COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2025-024

In the Matter of	)
Donald T. Nicell, M.D.	)

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Donald T. Nicell, M.D. ("Respondent") and the Board of Registration in Medicine ("Board") (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 C.M.R 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket number 24-808.

Findings of Fact

1. The Respondent graduated from University of Cape Town Faculty of Medicine in 1982. He has been licensed to practice medicine in Massachusetts under license number 220826 since 2004.

2. The Respondent is licensed to practice medicine in many other states including Maine, Minnesota, New Hampshire, and Wisconsin.

3. On or around November 20, 2024, the Wisconsin Medical Examining Board ("WI Board") imposed discipline on Respondent's license in Wisconsin due to Respondent's violation of Wisconsin state law governing the practice of medicine.

4. Specifically, the WI Board disciplined the Respondent for "engag[ing] in unprofessional conduct by departing from or failing to conform to the standard of minimally competent medical practice which creates an unacceptable risk of harm to a patient or the public whether or not the act or omission resulted in actual harm to any person," pursuant to Wis. Admin. Code § Med 10.03(2)(b), which is hereby incorporated by reference.

5. The WI Board disciplined the Respondent for the following conduct related to two patients (A & B):

a. On December 16, 2018, Patient A, experienced sudden onset right-sided numbness and tingling in his face and dizziness. He was taken to the emergency department ("ED") of a hospital in Winona, Minnesota.

b. After a neurology consultation, a CT Angiography of the neck with contrast was performed and read by Respondent remotely. Respondent was provided a clinical history that included Patient A's age and "right sided weakness/numbness episode."

c. Respondent's report included his impression that there was calcific plaque present in the right internal carotid artery, but no dissection or occlusion and overall, no acute findings.

d. Later that same day, Patient A underwent an MRI that revealed a small infarction in the left cerebellum and a stroke in the left medulla.

e. Respondent failed to identify a blockage in Patient A's left vertebral artery on the CT Angiography. Respondent maintains there was inadequate IV contrast in the left vertebral artery and poor imaging by the hospital technician but failed to note that in his report or request a repeat study.

f. The standard of minimally competent medical practice required Respondent to

note in his report that he could not accurately characterize the arteries in the neck due to insufficient contrast and marked degradation of the imaging, and request that a repeat study be performed.

g. On May 23, 2021, Patient B was injured in a motor vehicle accident and taken to a hospital in Portsmouth, New Hampshire, which the WI Board incorrectly identified as Portsmouth, Maine.

h. The ED providers ordered a CT Head without contrast and a CT Cervical Spine without contrast, which were read remotely by Respondent.

i. Respondent's impression in his CT Head report was no acute intracerebral abnormality or injury, and a scalp laceration with no underlying calvarial or orbital fractures. Respondent's impression in his CT Cervical Spine report was no acute fractures.

j. Two days later, Patient B presented to the ED with complaints of continued pain. Further imaging studies were performed, and Patient B was diagnosed with a non-displaced fracture of the 6th cervical vertebra, Grade 1 anterolisthesis of C6 and C7, and a non-displaced fracture of the right lamina of C5.

k. Respondent admitted that he missed the fractures and anterolisthesis of C6 and C7.

l. Respondent's failure to identify the fractures on May 23, 2021 resulted in a two-day delay in treating Patient B with a C-collar, causing instability of the cervical spine and ultimately the need for subsequent surgery.

6. The WI Board reprimanded the Respondent, imposed a fine of $1,022.00, and limited his medical license until Respondent completed at least three hours of education on the

topic of the CT appearance of neck trauma, including a course on vascular injury.

7. On or about January 15, 2025, Respondent's WI medical license was returned to full, unrestricted status.

Conclusions of Law

A. Respondent violated G.L. c. 112, § 5, eighth par. (h) when he violated 243 C.M.R. 1.03(5)(a)(12), by having been disciplined by the WI Board for reasons substantially the same as those set forth in G.L. c. 112, § 5 or 243 C.M.R. 1.03(5). More specifically, the reason discipline was imposed by the WI Board is substantially the same as Respondent having violated G.L. c. 112, § 5, eighth par. (c) and/or 243 C.M.R. 1.03(5)(a)(3) by engaging in conduct which places into question the Respondent's competence to practice medicine, including but not limited to gross negligence or negligence on repeated occasions.

Order

The Respondent's medical license is hereby REPRIMANDED. Furthermore, Respondent is assessed a $1,000.00 fine for violating 243 C.M.R. 1.03(5)(a)(12). This fine must be paid within sixty (60) days of the acceptance of this Consent Order by the Board. The Board will not renew the license of any physician who fails to pay a fine in a timely manner; this step will be taken automatically and no further notice of process will apply.

Execution of this Consent Order

Complaint Counsel and the Respondent agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel and the Respondent are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order, in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that he may have resulting from the Board's acceptance of this Consent Order.

The Respondent shall provide a complete copy of this Consent Order within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated in the year following the date of imposition of this reprimand. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

03/19/2025

Donald T. Nicell, M.D.
Licensee

Date

, Esq.
Attorney for the Licensee

Date

03/31/2025

Erik R. Bennett, Esq.
Complaint Counsel

Date

So ORDERED by the Board of Registration in Medicine this 12th day of June, 2025.

Booker T. Bush, M.D.
Board Chair