. On April 1, 2005, a CT scan ordered by Respondent was performed at Lenox Hill Hospital. The report containing the results of the CT scan indicates that the admitting diagnosis was malignant neoplasm of the rectosigmoid, but that the reason was colon cancer

(Ex 3, p. 76).

17. The CT scan report stated that there was increased soft tissue attenuation material seen in the region of the ileocecal valve and the proximal ascending colon, but it did not confirm the existence of a cecal carcinoma (Ex. 3, p. 76; T. 55-57)

18. On April 3, 2005, Patient A went to the hospital emergency room with nausea and vomiting. Respondent told Dr. Dawson, a partner of Dr. Nunez, that Patient A had cancer of the cecum and recommended admitting the patient to the hospital to get her ready for a surgery which was expected to be performed that week (T. 140-141, 146-147).

19. On April 4, 2005, Respondent provided a consultation for Patient A who had been admitted to the hospital. In his consultation report, Respondent wrote that the patient had an apple core lesion of the cecum and that a biopsy indicated adenocarcinoma (Ex. 3, p. 59; T. 147-150).

20. On April 5, 2005, Respondent wrote in Patient A's hospital record that the patient had colon cancer and that he had reviewed the CT scan of her abdomen and pelvis (Ex 3, p. 25; T. 63).

21. On April 6, 2005, the surgeon initially removed a portion of Patient A's colon. No lesion was found upon opening the specimen and a complete examination of the remaining intraabdominal colon showed no palpable tumor mass (Ex. 3; p. 40, T. 70).

22. At that point, the surgeon obtained a copy of the

outpatient colonoscopy report which diagnosed the patient with a tumor of the proximal rectum, not the cecum. After obtaining consent from the Patient's spouse, the surgeon proceeded with resection of the rectal lesion (Ex. 3, pp. 40-45; T. 70).

23. The surgery took 12 hours to complete. Upon transferring Patient A to a stretcher, she developed significant wheezing, cessation of breathing, and then a cardiopulmonary arrest leading to her demise (Ex 3, pp. 40-45; T. 70).

24. Respondent's care of Patient A did not comport with minimally acceptable standards of medical practice (Ex. 2, pp. 20, 83-87, Ex. 3, pp. 25, 59; T. 77, 145-147).

25. The medical record that Respondent maintained for Patient A did not meet minimally accepted standards (Ex. 2, pp. 20, 83-87, Ex. 3, pp. 25, 59; T. 77, 145-147).

CONCLUSIONS OF LAW

Respondent is charged with three specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum

prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law" includes suggested definitions for gross negligence and negligence.

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

Negligence is the failure to exercise the care that a reasonably prudent physician would exercise under the circumstances. It involves a deviation from acceptable standards in the treatment of patients. Bogdan v. Med. Conduct Bd., 195 A. D. 2d 86, 88-89 (3rd Dept. 1993). Injury, damages, proximate cause, and foreseeable risk of injury are not essential elements in a medical disciplinary proceeding. Id.

Gross Negligence may consist of a single act of negligence of egregious proportions, or multiple acts of negligence that cumulatively amount to egregious conduct. Multiple acts of negligence occurring during one event can amount to gross negligence on a particular occasion. Rho v. Ambach, 74 N.Y.2d 318, 322 (1991). While some courts have referred to gross negligence as negligence which is "egregious" or "conspicuously bad," it is clear that articulation of these words is not necessary to establish gross negligence. There is adequate proof of gross negligence if it is established that the physician's errors represent a significant or

serious deviation from acceptable medical standards that creates the risk of potentially grave consequence to the patient. Post v. New York State Department of Health, 245 A.D. 2d 985, 986 (3rd Dept. 1997); Minielly v. Commissioner of Health, 222 A.D. 2d 750, 751-752 (3rd Dept. 1995). A finding of gross negligence does not require a showing that a physician was conscious of impending dangerous consequences of his or her conduct.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

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

The Department presented testimony by John Pellicone, M.D. Dr. Pellicone opened a practice is pulmonary and critical care medicine in 1986. In 1989, he joined the staff of Helen Hayes Hospital and Columbia University as director of the special care unit. Five years ago, he was named the Medical Director, Chief of Medicine and the Director of the ICU at Nyack Hospital, and he subsequently became the Medical Director at Helen Hayes Hospital as well. Last year, he retired from the Nyack hospital position, but he

has maintained his Medical Director position at Helen Hayes Hospital and a private pulmonary and critical care practice. Dr. Pellicone has no stake in the outcome of this case, and he testified in a direct and forthright manner. The Hearing Committee found that Dr. Pellicone's testimony was credible.

Respondent offered the testimony of three character witnesses. Angelo Acquista, M.D., a partner in Respondent's medical practice testified that Respondent was a man of integrity, who was trustworthy and held in high esteem. Nevber Cemaletin, M.D., testified that Respondent is one of the brightest, most compassionate, endearing, and well respected physicians she has worked with. Stephen Joseph Huot, M.D., a professor of medicine at Yale, was the Resident's Program Director when Respondent was the Chief Medical Resident. Dr. Huot testified that he holds Respondent in high regard as a person and as a physician. Each of these witnesses testified in a forthright manner, and the Hearing Committee gave great weight to their testimony regarding Respondent's character.

Respondent testified himself regarding his actions. His testimony was forthright and direct. His demeanor was serious and thoughtful. He acknowledged his mistake in Patient A's care and showed deep remorse for his actions. The Hearing Committee found his testimony credible.

Respondent acknowledged that he made an error when he failed to read the colonoscopy and pathology reports, but contended that he committed only one act of negligence because his other mistakes were an outgrowth of his initial error. While it is true that Respondent's subsequent conduct during Patient A's hospitalization was an outgrowth of his initial negligent act which occurred during the office visit, the Hearing Committee finds that his care of Patient A during her hospitalization constituted a separate occasion of negligence. This conduct occurred in a distinct place and at a distinct time providing the Respondent with an opportunity to correct his failure to review the colonoscopy and pathology reports.

The factual allegations in the Statement of Charges allege that Respondent failed to record a complete an accurate Patient history in his office chart and the Patient's chart at Lenox Hill Hospital. At the hearing, Respondent admitted that he was negligent when he failed to read the colonoscopy and pathology reports in the office on March 31, 2005. Respondent's explanation for this negligence included his concern for a patient with whom he had a close relationship and his desire to expedite the authorization for a CT scan late on a Friday afternoon. Particularly in light of the emotional and time-pressured circumstances of this office visit,

however, Respondent had an obligation to accurately ascertain the results shown in the colonoscopy report when providing care during Patient A's hospitalization commencing on April 3, 2005.

Regarding Patient A's hospitalization, Respondent admitted that he was partially responsible for the fact that the colonoscopy report did not become a part of Patient A's hospital medical record before the surgery (T. 187). In addition, the reference to an admitting diagnosis of malignant neoplasm of the rectosigmoid on the CT scan report as well as the fact that the report did not confirm the existence of cecal carcinoma were two additional factors that should have alerted Respondent of a need to review the colonoscopy report which he had received in his office. Instead, Respondent made two entries in the hospital record repeating his incorrect assumption regarding Patient A's diagnosis. Accordingly, the Hearing Committee finds that Respondent's negligence during Patient A's hospitalization constitutes a second occasion of negligence within the meaning of §6530(3) of the Education Law.

Petitioner alleged that Respondent should be held to a higher standard of care because he was dealing with a life-threatening condition. Petitioner also contended that Respondent was reckless when he failed to review the documents that he had received and when he failed to ensure that the surgeon had an opportunity to review those documents prior to the surgery. The Hearing Committee

does find that Respondent's conduct was negligent; however, it rejects Petitioner's contention that these factors elevate Respondent's conduct from ordinary to gross negligence. Although Respondent committed a careless error, the Hearing Committee did not feel that his conduct was egregious.

Regarding the Statement of Charges in this matter, the Hearing Committee did not find evidence in the record to sustain four of the factual allegations. Since the record does not establish that Respondent informed Patient A that she had colon cancer or that Respondent spoke only with Dr. Dawson, the Committee found no basis to sustain allegations A - A.4, A - A.5, or A - A.6. The Hearing Committee also found that allegations A - A.1 and A - A.9 were redundant in part and that A - A.9 was not established in part because there was no evidence regarding a recommended medical procedure. As such, the Committee did not sustain allegation A - A.9.

Respondent argued that the specifications pertaining to the Respondent's medical record of Patient A should not be sustained because the record does accurately state his evaluation of the patient, albeit incorrectly because he had not read the reports in her record. The Hearing Committee considered and rejected this argument. Respondent had in his possession documents containing an evaluation of Patient A which clearly indicated that she had rectal

cancer. Accordingly, the Hearing Committee finds that Respondent failed to maintain a record which accurately reflects the evaluation of the patient. The Committee, however, felt that only one specification of failing to maintain a patient record should be sustained.

Factual Allegations

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

Paragraph A - A.1	Sustained (3-0)
Paragraph A - A.2	Sustained (3-0)
Paragraph A - A.3	Sustained (3-0)
Paragraph A - A.4	Not Sustained
Paragraph A - A.5	Not Sustained
Paragraph A - A.6	Not Sustained
Paragraph A - A.7	Sustained (3-0)
Paragraph A - A.8	Sustained (3-0)
Paragraph A - A.9	Not Sustained

Specifications

The First Specification charged Respondent with practicing with gross negligence on a particular occasion, in violation of New York Education Law §6530(4). As discussed in detail above, the Hearing Committee found Respondent's treatment of Patients A did not

constitute gross negligence. By a unanimous vote, the First Specification is **Dismissed.**

The Second Specification charged Respondent with practicing with negligence on more than one occasion within the meaning of New York Education Law §6530(3). As discussed in detail above, the Hearing Committee determined that the Respondent was negligent in his care of Patient A during the March 31, 2005 office visit and during her April 2005 hospitalization. As a result, the Second Specification is **Sustained.**

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

DETERMINATION AS TO PENALTY

Petitioner recommended that Respondent's license be suspended for a significant period of time, at a minimum several months, followed by at least three years of practice monitoring. While the Hearing Committee believes that the conduct committed

warrants a penalty such as the suspension of a license, it feels that no actual period of suspension or practice monitoring is required in light of the facts and circumstances of this case. The Hearing Committee believes that Respondent's intentions were good and that he wanted the best outcome for Patient A in the quickest time possible. With apparent sincerity, Respondent expressed regret that his careless haste had produced such a tragic outcome for a patient he cared for. Respondent credibly testified that he now carefully and repeatedly reviews documents to prevent the recurrence of such an error. Based upon his own forthright testimony and the credible testimony of his character witnesses, the Hearing Committee is convinced that Respondent is an honest and good practitioner who is not likely to repeat his misconduct. As such, the Hearing Committee sees no reason to prevent Respondent from practicing medicine or to monitor his practice, and it therefore imposes a fully stayed one-year suspension of Respondent's license. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

ORDER

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

1. The Second and Third Specifications of professional misconduct, as set forth in the Statement of Charges are **SUSTAINED;**

2. The First, Fourth and Fifth Specifications of professional misconduct, as set forth in the Statement of Charges are **DISMISSED;**

3. Respondent's license to practice medicine as a physician in New York State is hereby **SUSPENDED FOR A PERIOD OF ONE YEAR; HOWEVER, THE SUSPENSION IS STAYED IN WHOLE;**

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

DATED: Lake Success, New York
July 21, **2008**

Redacted Signature

FRANK E. IAQUINTA, M.D. (CHAIR)

PAUL F. TWIST, D.O.
CONSTANCE DIAMOND, D.A.

TO: Terrence Sheehan, Esq.
Associate Counsel
New York State Department of Health
90 Church Street -4th Floor
New York, New York 10007

Diego Diaz, M.D.

Redacted Address

Anthony Z. Scher, Esq.
Wood & Scher
222 Bloomingdale Road - Suite 311
White Plains, New York 10605

APPENDIX I

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

IN THE MATTER [redacted]

OF

DIEGO A. DIAZ, M.D.

[redacted]

[redacted] WL 4/21/08

NOTICE

OF

HEARING

TO: Diego A. Diaz, M.D.
c/o Anthony Z. Scher, Esq.
Wood & Scher
222 Bloomingdale Road
White Plains, NY 10583

PLEASE TAKE NOTICE:

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

[redacted] WL 4/21/08

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

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

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

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

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

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

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

DATED: New York, New York
April 4, 2008

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

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

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

IN THE MATTER
OF
DIEGO A. DIAZ, M.D.

STATEMENT
OF
CHARGES

Diego A. Diaz, M.D., the Respondent, was authorized to practice medicine in New York State in or about 1998, by the issuance of license number 211166 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. In or about March and April, 2005 Respondent treated Patient A (whose name is contained in the attached Appendix) at his medical office at 110 E. 59th Street, New York, N.Y. 10022 and at Lenox Hill Hospital, 100 East 77th Street, New York, NY 10021. Respondent's management and treatment of Patient A departed from accepted standards of medical practice in the following respects:

1. Respondent failed to take and record a complete and accurate Patient history in his office chart for Patient A and in the Patient's chart at Lenox Hill Hospital, including an accurate description of the results of diagnostic testing, including a colonoscopy and its accompanying pathology report.

2. Respondent misdiagnosed Patient A as having colon cancer.

3. Respondent diagnosed Patient A's condition without having read the complete text of the diagnostic colonoscopy and associated pathology report. The reports clearly describe not colon cancer but rectal cancer.

4. Respondent inaccurately informed Patient A that she had colon cancer and inaccurately described to her the nature of the surgery she would have to undergo.

5. Respondent referred the Patient to [redacted] DOMINGO NUNEZ, M.D., a surgeon, for surgery. Respondent failed to communicate directly with [redacted] NUNEZ about the nature of the Patient's illness, her diagnostic work up and the reason for the referral.

6. Instead, Respondent only spoke to an associate of [redacted] NUNEZ, a Dr. Dawson. The Respondent inaccurately informed Dr. Dawson that Patient A had colon cancer.

7. Respondent failed to forward to [redacted] NUNEZ, or place in the Lenox Hill Hospital chart , a copy of the out-patient colonoscopy and pathology reports.

8. As a result of Respondent's departures from accepted medical practices, Patient A initially underwent an unnecessary procedure before the correct procedure was performed, resulting in a greatly extended period of surgery, finally resulting in her expiration intra-

operatively.

9. Respondent failed to maintain a medical record for Patient A which accurately reflects the evaluations he provided, including accurate Patient history, diagnostic test results, diagnoses, recommended surgical procedures and treatment plans.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the following paragraphs:

1. A and A(1), A and A(2), A and A(3), A and A(4), A and A(5), A and A(6), A and A(7), A(8), A and A(9).

SECOND SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

2. A and A(1), A(2), A(3), A(4), A(5), A(6), A(7), A(8), A(9).

THIRD TO FIFTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

3. A and A(1).
4. A and A(7).
5. A and A(9).

DATE: April 7, 2008
New York, New York

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct