STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Lorna McBarnette
Executive Deputy Commissioner

April 15, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

E. Marta Sachey
Associate Counsel
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2429
Albany, New York 12237

Carlos A. Castro, M.D.
5 Proctor Court
Loudonville, New York 11211-1417

John T. Maloney, Esq.
Carter, Conboy, Bardwell, Case,
Blackmore & Napierski
20 Corporate Woods Boulevard
Albany, New York 12211

Effective Date: April 22, 1992

RE: In the Matter of Carlos A. Castro, M.D.

Dear Ms. Sachey, Mr. Maloney and Dr. Castro:

Enclosed please find the Determination and Order of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

The notice of review served on the Administrative Review Board should be forwarded to the New York State Department of Health, Bureau of Adjudication, Corning Tower - Room 2503, Empire State Plaza, Albany, New York 12237-0030, **Attention: James F. Horan, Esq., Administrative Law Judge.** 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.

Very truly yours,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	
OF	:	ORDER
CARLOS A. CASTRO, M.D.	:	BPMC 92-29

A Notice of Hearing and Statement of Charges were served upon the Respondent, **Carlos A. Castro, M.D.**, on September 30, 1991. Hearings were held on October 31, 1991, December 3, 1991, December 10, 1991, December 20, 1991 and February 5, 1992 (deliberations). **Joseph E. Geary, M.D. (Chair), John A. D'Anna, Jr., M.D., and Denise M. Bolan, R.P.A.**, served as the Hearing Committee. **Gerald H. Liepshutz, Administrative Law Judge**, served as the Administrative Officer. The Respondent appeared by Carter, Conboy, Bardwell, Case, Blackmore & Napierski, John T. Maloney, Esq., of Counsel. The Department of Health appeared by E. Marta Sachey, Esq., Associate Counsel. Evidence was received and witnesses were sworn and heard, and transcripts of these proceedings were made. THe Hearing Committee issued its Findings of Fact, Conclusions and Determination dated March , 1992.

IT IS HEREBY ORDERED BY THE HEARING COMMITTEE THAT:

1. The **FOURTH SPECIFICATION** and the **NINTH SPECIFICATION** of professional misconduct contained within the Statement of Charges (Petitioner's Exhibit 1) are **SUSTAINED;**

2. The **FIRST, SECOND, THIRD, FIFTH, SIXTH, SEVENTH, EIGHTH** and **TENTH SPECIFICATIONS** are **DISMISSED**; and

3. Respondent's license and registration to practice medicine in the State of New York are hereby suspended for one year with the execution of said suspension being stayed during the one year period provided that no further acts of medical misconduct are committed by Respondent.

This Order shall be effective upon service on the Respondent by personal service or certified mail.

DATED: Albany, New York
March 23, 1992

Joseph E. Geary Jr. M.D.
JOSEPH E. GEARY, M.D.
(Chair)

JOHN A. D'ANNA, JR., M.D.
DENISE M. BOLAN, R.P.A.

TO: E. Marta Sachey, Esq.
Associate Counsel
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2429
Albany, New York 12237

John T. Maloney, Esq.
Carter, Conboy, Bardwell, Case,
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Attorneys at Law
20 Corporate Woods Boulevard
Albany, New York 12211

Carlos A. Castro, M.D.
5 Proctor Court
Loudonville, New York 11211-1417

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

IN THE MATTER	:	HEARING COMMITTEE'S FINDINGS OF FACT, CONCLUSIONS AND DETERMINATION
OF	:	
CARLOS A. CASTRO, M.D.	:	

BPMC 92-29

Joseph E. Geary, M.D., Chairperson, **John A. D'Anna, Jr., M.D.** and **Denise M. Bolan, R.P.A.**, duly designated members of the State Board for Professional Medical Conduct, appointed pursuant to Section 230(1) of the Public Health Law of the State of New York, served as the hearing committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **Gerald H. Liepshutz, Esq.**, served as administrative officer for the hearing committee.

After consideration of the entire record, the hearing committee issues its findings of fact, conclusions and determination.

SUMMARY OF CHARGES

Respondent was charged with the following acts of professional misconduct as more fully set forth in a copy of the STATEMENT OF CHARGES attached hereto. Respondent denied all of the material allegations alleged in the STATEMENT OF CHARGES.

1. Practicing the profession of medicine with gross negligence on a particular occasion (FIRST THROUGH FOURTH SPECIFICATIONS)

2. Practicing the profession of medicine with gross incompetence (FIFTH THROUGH EIGHTH SPECIFICATIONS)

3. Practicing the profession of medicine with negligence on more than one occasion (NINTH SPECIFICATION)

4. Practicing the profession of medicine with incompetence on more than one occasion (TENTH SPECIFICATION)

RECORD OF PROCEEDINGS

Service of NOTICE OF HEARING and STATEMENT OF CHARGES:	September 30, 1991
Department of Health (Petitioner) appeared by:	E. Marta Sachey, Esq. Associate Counsel New York State Department of Health
Respondent appeared by:	Carter, Conboy, Bardwell, Case, Blackmore & Napierski Attorneys at Law 20 Corporate Woods Boulevard Albany, New York 12211 By: John T. Maloney, Esq.
Hearing dates:	October 31, 1991 December 3, 1991 December 10, 1991 December 20, 1991 February 5, 1992 (deliberations of hearing committee)
Adjournments:	November 14, 1991, due to unavailability of Petitioner's witness
Hearing Committee absences:	1. Denise M. Bolan, R.P.A., was unable to be present on the hearing day of

	December 3, 1991 due to inclement weather. The parties had no objection to proceeding with two hearing committee members on that date. Ms. Bolan affirms that she has read and considered evidence introduced at and the transcripts of the hearing day of December 3, 1991.
Witnesses for Petitioner:	David Barr, M.D. Peter A. Knight, M.D.
Witnesses for Respondent:	Carlos A. Castro, M.D. (Respondent) Clement A. Curd, M.D.
Petitioner's post-hearing written arguments received:	January 29, 1992
Respondent's post-hearing written arguments received:	January 30, 1992

LEGAL AND PROCEDURAL ISSUES

1. Petitioner's Exhibit 24, consisting of transcript corrections, was stipulated to by the parties as being accurate. It was marked into the record by the administrative officer on January 23, 1992. Copies of the exhibit were distributed to the members of the hearing committee.

2. On the record at the hearing on December 20, 1991, the parties waived the hearing committee's compliance with Public Health Law Section 230(10)(h) requiring the service of this report upon the parties within sixty days of the last day of hearing.

3. The Respondent and Petitioner submitted written

legal arguments received by the administrative officer on January 6, 1992, and January 13, 1992, respectively, concerning the definition of negligence to be used in this proceeding. The papers and citations submitted by both parties support the view that negligence is properly defined for purposes herein as a failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. This definition was used by the hearing committee during its deliberations. Specifically, the administrative officer adopted as his own the legal arguments received from Petitioner on January 13, 1992 by letter of that same date. The submissions of both parties are, of course, part of this record.

The other three definitions of medical misconduct relevant to this proceeding used by the hearing committee during its deliberations were as follows:

a. **gross negligence**: Negligence, as defined above, with a disregard of the consequences which might ensue from that negligence and an indifference to the rights of others. The conduct, to be gross, must be egregious or conspicuously bad (Stone v. Sobol, 171AD2d235).

b. **incompetence**: Conduct showing a lack of the skill or knowledge necessary to perform a particular act.

c. **gross incompetence**: Conduct showing an unmitigated lack of the skill or knowledge necessary to perform a particular act.

FINDINGS OF FACT

The following findings of fact were made after a review of the entire record in this matter. Numbers in parentheses preceded by "T." refer to transcript pages, while those preceded by "Ex." refer to an exhibit in evidence. These citations represent evidence found persuasive by the hearing committee while arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All findings of fact were made by a unanimous vote of the hearing committee.

1. Carlos A. Castro, M.D., Respondent, was authorized to practice medicine in New York State on June 11, 1976, by the issuance of license number 127153 by the New York State Education Department. Respondent is currently registered with the Education Department to practice medicine for the period January 1, 1991 through December 31, 1992 at 5 Proctor Court, Loudonville, New York 11211-1417 (Ex.3; uncontested).

Regarding Patient A - FIRST, FIFTH, NINTH AND TENTH SPECIFICATIONS

2. Patient A was admitted to St. Mary's Hospital, Troy, New York on July 8, 1990 for evaluation and work-up of possible diagnoses, including lymphoma, sarcoidosis and metastatic lung carcinoma (Ex. 6 at p. 19).

3. Respondent provided medical care to Patient A at various times from July 8, 1990 through August 4, 1990

(Ex.6).

4. Patient A was a forty-four year old woman with complaints of weakness, lassitude and anorexia. She had lost a "tremendous amount of weight" and looked "chronically ill". Upon her admission to the hospital, Patient A was in a very debilitated condition (Ex.6 at p.19; T.44, 369, 531).

Regarding Paragraph A(1) of the Statement of Charges:

5. Respondent, on July 9, 1990, performed a fiberoptic bronchoscopy on Patient A using general anesthesia (Ex.6 at pp. 145-146). The bronchoscopy was appropriate to do to obtain histologic proof of the suspected diagnosis of cancer (T. 52-53, 79).

6. Respondent's usual practice was to perform elective bronchoscopy under local anesthesia. Patient A, however, adamantly refused the bronchoscopy under local anesthesia, even after additional assurances. Respondent spent approximately one hour with Patient A attempting to convince her to submit to the bronchoscopy by local anesthesia, but he was unable to do so. He then decided to proceed with the bronchoscopy under general anesthesia (T. 370-374).

7. Given the patient's refusal, the use of general anesthesia was appropriate (T.82).

8. Even if Patient A had not refused local anesthesia, the use of general anesthesia would have been appropriate. The surgery on July 9, 1990 included a mediastinoscopy. Bronchoscopies are often done under general anesthesia when

performed in tandem with mediastinoscopy, and it is common to schedule the two procedures together (Ex.6 at pp. 145-148; T. 522, 536).

Regarding Paragraph A(2) of the Statement of Charges:

9. Respondent, on July 9, 1990, after performing the diagnostic bronchoscopy, proceeded to perform a left mediastinotomy without waiting for the final pathology report on the specimens obtained from the bronchoscopy (Ex. 6 at pp. 145-146).

10. Under the circumstances, it was proper for Respondent to have proceeded without waiting for the final pathology report. A brush biopsy procedure had been inconclusive which rendered the mediastinotomy proper to perform at that time (T. 89, 523-524).

Regarding Paragraph A(3) of the Statement of Charges:

11. This allegation was withdrawn by Petitioner in its post-hearing written submission.

Regarding Patient B - SECOND, SIXTH, NINTH AND TENTH SPECIFICATIONS

12. Patient B was a patient at the Albany Memorial Hospital, Albany, New York, from August 10, 1989 to September 3, 1989. Respondent provided medical care to Patient B at the hospital from August 15, 1989 to August 22, 1989 (Ex. 10).

13. Patient B had been admitted with respiratory distress consisting of stridor (Ex. 10 at p.3).

14. The patient's cardiologist, Dr. Rosenthal, initiated her workup and he had a consultation with Dr. Gold, a pulmonologist, who recommended a bronchoscopy (Ex.10 at p.33).

15. Dr. Gold performed a bronchoscopy on August 15, 1989 (Ex. 10 at p. 488).

16. Later that same day, Respondent was asked by Dr. Gold to see Patient B in consultation due to increased respiratory distress following the bronchoscopy (Ex. 10 at p. 32). Respondent found that the patient had developed endobronchial stenosis following the bronchoscopy. He intubated her with fiberoptic bronchoscopic guidance (T. 409).

17. The primary cause of Patient B's breathing difficulty was an external mass compressing the trachea (T. 411).

Regarding Paragraph B(1) of the Statement of Charges:

18. Respondent did not perform a needle biopsy to attempt to establish a diagnosis of the mediastinal mass before he, on August 18, 1989, performed surgery on Patient B which included a neck exploration, median sternotomy, resection of the mediastinal mass, and thyroidectomy (T. 142-143; Ex.10).

19. It was, however, proper for Respondent to not have performed a needle biopsy. That procedure does not assure a diagnosis (T. 147, 173, 558). Furthermore, there was little

or nothing palpable in Patient B's neck. A needle biopsy would have had to be done in the upper mediastinum which would present the dangerous risk of bleeding causing a further obstruction in Patient B's airway (T. 557-558).

Regarding Paragraph B(2) of the Statement of Charges:

20. During the surgery on August 18, 1989, Respondent did not send biopsies for frozen section analysis to attempt to establish an intraoperative diagnosis of the mediastinal mass before he performed a median sternotomy, resection of the mediastinal mass, and thyroidectomy on Patient B (T. 147; Ex.10).

21. It was, however, proper for Respondent to not have sent biopsies for frozen section analysis because it would not have changed the procedure (T. 572). The trachea had to be freed up and intraoperative frozen section would have had little bearing (T. 559). The purpose of the procedure was to relieve the tracheal compression (T. 142). Additionally, lymphoma is not easily diagnosed on frozen section (T. 149-150).

Regarding Paragraph B(3) of the Statement of Charges:

22. The median sternotomy, resection of the mediastinal mass, and thyroidectomy performed by Respondent on Patient B on August 18, 1989 were indicated because, as previously found herein , obtaining a frozen section would not have changed the diagnosis. The primary reason for operating at that point was to relieve the patient's airway

obstruction. During the surgery, Respondent found that the mass could not be removed with a limited cervical approach and, therefore, a median sternotomy was necessary. The mass was removed to relieve the obstruction in the trachea. Under these circumstances, it is understandable that it was only after dividing the thyroid following the median sternotomy that Respondent realized that the mass was probably a malignancy (T. 417-421, 429, 572).

Regarding Patient C - THIRD, SEVENTH, NINTH AND TENTH SPECIFICATIONS

23. Respondent, from May 18, 1989 and at various times through June 20, 1989, provided medical care to Patient C at St. Mary's Hospital, Troy, New York (Ex.14).

Regarding Paragraph C(1) of the Statement of Charges:

24. Admission chest x-rays showed a large 5 1/2 to 6 cm. mass in the left mid-lung field (T. 182-183; Ex. 15A, Ex.15B, Ex.14 at p. 107). The mass contained air (T. 183; Ex.15C). A CAT scan of the chest showed a large cavitating mass centered in about the level of the bifurcation of the trachea with left hilar density and with an air/fluid level in it (T. 183-184, 186-187). The radiologic material showed that the lesion was not confined to the left upper lobe (T. 189, 592-594). This was not apparent to Respondent (T. 444).

25. Patient C had pulmonary function testing, which was a limited study, but it resulted in a finding of "severe

restriction" (Ex. 14 at p. 114). The patient's FEV-I was 1.15. Based on this testing, it was questionable whether the patient could stand a lobectomy, and he would not likely tolerate a pneumonectomy (T. 185, 440).

26. A diagnosis of squamous cell carcinoma of the lung was established (Ex. 14 at p. 124; T. 186).

27. Therefore, Patient C presented as a patient with advanced lung cancer. The tumor was large and the cavitating lesion was typical for squamous cell carcinoma of the lung. The seventy-four year old patient's condition was such that it was likely that he could not tolerate extensive major surgery (T. 186-187).

28. Respondent, on May 24, 1989, after performing a mediastinotomy, performed a left thoracotomy and left pneumonectomy on Patient C (Ex.14 at pp. 135-136).

29. The performance of a thoracotomy on Patient C was not in accordance with accepted standards of medical care (T. 189-191). Patient C was an extremely poor risk for a major thoracic procedure. It would be reasonable to treat an excavating squamous cell carcinoma by resection if that could be accomplished by lobectomy. However, the CAT scan showed with reasonable certainty that more than a lobectomy would be needed. Resecting the lesion would require removal of a superior segment of the lower lobe and perhaps even the entire lung (T. 189, 219, 599-600).

Regarding Paragraph C (2) of the Statement of Charges:

30. Once Respondent had erroneously performed a left thoracotomy on Patient C, he had no choice except to perform a left pneumonectomy (T. 190, 460-461). The hearing committee finds that the charge under paragraph C(2) of the Statement of Charges cannot be separated from the charge in paragraph C (1). Therefore, it should not be sustained as a separate charge.

Regarding Patient D - FOURTH, EIGHTH, NINTH, AND TENTH SPECIFICATIONS

31. Respondent provided medical care to Patient D at Samaritan Hospital, Troy, New York from August 2, 1989 through August 4, 1989 (Ex.17).

32. On August 2, 1989 Patient D was admitted to the Hospital for the treatment of broncogenic carcinoma of the left lung. Patient D was 62 years old and had been a three pack a day smoker for about fifty years. He complained of shortness of breath and dyspnea on exertion and had a history of weight loss and orthopnea. He had a fever on admission. Physical examination revealed increased A-P chest diameter, a physical manifestation of the patient's diagnosed chronic obstructive pulmonary disease. The patient had a history of coughing and edema in the lower extremities (T. 263-265; Ex. 17 at pp. 6-9, 10, 17, Ex. 19 at p. 3).

33. Laboratory tests showed that on admission, August 2, the patient had an elevated white blood count of 24.9 and a hematocrit of 35. By August 4, the white count had gone down to 16.6. An elevated white blood count is often indicative of infection and a decreasing count often indicates improvement in that. The patient's elevated BUN (41) and creatinine (2.4) showed moderate renal insufficiency (T. 266-267; Ex. 17 at pp. 25, 27-28).

34. Pulmonary function testing revealed an FEVI of 1.17 and 1.4 after bronchodilation, which is 39% and 47% of predicted, respectively. A profusion lung scan showed an essentially normal distribution of blood flow to both lungs (Ex. 19 at pp. 8, 20; T. 268-269).

35. The cardiology consult characterized Patient D as a "marginal" candidate for pulmonary surgery due to the severity of his COPD and advised that any stress testing would be limited by the patient's debilitated state and pulmonary disease (Ex. 17 at pp. 20-21; T. 269-270). The pulmonary consult assessed Patient D as a "borderline to poor candidate" for pneumonectomy and acceptable for lobectomy (Ex.17 at p. 18; T. 269).

36. The overall picture of Patient D was that of a 62 year old heavy smoker with COPD, a productive cough on admission and a several week history of coughing. He had shortness of breath on exertion and when lying supine, and a not well-defined cardiac problem as reflected in left

ventricular hypertrophy on the EKG. He was debilitated, multiple organs were not functioning normally, and he was sick and frail (T. 270-271).

37. A July 19, 1989 outpatient chest x-ray revealed a mass in the upper section of the lower left lobe approximately 5 cm. in size with an air/fluid level and some atelectasis (T. 272; Ex. 21A, Ex. 21B, Ex. 19 at p.5). The August 2, 1989 x-rays, when compared with the July 19, 1989 x-rays, show a decrease in the amount of fluid and an increase in the amount of air in the mass (T. 273-274; Ex. 21E). The change in the air and fluid levels was significant in that it indicated that the cavity was communicating in some way with the endobronchial tree (T. 275-276). A chest CAT scan showed adenopathy (T. 328-329); Ex. 21G). It showed a large mass in the left lung field which extended toward the hilum of the left lung, extended around the left main stem bronchus and extended toward the left pulmonary artery (T. 274; Ex. 18 at p. 3, Exhs. 21F-21J).

Regarding Paragraph D(1) of the Statement of Charges:

38. This allegation was withdrawn by Petitioner during the hearing on December 3, 1991.

Regarding Paragraph D(2) of the Statement of Charges:

39. Respondent, on August 4, 1989, after performing a thoracotomy, attempted to resect the abscessed portion of Patient D's lower left lung. This did not comport with

accepted standards of medical care (T. 281, 338-339).

40. This attempt at the resection of the abscessed portion of the lung was totally ill-advised. It led Respondent to the inevitable of having to do a pneumonectomy to control the blood supply to the lung. Based on the operative report one could have determined that the patient was unresectable prior to the beginning of any significant bleeding. It was not a matter of surgical technique or having to address the unavoidable due to circumstances during surgery (T. 336. 339-340). It was Respondent's decision to attempt the resection and it was a wrong one. It was not reasonable to expect to be able to remove part of the lung and to be able to control the blood supply with anything short of a pneumonectomy (T. 280-282, 629).

41. Respondent attempted the resection to address the tumor as a source of infection. That rationale was faulty. First, the patient was improving on a medical regime initiated on the first day of admission. His white blood count and fever went down with limited medical therapy and a not particularly aggressive antibiotic (T. 283-284). He was improving and may have continued to do so by medical as opposed to surgical treatment (T. 636). However, even if no medical treatment was available to address the sepsis, that would not be a basis to attempt the resection. Nor would the kind of cancer or cell type of the patient's tumor change the conclusion that Respondent still should not have

attempted the resection. The operation could not be executed safely (T. 285-286, 327-328). The patient died on the operating table (Ex. 17 at p. 5).

CONCLUSIONS

The following conclusions were reached pursuant to the findings of fact herein. All conclusions resulted from a unanimous vote of the hearing committee.

Regarding Patient A - FIRST, FIFTH, NINTH AND TENTH SPECIFICATIONS

Findings of Fact 2 through 11 herein relate to these Specifications. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph A(1)	not sustained (Findings of Fact 2-8)
paragraph A(2)	not sustained (Findings of Fact 9-10)
paragraph A(3)	withdrawn (Finding of Fact 11)

Conclusions regarding commission of medical misconduct

Medical misconduct was not committed regarding Patient A, inasmuch as the relevant factual allegations were either not sustained or withdrawn.

Regarding Patient B - SECOND, SIXTH, NINTH AND TENTH SPECIFICATIONS

Findings of Fact 12 through 22 herein relate to these Specifications. The Hearing Committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph B(1)	not sustained (Findings of Fact 18-19)
paragraph B(2)	not sustained (Findings of Fact 20-21)
paragraph B(3)	not sustained (Finding of Fact 22)

Conclusions regarding commission of medical misconduct

Medical misconduct was not committed regarding Patient B, inasmuch as the relevant factual allegations were not sustained.

Regarding Patient C - THIRD, SEVENTH, NINTH AND TENTH SPECIFICATIONS

Findings of Fact 23 through 30 herein relate to these Specifications. The hearing committee reached the following conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph C(1)	sustained (Findings of Fact 24-29)
paragraph C(2)	not sustained (Finding of Fact 30)

Conclusions regarding commission of medical misconduct

Respondent's conduct as described in Findings of Fact 24-29 constituted negligence as defined herein. It did not constitute gross negligence, gross incompetence or incompetence as defined herein. The other charge regarding Patient C [paragraph C(2)] was not sustained as it was found to be duplicative.

Regarding Patient D - FOURTH, EIGHTH, NINTH AND TENTH SPECIFICATIONS

Findings of Fact 31 through 41 relate to these Specifications. The hearing committee reached the following

conclusions regarding the factual allegations in the Statement of Charges:

Factual Allegations	Conclusions as to Factual Allegations
paragraph D(1)	withdrawn (Finding of Fact 38)
paragraph D(2)	sustained (Findings of Fact 39-41)

Conclusions regarding commission of medical misconduct

Respondent's conduct as described in Findings of Fact 39-41 constituted gross negligence, negligence and incompetence as defined herein. It did not constitute gross incompetence as defined herein.

SUMMARY OF CONCLUSIONS

The FOURTH SPECIFICATION (gross negligence as to Patient D) and the NINTH SPECIFICATION (negligence on more than one occasion as to Patient C and Patient D) are sustained. All other Specifications are not sustained. It is noted that the TENTH SPECIFICATION (incompetence on more than one occasion) is not sustained because Respondent's conduct was found to be incompetent on one occasion only.

DETERMINATION OF PENALTY

The appropriate penalty for Respondent's acts of medical misconduct is suspension of his license to practice medicine for one year, with said suspension being stayed under the condition that no further acts of medical misconduct are committed during the suspension period.

The hearing committee does not conclude that a stricter penalty is warranted in this matter. It is noted that most of the charges against Respondent were not sustained, and

that the hearing committee was, except for the sustained acts of misconduct, generally impressed with Respondent's competence as a physician. His truthfulness and candor during the hearing were also noted.

DATED: Rochester, New York
March 23, 1992

JOSEPH E. GEARY, M.D.
Chairperson

JOHN A. D'ANNA, JR., M.D.
DENISE M. BOLAN, R.P.A.

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
CARLOS A. CASTRO, M.D.	:	CHARGES

----------X

CARLOS A. CASTRO, M.D., the Respondent, was authorized to practice medicine in New York State on June 11, 1976 by the issuance of license number 127153 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, 1991 through December 31, 1992, at 5 Proctor Court, Loudonville, New York 11211-1417.

FACTUAL ALLEGATIONS

A. Respondent, on approximately July 8, 1990 and at various times through August 4, 1990, provided medical care to Patient A [patients are identified in the Appendix] at St. Mary's Hospital, Troy, New York. Upon admission to the Hospital Patient A was in a debilitated condition and there was evidence of bilateral lung disease, which was diagnosed in a July 10, 1990 final pathology report as squamous cell carcinoma.

1. Respondent, on July 9, 1990, performed a diagnostic bronchoscopy on Patient A with general and not local anesthesia, which anesthesia was not indicated.

2. Respondent, on July 9, 1990, after performing the aforesaid diagnostic bronchoscopy, proceeded to perform a left mediastinotomy on Patient A without waiting for the final pathology report on the specimens obtained from the bronchoscopy.

Withdrawn by Petitioner in post-hearing submission. EHL

~~3. Respondent, on July 9, 1990, performed a pericardiotomy on Patient A, which was not indicated.~~

B. Respondent, on approximately August 15, 1989 and at various times through August 22, 1989, provided medical care to Patient B at Albany Memorial Hospital, 600 Northern Boulevard, Albany, New York. Upon admission to the Hospital Patient B had acute respiratory distress. She had a large superior mediastinal mass, which was diagnosed in an August 22, 1989 final pathology report as lymphoma infiltrating the thyroid.

1. Respondent failed to perform a needle biopsy to attempt to establish a diagnosis of the mediastinal mass before Respondent, on August 18, 1989, performed surgery on Patient B, which included a neck exploration, median sternotomy, ~~partial~~ resection of the mediastinal mass, and thyroidectomy.

2. Respondent, on August 18, 1989, failed to send biopsies for frozen section analysis to attempt to establish an intraoperative diagnosis of the mediastinal mass before Respondent performed a median sternotomy, ~~partial~~ resection of the mediastinal mass, and thyroidectomy on Patient B.

3. Respondent, on August 18, 1989, performed a median sternotomy, ~~partial~~ resection of the mediastinal mass, and thyroidectomy on Patient B, which were not indicated.

C. Respondent, on approximately May 18, 1989 and at various times through June 20, 1989, provided medical care to Patient C at St. Mary's Hospital, Troy, New York. Patient C had squamous cell carcinoma of the left lung and severely impaired pulmonary function.

1. Respondent, on May 24, 1989, performed a left thoracotomy on Patient C, which was not indicated.

2. Respondent, on May 24, 1989, performed a left pneumonectomy on Patient C, which was not indicated and/or contraindicated.

D. Respondent, on approximately August 2, 1989 and at various times through August 4, 1989, provided medical care to Patient D at Samaritan Hospital, 2215 Burdett Avenue, Troy, New York. Patient D had lung cancer, which was diagnosed as small cell carcinoma in an August 8, 1989 final pathology report. In a cytology report on specimens from a July 11, 1989 preoperative bronchoscopy a diagnosis of non-small cell carcinoma was favored but histologic confirmation of that diagnosis was advised. Patient D also had a history of chronic obstructive pulmonary disease and had severely impaired pulmonary function.

1. Respondent, on August 4, 1989, failed to send biopsies for frozen section analysis to establish a definitive diagnosis of the cell type of Patient D's lung cancer before Respondent attempted a resection of the abscessed portion of the lower left lung.

Withdrawn by Petitioner 12-3-91 GHL

2. Respondent, on August 4, 1989, after performing a thoracotomy, attempted a resection of the abscessed portion of Patient D's lower left lung, which was not indicated and/or contraindicated.

FIRST THROUGH FOURTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ. Law §6530(4), as added by ch. 606, laws of 1991, in that Petitioner charges:

1. The facts in Paragraph A and A.2 ~~and/or A and A.3~~.

Withdrawn by Petitioner in post-hearing submission. GHL

2. The facts in Paragraph B and B.1, B and B.2 and/or B and B.3.

3. The facts in Paragraph C and C.1 and/or C and C.2.

4. The facts in Paragraph ~~D and D.1 and/or~~ D and D.2.

Withdrawn by Petitioner 12-3-91 GHL

FIFTH THROUGH EIGHTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under N.Y. Educ. Law §6530(6), as added by ch. 606, laws of 1991, in that Petitioner charges:

5. The facts in Paragraph A and A.2 ~~and/or A and A.3~~.

withdrawn by Petitioner in post-hearing submission, GAL

6. The facts in Paragraph B and B.1, B and B.2 and/or B and B.3.

7. The facts in Paragraph C and C.1 and/or C and C.2.

8. The facts in Paragraph ~~D and D.1 and/or~~ D and D.2.

withdrawn by Petitioner 12-3-91 GAL

NINTH SPECIFICATION

PRACTICING WITH NEGLIGENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with negligence on more than one occasion under N.Y. Educ. Law §6530(3), as added by ch. 606, laws of 1991, in that Petitioner charges that Respondent has committed two or more of the following:

withdrawn by Petitioner in post-hearing submission GAL

9. The facts in Paragraph A and A.1, A and A.2, ~~A and A.3,~~ B and B.1, B and B.2, B and B.3, C and C.1, C. and C.2, ~~D and D.1~~ and/or D and D.2.

withdrawn by Petitioner 12-3-91 GAL

PRACTICING WITH INCOMPETENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession of medicine with incompetence on more than one occasion under N.Y. Educ. Law §6530(5), as added by ch. 606, laws of 1991, in that Petitioner charges that Respondent has committed two or more of the following:

10. The facts in Paragraph A and A.1, A and A.2, ~~A and A.3~~, B and B.1, B and B.2, B and B.3, C and C.1, C. and C.2, ~~D and D.1~~ and/or D and D.2.

Withdrawn by Petitioner in post-hearing submission. GHL

Withdrawn by Petitioner 12-3-91 GHL

DATED: Albany, New York
September 4, 1991

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct