



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

433 River Street, Suite 303

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Antonia C. Novello, M.D., M.P.H., Dr.P.H.  
Commissioner

*Public*

Dennis P. Whalen  
Executive Deputy Commissioner

December 15, 2006

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

James Darrigo, D.O.



James A. Steinberg, Esq.  
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Nancy Strohmeier, Esq.  
NYS Department of Health  
90 Church Street - 4<sup>th</sup> Floor  
New York, New York 10007-2919

**RE: In the Matter of James Darrigo, D. O.**

Dear Parties:

Enclosed please find the Determination and Order (No. 06-166) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

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

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

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

Sincerely,

  
Sean D. O'Brien, Director  
Bureau of Adjudication

SDO:cah

Enclosure

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

**In the Matter of**

**James Darrigo, M.D. (Respondent)**

**Administrative Review Board (ARB)**

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

**Determination and Order No. 06-166**

**COPY**

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

**For the Department of Health (Petitioner):**

**Nancy Strohmeier, Esq.**

**For the Respondent:**

**James A. Steinberg, Esq.**

After a hearing below pursuant to N.Y. Public Health Law (PHL) § 230(10)(McKinney Supp. 2006), a BPMC Committee determined that the Respondent committed professional misconduct in treating six patients. The Committee voted to suspend the Respondent's License to practice in New York State (License) for three years, to stay the suspension and to place the Respondent on probation for three years, under the terms that appear as Appendix 3 to the Committee's Determination. In this proceeding pursuant to PHL § 230-c (4)(a), the Petitioner asks the ARB affirm additional charges, to overturn the Committee's Determination on penalty and to revoke the Respondent's License. After reviewing the hearing record and the parties' review submissions, the ARB votes to overturn the Committee and sustain the additional charge that the Respondent practiced with gross negligence in treating one patient. The ARB also overturns the penalty that the Committee imposed and we vote unanimously to revoke the Respondent's License.

### Committee Determination on the Charges

The Committee conducted a hearing on charges that the Respondent violated N. Y. Education Law (EL) §§ 6530(3-6) & 6530(32)(McKinney Supp. 2006) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,
- practicing the profession with gross negligence,
- practicing the profession with incompetence on more than one occasion,
- practicing the profession with gross incompetence, and,
- failing to maintain accurate records.

The charges related to the Respondent's on-call responsibilities for admitting six persons (Patients A-F) into St. Luke's Cornwall Hospital from that Hospital's Emergency Room. The cases involved a time period between February 2002 and July 2003. The Respondent challenged the allegations and a four-day hearing followed. The ARB now reviews the Determination that the Committed rendered following that hearing.

The Committee dismissed charges that the Respondent practiced with gross negligence and gross incompetence. The Committee sustained charges that the Respondent practiced with negligence on more than one occasion in treating all six patients, that the Respondent practiced with incompetence on more than one occasion in treating three of the Patients (D-F) and that the Respondent failed to maintain accurate records for all six Patients.

The Respondent held responsibility as an on-call physician at St. Luke's Cornwall to admit patients to the Hospital who had presented at the Emergency Department in need of more extensive care. The Committee found in several instances that the Respondent failed to obtain or perform adequate histories or physical examinations on the Patients. The Committee found that the Respondent failed to come to the Hospital and attend Patients A and C in a timely manner. The Committee found that the Respondent never came to the Hospital to attend Patient A even though the Patient was unstable and the Patient's condition was deteriorating. In the treatment for Patient B, the Committee found that the Respondent's failure to perform and document an

adequate examination resulted in a direct impact on patient care. The Committee found that the Respondent failed to evaluate Patient D adequately for diabetes and that the Respondent discharged the Patient from the Hospital prematurely. The Committee found that the Respondent failed to obtain a cardiac consult following an abnormal EKG for Patient E. The Committee also found that the Respondent failed to address the possibility of alcohol withdrawal for Patient F.

In making their findings, the Committee credited the testimony by the Petitioner's expert, Robert Ostrander, M.D. The Committee found that Dr. Ostrander answered questions knowledgeably, directly and without evasion, although the Committee found Dr. Ostrander a "bit too much of a perfectionist". The Committee quoted Dr. Ostrander characterizing the Respondent's work-ups as substandard and concluding that the Respondent's progress notes reflect care lacking in detail, organization and likely knowledge. The Committee found the Respondent's testimony sometimes believable, but not necessarily supported by medical records and lacking insight into the Respondent's shortcomings.

The Committee voted to suspend the Respondent from practice for three years, to stay the suspension and to place the Respondent on probation for three years. The probation terms require a practice monitor and require that the Respondent complete at least fifty hours continuing medical education, including ten hours in documentation and or medical record keeping. The Committee barred the Respondent from practicing in an Article 28 Facility for five years. The Committee found the Respondent unsuited for a structured environment such as a hospital setting. The Committee voted against revocation. The Committee found the actual patient treatment was "not bad" and found a majority of the Respondent's misconduct involved a failure to document. The Committee found that the Respondent provides service that can improve with oversight.

#### Review History and Issues

The Committee rendered their Determination on July 25, 2006. This proceeding commenced on August 4, 2006, when the ARB received the Petitioner's Notice requesting a

Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and the Respondent's reply brief. The record closed when the ARB received the reply brief on September 5, 2006.

The Petitioner asks that the ARB sustain additional negligence charges concerning Patient B and the Petitioner requests that the ARB overturn the Committee's Determination and revoke the Respondent's License. The Petitioner criticizes the Committee's Determination to allow the Respondent to practice in an unsupervised setting. The Petitioner also describes the Respondent as a poor candidate to reform his practice. The Petitioner notes that St. Luke's Cornwall previously reprimanded the Respondent for poor record keeping. That reprimand came prior to the time that the Respondent provided care in three of the cases at issue in this matter. The Petitioner argues that the Respondent failed to correct his practice after that prior reprimand and will fail to correct his practice now.

In reply, although the Respondent criticized the testimony by Dr. Ostrander, the Respondent made no request for the ARB to overturn the Hearing Committee. Instead, the Respondent challenged statements and representations in the Petitioner's brief and the Respondent indicated that he would abide by the Committee's Determination, although the Respondent found that Determination quite harsh.

#### ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty

is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3<sup>rd</sup> Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3<sup>rd</sup> Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3<sup>rd</sup> Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3<sup>rd</sup> Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

### Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent practiced with negligence on more than one occasion in treating all six Patients, that the Respondent practiced with incompetence on more than one occasion in treating Patients D-F and that the Respondent failed to maintain accurate records for all six Patients. On our own motion, the ARB votes to sustain the additional charge that the Respondent practiced with gross negligence in treating Patient A. The ARB votes unanimously to overturn the Committee and revoke the Respondent's License.

The Respondent's brief asked for no change in the Committee's Determination, but did criticize the Committee's reliance on the testimony by Dr. Ostrander. Although the Committee found Dr. Ostrander too much of a perfectionist in some of his testimony, the Committee rejected contrary testimony by the Respondent as unsupported by even the medical records that the Respondent himself created and as lacking insight into the Respondent's shortcomings. We defer to the Committee in their findings on the credibility of the expert testimony. We also defer to the Committee's judgment concerning the findings on Patient B and we reject the Petitioner's request that we sustain additional negligence allegations concerning Patient B.

The ARB finds the Committee's findings inconsistent with the Committee's Determination dismissing the charge that the Respondent practiced with gross negligence in treating Patient A. The Committee found that the Respondent admitted Patient A to Cornwall at approximately 9:30 p.m. on May 18, 2003, in unstable condition and with the possibility of underlying lung disease. The Respondent admitted the Patient following a telephone consultation with the Emergency Room physician and the Respondent became responsible for the Patient's care thereafter. The Respondent failed to appear at the Hospital to examine the Patient that



evening despite the Patient's unstable condition and despite three telephone calls from the nursing staff over the course of six hours informing the Respondent about the nursing staff's concerns and about the Patient's deteriorating condition. The Patient died at 6:50 a.m. on May 19, 2003 without the Respondent seeing the Patient. The Committee found that the Respondent deviated from accepted medical standards by failure to come to the Hospital in a timely fashion to examine an unstable, deteriorating patient unknown to the Respondent. The ARB concludes that the Respondent's failure constituted an egregious deviation from accepted standards of care and the ARB holds that the failure constituted practice with gross negligence.

The ARB finds further that the Committee selected a penalty inconsistent with their findings on the Respondent. The Committee found that:

- the Respondent could correct his practice deficiencies despite findings to the contrary in their Determination;
- the majority of the Respondent's conduct involved record keeping problems, despite findings to the contrary in their Determination; and,
- concluded that the Respondent should practice away from supervision, despite findings to the contrary in their Determination.

The ARB disagrees that the misconduct involved primarily record keeping. In the cases of Patient's A and C, the Respondent failed to appear at the Hospital to see the Patients. In the cases of Patients D, E and F, the Respondent appeared at the Hospital, but didn't know what to do to treat the Patients. In the case of Patient B, the Committee found the Respondent's failure to perform or document a thorough physical examination resulted in a direct impact on patient care.

The Committee also found that the Respondent's sloppy record keeping reflected itself in the Respondent's attention to his patients. We further disagree that the Respondent can improve his

practice. The Committee found that the Respondent lacked insight into his deficiencies and that the Respondent failed to correct his record keeping deficiencies after a prior reprimand on record keeping by St. Luke's Cornwall. The ARB concludes that such lack of insight and failure to learn from a prior reprimand presents the Respondent as a poor candidate to reform his practice. The ARB also disagrees with the Committee's Determination to bar the Respondent from practice in a supervised setting such as a hospital. Even if we found that the Respondent could change and improve, the program for correction and re-education would require greater supervision in a public setting with an established quality assurance system, such as a hospital. We find totally inadequate the Committee's plan for a practice monitor to perform only quarterly reviews on only ten per cent of the Respondent's records. The Committee's Determination stated that the Committee found that the Respondent's practice could improve with oversight, but the Committee's penalty would remove the Respondent from meaningful oversight.

The Respondent showed an inattention to patients, a lack of skill or knowledge necessary to treat patients and a lack of insight into his deficiencies. The Respondent's misconduct involved six different patients over a period from February 2002 to July 2003. The ARB concludes that the evidence demonstrates a pattern in the Respondent's practice. We see no evidence from this record that the Respondent can correct that pattern or that the Respondent sees the need to correct that pattern. We conclude that the Respondent's continued practice would represent a continuing risk to his patients. We vote 5-0 to revoke the Respondent's License.

**ORDER**

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

1. The ARB affirms the Committee's Determination that the Respondent practiced with negligence on more than one occasion and with incompetence on more than one occasion and that the Respondent failed to maintain accurate records.
2. The ARB overturns the Committee's Determination and sustains the charge that the Respondent practiced with gross negligence in treating Patient A.
3. The ARB overturns the Committee's Determination on penalty and we vote 5-0 to revoke the Respondent's License.

Robert M. Briber  
Thea Graves Pellman  
Datta G. Wagle, M.D.  
Stanley L. Grossman, M.D.  
Therese G. Lynch, M.D.

**In the Matter of James Darrigo, M.D.**

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

**Dated: 12/5/2006**

  
  
**Robert M. Briber**

In the Matter of James Darrigo, M.D.

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

Dated: Dec 6, 2006

A large black rectangular redaction box covering the signature of Thea Graves Pellman.

Thea Graves Pellman

In the Matter of James Darrigo, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the

Matter of Dr. Darrigo.

Dated: 12/10/, 2006



Datta G. Wagle, M.D.

In the Matter of James Darrigo, M.D.

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

Dated: December 8, 2006



Stanley L. Grossman, M.D.

In the Matter of James Darrigo, M.D.

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

Dated: Dec. 5, 2006 -



Therese G. Lynch, M.D.