STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

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

Public

Dennis P. Whalen
Executive Deputy Commissioner

July 25, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

James Darrigo, D.O.

Nancy Strohmeyer, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007-2919

James A. Steinberg, Esq.
Steinberg & Symer, LLP
27 Garden Street
Poughkeepsie, New York 12601

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

Dear Parties:

Enclosed please find the Determination and Order (No. 06-166) 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), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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.

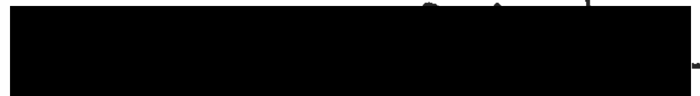
The notice of review served on the Administrative Review Board should be forwarded to:

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,



Sean D. O'Brien, Director
Bureau of Adjudication

SDO:nm

Enclosure

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

COPY

IN THE MATTER OF JAMES DARRIGO, D.O.	DETERMINATION AND ORDER BPMC 06 - 166

Kenneth Kowald, (Chairperson), Cindy Hoffman, D.O., and Ralph Lucariello, M.D., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law. Marc P. Zylberberg, Esq., Administrative Law Judge, ("ALJ") served as the Administrative Officer.

The Department of Health appeared by Nancy Strohmeyer, Esq., Assistant Counsel. Respondent, James Darrigo, D.O., appeared personally and was represented by Steinberg & Symer, LLP by James A. Steinberg, Esq. of Counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	November 23, 2005
Date of Answer to Charges:	December 27, 2005
Hearings Held: - (First Hearing day):	January 19, 2006 March 21, 2006 April 6, 2006 April 28, 2006

Pre-Hearing Conferences Held:	December 27, 2005 January 19, 2006
Intra-Hearing Conferences Held:	April 6, 2006 April 28, 2006
Location of Hearings:	Offices of New York State Department of Health 90 Church Street, 4th Floor New York, NY 10007
Witness called by the Department of Health:	Robert John Ostrander, M.D.
Witness called by the Respondent:	James Darrigo, D.O.
Department's Proposed Findings of Fact Conclusions of Law, and Sanction:	Received June 6, 2006
Respondent's Post-Hearing Memorandum:	Received June 6, 2006
Deliberations Held: (last day of Hearing)	Tuesday, June 13, 2006

STATEMENT OF CASE

The State Board for Professional Medical Conduct 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 ["P.H.L."]). This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct (**"Petitioner"** or **"Department"**) pursuant to §230 of the P.H.L. James Darrigo, D.O. (**"Respondent"**) is charged with five (5) specifications of professional misconduct as set forth in §6530 of the Education Law of the State of New York (**"Education Law"**).

Respondent is charged with professional misconduct by reason of: (1) practicing the profession of medicine with gross negligence on a particular occasion[1]; (2) practicing the profession

[1] Education Law §6530(4) - (First Specification in the Statement of Charges [Department's Exhibit # 1]).

of medicine with gross incompetence[2]; (3) practicing the profession of medicine with negligence on more than one occasion[3]; (4) practicing the profession of medicine with incompetence on more than one occasion[4]; and (5) failing to maintain a record for each patient (six patients) which accurately reflects the care and treatment of the patient[5].

These Charges and Specifications of professional misconduct result from Respondent's alleged conduct towards six (6) patients[6] at various times between 2002 and 2003. Respondent admits to the identity of the patients, and the dates and location of treatment but denies all other allegations and all Specifications of Misconduct contained in the Statement of Charges. A copy of the Statement of Charges and the Answer is attached to this Determination and Order as Appendices 1 and 2.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record available to the Hearing Committee in this matter. These facts represent documentary evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Where there was conflicting evidence the Hearing Committee considered all of the evidence presented and rejected what was not relevant, believable or credible in favor of the cited evidence. The Department, which has the burden of proof, was required to prove its case by a preponderance of the evidence.

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[2] Education Law §6530(6) - (Second Specification in the Statement of Charges [Department's Exhibit # 1]).

[3] Education Law §6530(3) - (unnumbered Specification in the Statement of Charges [Department's Exhibit # 1]).

[4] Education Law §6530(5) - (incorrectly labeled as Second Specification in the Statement of Charges [Department's Exhibit # 1]).

[5] Education Law §6530(32) - (incorrectly labeled as Third Specification in the Statement of Charges [Department's Exhibit # 1]).

[6] The record and this Determination and Order refers to the patients by letter to protect patient privacy. All Patients are identified in the Appendix annexed to the Statement of Charges (Department's Exhibit #1).

Unless otherwise indicated, the Hearing Committee unanimously agreed on all Findings of Fact. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was authorized to practice medicine in New York State on September 6, 1991 by the issuance of license number 186808 by the New York State Education Department (Department's Exhibit # 2)[7].

2. The State Board for Professional Medical Conduct has obtained personal jurisdiction over Respondent and has jurisdiction over Respondent's license and this disciplinary proceeding (determination made by the ALJ; Respondent had no objection regarding service effected on him); (P.H.L. §230[10][d] & §230[7] & §230[10]); [P.H.T-9][8].

3. Respondent completed a residency in family practice medicine at Peninsula General Hospital in Queens, New York in 1993. Respondent then opened a private medical practice in Newburgh, New York. Respondent is board-certified in family practice medicine [T-221-223, 301].

4. In 2002 and 2003, Respondent maintained admitting privileges at St. Luke's Cornwall Hospital, a community hospital which has campuses in Newburgh and Cornwall, New York. Respondent's duties at St. Luke's Cornwall included being on call to admit patients who presented to the emergency room in need of more extensive care. This on call duty consisted of a twenty four hour rotation about every two to three weeks [T-301, 304-305].

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[7] Refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit #) or by Dr. Darrigo (Respondent's Exhibit #).

[8] Numbers in brackets refer to Hearing transcript page numbers [T-] or to Pre-Hearing transcript page numbers [P.H.T-]. The Hearing Committee did not review the Pre-Hearing transcripts or the Intra-Hearing transcripts but, when necessary, was advised of the relevant legal decisions or rulings made by the ALJ.

Patient A

5. On May 18, 2003, at 3:33 p.m., Patient A, a 42 year old male at the time, presented to the emergency room of St. Luke's Cornwall Hospital in Cornwall. Patient A complained of shortness of breath. Patient A's pulse and respiration were both elevated. Patient A was moderately distressed, and his condition was unstable (Department's Exhibit # 3); [T-46].

6. A chest x-ray revealed infiltrates in Patient A's right lung and arterial blood gas tests ("ABG"s) performed on samples collected at 4:25 p.m. revealed that Patient A's blood oxygen saturation while breathing room air was significantly low at 79.5% and his blood was not adequately oxygenated (Department's Exhibit # 3); [T-47-48].

7. An electrocardiogram performed at 5:13 p.m. showed Patient A's heart rate was 128 beats per minute, his condition was unstable and there was a possibility of underlying lung disease (Department's Exhibit # 3); [T-50-51].

8. A second set of ABGs were performed on blood samples collected at 6:25 p.m. after Patient A had been receiving oxygen via nasal cannula. Patient A's oxygen saturation had increased to 95.1% (Department's Exhibit # 3).

9. Dr. Shah, an emergency room physician, telephoned Respondent that evening (some time between 5:20 p.m. and 8:20 p.m.) to discuss Patient A. Dr. Shah told Respondent about Patient A's ABGs, his chest x-ray (pneumonia), the shortness of breath and tachycardia (Department's Exhibit # 3); [T-236-241, 281].

10. Patient A was admitted to the hospital's telemetry unit (approximately 9:30 p.m.) and Respondent gave his admitting orders for Patient A to the nursing staff via telephone some time after 8:30 p.m. (Department's Exhibit # 3); [T-129-130, 163].

11. Once Respondent transmitted the admitting orders to the nursing staff, he assumed responsibility for Patient A's care. Subsequent to Respondent submitting the admitting orders, the nursing staff informed him of their concerns regarding Patient A (approximately 10:45 p.m.) (Department's Exhibit # 3); [T-161-164, 166, 203-204, 285].

12. Given Patient A's emergency room presentation, a reasonably prudent physician would have come to the hospital within a reasonable time period to personally examine Patient A and obtain a thorough medical history from the patient. This is especially important when the patient is not previously known to the physician (Department's Exhibit # 3); (Respondent's Exhibit # B); [T-52-54, 62, 278].

13. At 10:23 p.m., Patient A experienced an episode of ventricular tachycardia. The nurse notified Respondent. Over the telephone, Respondent gave orders for a consultation with a cardiologist and ABGs in the morning (Department's Exhibit # 3); [T-62, 84-86, 269].

14. At approximately 1:15 a.m. on May 19, 2003, a nurse telephoned Respondent concerning Patient A. Respondent's orders included moving Patient A to a private room and consulting with an infectious disease specialist (Department's Exhibit # 3); [T-61, 267-271].

15. At approximately 3:49 a.m. the nursing staff telephoned Respondent to inform him that Patient A's respiratory status was declining and that he was tachycardic. Respondent ordered consultation with a pulmonologist, and the pulmonologist ordered that Patient A be moved to the intensive care unit (Department's Exhibit # 3); [T-59-60, 269-271].

16. Respondent failed to come to the hospital and personally attend to Patient A when he was informed of the patient's deteriorating condition (Department's Exhibit # 3).

17. Patient A died at 6:50 a.m. on May 19, 2003 and Respondent never saw the patient (Department's Exhibit # 3); [T-57-58, 269].

Conclusions

A. Respondent's failure to come to the hospital and examine Patient A (who was unstable) in a timely fashion was a deviation from minimum accepted standards of medical care (Department's Exhibit # 3); (Respondent's Exhibit # B); [T-52-55, 151-152, 187-188, 193].

Factual Allegation A.1. is sustained.

B. Respondent's failure to attend to Patient A (who was unstable) on the patient's deterioration was a deviation from minimum accepted standards of medical care (Department's Exhibit # 3); (Respondent's Exhibit # B); [T-55, 62-64, 187-188, 193].

Factual Allegation A.2. is sustained.

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18. During Patient A's stay in the hospital, Respondent did not obtain a medical history of Patient A (Department's Exhibit # 3); (Respondent's Exhibit # B); [T53-55, 57].

19. During Patient A's stay in the hospital Respondent did not perform a physical examination of Patient A (Department's Exhibit # 3); (Respondent's Exhibit # B); [T57-58].

20. Other than telephone orders Respondent did not render adequate care to Patient A. By failing to attend to the patient Respondent failed to maintain a record which accurately reflected the care and treatment of Patient A (Department's Exhibit # 3); (Respondent's Exhibit # B); [T-63-65, 183-184].

Conclusions

C. The failures to obtain a medical history, perform a physical exam and maintain an accurate record of Patient A constituted a deviation from minimum accepted standards of medical care (Department's Exhibit # 3); (Respondent's Exhibit # B); [T-57-58].

Factual Allegation A.3. is sustained.

Factual Allegation A.4. is sustained.

Factual Allegation A.5. is sustained.

Patient B

21. On February 5, 2002 at approximately 6:04 a.m. Patient B, a 43 year old male at the time, presented to the emergency room of St. Luke's Cornwall Hospital in Cornwall. Patient B, , had been treated by Respondent a day earlier for a sore throat and coughing. Respondent had prescribed the antibiotics Avelox and Biaxin (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-404, 498, 553].

22. On presentation to the emergency room, Patient B had difficulty breathing and swallowing. Respondent arrived at the emergency room shortly after Patient B. Respondent and an ear, nose and throat specialist ("ENT") examined Patient B with an endoscope. The specialist made a probable diagnosis of epiglottitis, and Patient B was admitted to the hospital under Respondent's care (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-432, 465, 508-511].

23. Respondent performed a physical examination and documented that Patient B's lungs were clear, his heart had a normal sinus rhythm, and his extremities had no edema (Department's Exhibit # 4); [T-511].

24. When performing an admitting physical on a patient with complaints such as Patient B, a reasonably prudent physician would have included a much more extensive review of systems. Respondent's physical examination note does not reflect a complete admission physical examination nor does it reflect an adequate medical history (Department's Exhibit # 4); [T-344-345].

25. Between February 6 and February 21, 2002, Respondent saw Patient B on a daily basis. Throughout Patient B's hospitalization Respondent did not perform (or document in Patient B's medical record that he performed) adequate physical examinations and evaluations of Patient B (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-360-361].

Conclusions

D. Respondent's physical examinations of Patient B and his documentation thereof did not meet minimum accepted standards of medical care (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-345].

E. The medical history documented by Respondent for Patient B did not meet minimum accepted standards of medical care (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-346].

F. Respondent did not maintain a medical record for Patient B which accurately reflected the care and treatment rendered to Patient B (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-370-371].

G. The failures to obtain a medical history, perform and/or document physical examinations and maintain an accurate record of Patient B constituted a deviation from minimum accepted standards of medical care (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-371].

Factual Allegation B.2. is sustained.

Factual Allegation B.4. is sustained.

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26. Respondent consulted with an ENT specialist on the day of Patient B's admission in the emergency room (Department's Exhibit # 4).

27. Patient B's diabetes and his unusual and uncertain diagnosis of epiglottitis made a consultation with an infectious disease specialist necessary (Department's Exhibit # 4); (Respondent's Exhibit # B); [T-350-351].

28. Respondent consulted with an infectious disease specialist on February 8, 2002, three days after Patient B's admission to the hospital (Department's Exhibit # 4); [T-351].

29. Respondent consulted with a critical care specialist (pulmonologist/intensivist) on February 12, 2002 (Department's Exhibit # 4); [T-469-472, 550].

30. Respondent consulted with a endocrinologist on February 16, 2002 (Department's Exhibit # 4); [T-470-472].

Conclusions

H. Respondent consulted appropriate specialists regarding Patient B's care (Department's Exhibit # 4); [T-498-582].

Factual Allegation B.1. is not sustained.

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31. As part of his admitting orders for Patient B, Respondent ordered that Patient B's blood sugar be tested four times a day and prescribed a sliding scale for daily insulin coverage (Department's Exhibit # 4).

32. Respondent consulted with a critical care specialist and an endocrinologist (Department's Exhibit # 4) (see Findings # 29 and # 30 above).

Conclusions

I. Respondent adequately addressed the need to obtain glycemic control in Patient B (Department's Exhibit # 4); [T-498-582].

Factual Allegation B.3. is not sustained.

Patient C

33. On July 1, 2002, at approximately 9:10 a.m. Patient C, a 74 year old male at the time, presented to the emergency room of St. Luke's Cornwall Hospital in Newburgh. Patient C had been found unresponsive with a blood sugar level of 15 (Department's Exhibit # 5); [T-584].

34. Patient C was given Glucagon and dextrose in the emergency room and his blood sugar levels ranged from 39 to 63 during his hours awaiting admission to the hospital (Department's Exhibit # 5); [T-585-586].

35. At approximately 3:45 p.m. Respondent spoke with the emergency room physician regarding Patient C prior to admitting him to the hospital. Respondent was told about Patient C's blood sugar levels and mental status (Department's Exhibit # 5); [T-733-735].

36. Respondent's telephone admitting orders included therapy with the antibiotics Unasyn and Cipro (Department's Exhibit # 5); [T-602].

37. Unasyn is a broad-spectrum penicillin-related antibiotic that has a second drug contained in it to overcome resistence. It is used to combat a wide range of infections including abdominal infections and others [T-602, 685-686, 766-771].

38. Cipro belongs to a class of antibiotics knows as quinolines which are particularly useful to fight gram-negative infections [T-602, 685-686, 766-771].

39. At approximately 9:25 p.m. on July 1, 2002, Patient C became unresponsive to verbal and tactile stimuli and suffered a tonic-clonic seizure. On July 2, 2002, at 5:45 a.m. Respondent was called by a hospital nurse (Department's Exhibit # 5); [T- 588-589, 620-621, 632].

40. By 9:45 p.m. Patient C's seizure had ended. Respondent had not returned the nursing staff's call (Department's Exhibit # 5).

41. Patient C remained unresponsive through the early morning hours of July 2, 2002, and his blood sugar level dropped to 15 (Department's Exhibit # 5).

42. Respondent called the hospital regarding Patient C at approximately 5:45 a.m. on July 2, 2002 and ordered that an ampule of D50 be given intravenously to address Patient C's blood sugar level (Department's Exhibit # 5).

43. At approximately 11:30 a.m. on July 2, 2002 Respondent telephoned in an order for another ampule of D50 (Department's Exhibit # 5); [T-633].

44. Respondent personally wrote an order in Patient C's chart and that order was "taken off" the chart and acknowledged by nursing staff at 2:45 p.m. on July 2, 2002 (Department's Exhibit # 5).

45. A reasonably prudent physician would have personally attended to Patient C within three to four hours of his presentation at the hospital (Department's Exhibit # 5); (Respondent's Exhibit # B); [T-591, 692].

46. Patient C's seizure activity and ongoing significant instability required that Respondent obtain a comprehensive medical history, conduct a good physical examination, order diagnostic testing and a follow up monitoring and treatment plan that could be carried out frequently and regularly. This requires personal attention from a physician and can not be accomplished by managing patient care over the telephone (Respondent's Exhibit # B); [T-591-592].

47. On July 3, 2002, Respondent noted that Patient C's hematocrit and hemoglobin ("H + H") measures had declined and ordered transfusion of two units of blood (Department's Exhibit # 5); [T-600].

48. When faced with decline in a patient's H + H count, a reasonably prudent physician would document any known cause of the decline or, if the cause was unknown, he would evaluate the cause or reason for the patient's anemia (Respondent's Exhibit # B); [T-600, 688-690].

49. There is no indication in Patient C's medical record that Respondent ever took steps to evaluate Patient C's possible anemia (Department's Exhibit # 5); (Respondent's Exhibit # B); [T-600-601].

Conclusions

J. Respondent's failure to come to the hospital and examine Patient A (who was unstable) in a timely fashion was a deviation from minimum accepted standards of medical care (Department's Exhibit # 5); (Respondent's Exhibit # B); [T-586-592].

Factual Allegation C.1. is sustained.

K. Respondent's failure to evaluate Patients C's possible anemia was a deviation from minimum accepted standards of medical care (Department's Exhibit # 5); (Respondent's Exhibit # B); [T- 600-601, 688-690].

Factual Allegation C.2. is sustained.

L. Respondent's use of the antibiotics Unasyn and Cipro are questionable but not inappropriate (Department's Exhibit # 5); [T-602, 685-686, 766-771].

Factual Allegation C.3. is not sustained.

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50. Sometime on July 2, 2002, on or about 2:25 p.m. Respondent obtained a medical admission history and performed a physical on Patient C (Department's Exhibit # 5); [T-591].

51. Respondent did not obtain an adequate medical history regarding Patient C (Department's Exhibit # 5); (Respondent's Exhibit # B); [T-593-594].

52. Between July 2 and July 11, 2002, Respondent saw Patient C on a daily basis. Except for Patient C's admission physical examination, Respondent did not perform or record in Patient C's medical record an adequate physical examination of Patient C (Department's Exhibit # 5).

53. Throughout Patient C's hospital stay, the medical records Respondent maintained did not accurately reflect the care Respondent rendered to Patient C (Department's Exhibit # 5); [T- 604, 693-694].

Conclusions

M. The medical history obtained by Respondent was inadequate and does not meet minimum accepted standards of medical care (Department's Exhibit # 5); (Respondent's Exhibit # B); [T-593-594].

N. Respondent's failure to perform adequate physical examinations was a deviation from minimum accepted standards of medical care (Department's Exhibit # 5); (Respondent's Exhibit # B); [T-597-598].

O. Respondent's medical record keeping regarding Patient C's care deviated from minimum accepted standards of medical care (Department's Exhibit # 5); (Respondent's Exhibit # B); [T-604, 693-694].

Factual Allegation C.4. is sustained.

Factual Allegation C.5. is sustained.

Factual Allegation C.6. is sustained.

Patient D

54. On May 20, 2003, at approximately 12:23 a.m. Patient D, a 24 year old male at the time, presented to the emergency department of St. Luke's Cornwall Hospital in Newburgh. Patient D was complaining of excessive thirst, urination and twinges of chest pain (Department's Exhibit # 6); [T-837].

55. When confronted with a patient who presents with Patient D's blood chemistry and symptoms, a reasonably prudent physician would have ordered diagnostic testing including serum electrolytes, blood gas readings and hemoglobin A1C testing. A detailed account of the patient's past medical history, past symptoms and a family history should be obtained. A reasonably prudent physician would also conduct a thorough physical examination of the patient's heart, lungs, abdomen and skin and would assess the patient's mental and neurological status [T-838-839].

56. The plan of care for a new onset diabetic such as Patient D should include insulin. A patient such as Patient D, whose diabetes has not been characterized as Type I or Type II and who had very high blood sugar elevations should be treated with intravenous insulin and very frequent blood sugar monitoring. In addition, such a patient's serum electrolyte levels should be monitored every one to two hours initially [T-839-840].

57. Respondent's admitting orders for Patient D were communicated to the nursing staff on May 20, 2003 at 3:25 a.m. Respondent's plan included intravenous fluids, a diabetic diet, subcutaneous and intravenous insulin, blood sugar testing four times a day, an insulin coverage scale for elevations of blood sugar and Glucophage and Actos (Department's Exhibit # 6); [T-842-843].

58. On May 20, 2003 at 1:00 p.m. Respondent communicated a discharge order for Patient D. This order prescribed Glucophage and Actos, and noted that the patient had been given a glucose monitor and instructions to follow up with Respondent in a week (Department's Exhibit # 6); [T-849-850].

Conclusions

P. Respondent failed to adequately evaluate Patient D's diabetes and Respondent discharged Patient D from the hospital prematurely. The plan of care that Respondent outlined for Patient D's diabetes deviated from minimum accepted standards of medical care (Department's Exhibit # 6); (Respondent's Exhibit B); [T-843]. VOTE OF 2 TO 1

Q. Respondent's discharge plan for Patient D was inadequate in that Patient D still needed hospital care. A reasonably prudent physician would not have discharged Patient D at this time. Therefore the discharge plan was inadequate (Department's Exhibit # 6); (Respondent's Exhibit B).

R. Respondent's decision to discharge Patient D was a deviation from minimum accepted standards of medical care (Department's Exhibit # 6); (Respondent's Exhibit B); [T-851]. *Factual Allegation D.1. is sustained.* - VOTE OF 2 TO 1 sustaining the deviation regarding the adequate evaluation. VOTE to sustain is unanimous regarding the inadequate discharge plan.

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59. Respondent did not document an adequate medical history concerning Patient D (Department's Exhibit # 6); (Respondent's Exhibit # B); [T-845-846].

60. Sometime on May 20, 2003, Respondent performed and documented a physical examination. This examination consisted of obtaining Patient D's vital signs (Department's Exhibit # 6); [T-846=849].

61. Respondent did not document adequate physical examinations concerning Patient D (Department's Exhibit # 6); (Respondent's Exhibit # B); [T-848-849].

62. The records maintained by Respondent accurately reflected the care and treatment rendered by Respondent to Patient D (Department's Exhibit # 6); [T-851-853].

Conclusions

S. The medical history Respondent documented for Patient D failed to meet minimum accepted standards of medical care (Department's Exhibit # 6); [T-846].

T. The physical examinations documented for Patient D failed to meed minimum accepted standards of medical care (Department's Exhibit # 6); [T-849].

U. Respondent failed to maintain a record which accurately reflected the care and treatment rendered to Patient D (Department's Exhibit # 6); [T-846, 849, 851-853].

Factual Allegation D.2. is sustained.

Factual Allegation D.3. is sustained.

Factual Allegation D.4. is sustained.

Patient E

63. On June 4, 2002, at approximately 4:18 p.m. Patient E, a 42 year old male at the time, presented to the emergency room at St. Luke's Cornwall Hospital in Newburgh. Patient E complained of a continuous cough for the past day (Department's Exhibit # 7) [T-1004].

64. On June 4, 2002 a chest x-ray, taken at approximately 4:44 p.m., revealed that Patient E had an enlarged heart, mild congestive heart failure and that he had had a mitral valve replacement. An electrocardiogram ("EKG") performed that same day, at approximately 6:19 p.m., showed a conduction system abnormality know as an incomplete right bundle branch block. The EKG also recorded an ST depression and inversion of T waves in the V2, V3, and V4 leads (Department's Exhibit # 7); [T-1005-1007].

65. When confronted with Patient E's EKG reading, a reasonably prudent physician would repeat the EKG every six to eight hours for at least two to three more readings and closely monitor any changes in the tests. Blood work including troponin and CPK levels should be drawn to determine whether there is muscle damage. Once satisfied that the patient was not experiencing an acute process of coronary syndrome which would require immediate intervention, a reasonably prudent physician would perform some sensitive form of stress testing [T-1006-1007].

66. Patient E had another EKG on June 5, 2002 at 12:43 a.m. The tracing of this test showed profound worsening and spread of the ST and T wave abnormalities as compared to the previous EKG. New T wave inversions appeared on three separate leads, and there was worsening of the previously identified ST depressions and T wave inversions. This latest EKG suggested that Patient E was having an acute coronary ischemia (Department's Exhibit # 7); [T-1008].

67. A reasonably prudent physician would have placed Patient E in a highly monitored situation such as an intensive care unit and consulted a cardiologist to determine whether there was a need for immediate coronary angiography and possible intervention (Department's Exhibit # 7); (Respondent's Exhibit # B); [T-1009].

68. Considering Patient E's history, chest x-rays, EKG's, and laboratory results, a reasonably prudent physician would have ordered a cardiac consultation to initiate immediate evaluation and, depending on the results, probable intervention [T-1012-1013, 1015].

<u>**Conclusions**</u>

V. Respondent's failure to address Patient E's cardiac symptoms by not obtaining a consultation was a deviation from minimum accepted standards of medical care [T-1016].

Factual Allegation E.1. is sustained.

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69. On admission, Respondent gave Patient E a diagnosis of exacerbation of chronic obstructive pulmonary disease ("COPD") and prescribed the antibiotic Keflex (Department's Exhibit # 1); [T-1017].

70. There was no indication in Patient E's medical record as to why Respondent prescribed Keflex (Department's Exhibit # 7); [T-1017].

71. Respondent testified that the Keflex was given as a prophylaxis against endocarditis secondary to the metal valve in the patient's heart [T-1105].

<u>**Conclusions**</u>

Factual Allegation E.2. is not sustained.

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72. Respondent obtained a medical history from Patient E which included only cursory description of the present illness and Patient E's history of rheumatic fever and heart surgery. The history also noted Patient E's COPD and that he takes an aspirin a day. Respondent notes a brief social history in Patient E's medical history (Department's Exhibit # 7); [T-1019-1020].

73. A reasonably prudent physician would have included a detailed history of the present illness including the onset of symptoms, their severity, duration and pertinent positives and negatives regarding associated symptoms such as chest pain, fever, chills, faintness, sputum production, and blood in the sputum. More details concerning Patient E's rheumatic fever, open heart surgery and premorbid heart condition should have been obtained. A detailed review of systems should have been conducted as well [T-1020-1021].

74. In his daily hospital visits to Patient E, Respondent never obtained and documented an adequate interval medical history (Department's Exhibit # 7); [T-1025-1026].

Conclusions

W. The medical history Respondent obtained and documented for Patient E failed to meet minimum accepted standards of medical care (Department's Exhibit # 7); [T-1020, 1026].

Factual Allegation E.3. is sustained.

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75. For a patient such as Patient E, a reasonably prudent physician would have conducted a comprehensive physical examination which included statement about the patient's general condition, health and appearance. A head and neck examination which would include a comment about the eyes, ears, nose and throat. A detailed lung examination, a cardiac examination, a detailed abdominal examination, a neurological and skin examinations should have been conducted as well [T-1022-1023].

76. Respondent failed to perform and document such an examination on Patient E (Department's Exhibit # 7); [T-1023].

77. Between June 4, 2002 and June 7, 2002, Respondent saw Patient E on a daily basis. Subsequent to Patient E's hospital admission and during his entire hospital stay, Respondent never conducted and documented an adequate physical examination (Department's Exhibit # 7); [T-1024-1025].

Conclusions

X. Respondent's failure to perform and document a thorough physical examination and subsequent failures to perform adequate physical examinations on Patient E was a deviation from minimum accepted standards of medical care [T-1024-1025].

Factual Allegation E.4. is sustained.

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78. In his physical examination and history of Patient E, Respondent characterized the patient as having "normal sinus rhythm." A complete characterization would have included the pertinent abnormalities such as the ST and T wave changes and the bundle branch block. Respondent did not document his reasons for prescribing Keflex (Department's Exhibit # 7); [T-1010-1011, 1017, 1105].

Conclusions

Y. Respondent failed to maintain a record which accurately reflected the care and treatment he rendered to Patient E (Department's Exhibit # 7); [T-1026].

Z. Respondent's medical record keeping regarding Patient E's care deviated from minimum accepted standards of medical care [T-1026].

Factual Allegation E.5. is sustained.

Patient F

79. On July11, 2003, at approximately 6:30 p.m. Patient F, an 83 year old male at the time, presented to the emergency room of St. Luke's Cornwall Hospital in Newburgh. Patient F had fallen face forward and hit the left side of his rib cage (Department's Exhibit # 8); [T-1148].

80. In his admitting orders, Respondent's diagnosis for Patient F included, among other things, ethanol abuse. Respondent ordered blood alcohol testing, and Patient F's blood was drawn at approximately 9:30 p.m. Patient F's blood alcohol level, three hours after presentation to the emergency room, was .149 (Department's Exhibit # 8); [T-1148-1149].

81. Given Patient F's blood alcohol level and his fall prior to presentation, a reasonably prudent physician would have conducted a detailed neurological and physical examination to look for both the causes and effects of Patient F's fall. Due to Patient F's blood alcohol level, a reasonably prudent physician would institute a procedure to monitor or preventively treat alcohol withdrawal [T-1149-1150].

82. Monitoring or preventively treating alcohol withdrawal should have included close monitoring of vital signs, the patient's mental status, his emotional state, and the presence or absence of tremors and hallucinations. Additionally, medications should be considered to address any symptoms of withdrawal [T-1164-1168, 1200-1201].

83. Respondent took no steps to address Patient F's ethanol abuse and possible alcohol withdrawal (Department's Exhibit # 8); [T-1150-1151].

Conclusions

AA. Respondent's failure to address the possibility of alcohol withdrawal was as deviation from minimum accepted standards of medical care [T-1151, 1166].

Factual Allegation F.1. is sustained.

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84. On July 14, 2003 Respondent prescribed the antibiotic, Biaxin, and three hours later prescribed the more appropriate antibiotic Primaxin for Patient F's productive cough and slight rhonchi (Department's Exhibit # 8); [T-1152-1153, 1240].

85. When Respondent discharged Patient F on July 18, 2003, Respondent prescribed the antibiotic Keflex (Department's Exhibit # 8).

Conclusions

BB. Respondent did not inappropriately order antibiotics for Patient F (Department's Exhibit # 8); [T-1240-1243].

Factual Allegation F.2. is not sustained.

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86. Respondent obtained a medical history from Patient F which included a brief description of the present illness and a brief past medical history. A list of medications was included but not their dosage or schedule. There was limited review of systems (Department's Exhibit # 8); [T-1155].

87. A reasonably prudent physician would have included a detailed history of the present illness including results of questioning about Patient F's alcohol intake immediately leading up to the fall and his overall drinking. The medical history should include more details about Patient F's congestive heart failure, including the onset of symptoms, their severity, duration and results of cardiac testing. Medication lists should include dose and schedule. Patient F's family and social history should be detailed as well. A more comprehensive review of systems should have been conducted. The fact that Respondent knows the Patient is insufficient and is undocumented (Department's Exhibit # 8); [T-1155-1157].

88. In his daily hospital visits to Patient F, Respondent never obtained and documented an adequate interval medical history (Department's Exhibit # 8); [T-1162-1164].

89. For a patient such as Patient F, who had sustained a fall, a reasonably prudent physician would have conducted a comprehensive physical examination including a detailed description of the head and face as well as an eye examination (Department's Exhibit # 8); [T-1158-1159].

90. Between July 12, 2003 and July 18, 2003, Respondent saw Patient F on a daily basis. Subsequent to Patient F's hospital admission and during his entire hospital stay, Respondent never conducted and documented an adequate physical examination (Department's Exhibit # 8); [T-1161-1163].

__Conclusions__

CC. Respondent failed to obtain an adequate medical history of Patient F (Department's Exhibit # 8).

DD. The medical history Respondent obtained and documented for Patient F failed to meet minimum accepted standards of medical care [T-1157, 1163-1164].

EE. Respondent failed to perform and document adequate physical examinations on Patient F (Department's Exhibit # 8); [T-1160].

FF. Respondent's failure to perform and document adequate physical examinations on Patient F was a deviation from minimum accepted standards of medical care (Department's Exhibit # 8) [T-1160, 1163].

GG. Respondent failed to maintain a record which accurately reflected the care and treatment he rendered to Patient F (Department's Exhibit # 8); [T-1163-1164].

HH. Respondent's medical record keeping regarding Patient F's care deviated from minimum accepted standards of medical care (Department's Exhibit # 8); [T-1163].

Factual Allegation F.3. is sustained.

Factual Allegation F.4. is sustained.

Factual Allegation F.5. is sustained.

CONCLUSIONS OF LAW

Based on the above, the complete Findings of Fact and the discussion below, the Hearing Committee, by a unanimous vote, concludes that Respondent committed professional misconduct by practicing the profession of medicine with Negligence on more than one occasion (Patients A through F). Respondent committed professional misconduct in the practicing of medicine by failing to maintain a record for each patient (Patients A through F) which accurately reflected the care and treatment for that patient. Respondent committed professional misconduct by practicing the profession of medicine with Incompetence on more than one occasion (Patients D through F).

The Specifications of Misconduct alleging NEGLIGENCE ON MORE THAN ONE OCCASION, INCOMPETENCE ON MORE THAN ONE OCCASION, and FAILURE TO MAINTAIN RECORDS, contained in the Statement of Charges are **SUSTAINED.**

The Hearing Committee, by a unanimous vote, concludes that Respondent did not commit professional misconduct by practicing the profession of medicine with Gross Negligence. Respondent did not commit professional misconduct by practicing the profession of medicine with Gross Incompetence. Respondent did not commit professional misconduct by practicing the profession of medicine with Incompetence with regard to the care and treatment rendered to Patients A through C.

The Specifications of Misconduct alleging GROSS NEGLIGENCE and GROSS INCOMPETENCE contained in the Statement of Charges are **NOT SUSTAINED.** The rationale for the Hearing Committee's conclusions is set forth below.

DISCUSSION

Respondent is charged with five (5) specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However §6530 of the Education Law does not provide definitions or explanations of some of the misconduct charged in this matter.

The ALJ provided to the Hearing Committee certain instructions and definitions of medical misconduct as alleged in this proceeding. These instructions and definitions were obtained from a memoranda entitled: Definitions of Professional Misconduct under the New York Education Law[9].

During the course of its deliberations on these charges, the Hearing Committee considered the following instructions from the ALJ:

Gross Negligence

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions. Gross Negligence may also consist of multiple acts of negligence that cumulatively amount to egregious conduct. Gross Negligence does not require a showing that a physician was conscious of impending dangerous consequences of his conduct.

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[9] A copy was made available to both parties at the Pre-Hearing conference [P.H.T-32-33, 51]; [T-4].

Gross Incompetence

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

Negligence on More Than One Occasion

Negligence in a medical disciplinary proceeding is defined as the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. It is not necessary for the Department to prove that any negligence by Dr. Darrigo caused actual harm to a patient. If the Hearing Committee should find negligence on more than one occasion, but that the negligence did not cause harm to a patient, then the lack of harm is a factor that may be considered on the question of what penalty, if any, should be imposed. Similarly, if the negligence did cause harm to a patient, then that is a factor that may be considered on the question of what penalty, if any, should be imposed.

The failure to maintain records which accurately reflect the evaluation and treatment of the patient and which does not affect patient treatment will not constitute negligence. Where there is a relationship between inadequate record-keeping and patient treatment, the failure to keep accurate records may constitute negligence.

Incompetence on More Than One Occasion

Unlike negligence, which is directed to an act or omission constituting a breach of the duty of due care, incompetence on more than one occasion is directed to a lack of the requisite knowledge or skill in the performance of the act or the practice of the profession. The word "incompetence" is to be interpreted by its everyday meaning. These factors may include the Hearing Committee's impression of Dr. Darrigo's technical knowledge and competence on the various issues and the charges under consideration.

The ALJ also instructed the Hearing Committee of the following commonly understood concepts:

Failure to Maintain Records

A physician must record meaningful and accurate information in a patient's medical records which accurately reflects the care and treatment of the patient for a number of reasons. These reasons include: (1) for the physician's own use; (2) for the use of the treatment team; (3) for the use of subsequent care providers; (4) for the use of the patient.

Preponderance of the Evidence

The burden of proof in these proceedings rests on the Department. The Department must establish by a fair preponderance of the credible evidence that the allegations made are true. Credible evidence means the testimony or exhibits found worthy to be believed. Preponderance of the evidence means that the allegation presented is more likely than not to have occurred. The evidence that supports the claim must appeal to the Hearing Committee as more nearly representing what took place than the evidence opposed to its claim. The Charges of misconduct must be supported by the sustained or believed allegations by a preponderance of the evidence.

The Hearing Committee used ordinary English usage and understanding for all other terms and allegations. The Hearing Committee was aware of its duty to keep an open mind regarding the allegations and testimony. With regard to the testimony presented, the Hearing Committee evaluated both witnesses for possible bias or motive. The witnesses were also assessed according to their training, experience, credentials, demeanor, and credibility. We considered whether the testimony was supported or contradicted by other independent objective evidence The Hearing Committee understood that as the trier of fact we may accept so much of a witnesses' testimony as is deemed true and disregard what we find and determine to be false.

Credibility

Robert Ostrander, M.D. was called by the Department as its expert witness. Dr. Ostrander has been in family practice since 1986. Dr. Ostrander is currently in a three physician family practice group and is an attending at F.F. Thompson Hospital in Canandaigua, New York. He has maintained certification with the American Board of Family Physicians. Dr. Ostrander is a clinical associate professor in the department of family medicine at Upstate Medical Center.

Dr. Ostrander was a credible witness. Both on direct and cross examination he answered questions knowledgeably, directly and without evasion. Dr. Ostrander was accurate, unbiased and familiar with the medical records of each patient. At times the Hearing Committee found Dr. Ostrander just a little bit too much of a perfectionist which we understand is not always possible under certain hospital circumstances.

Dr. James Darrigo testified on his own behalf and as is own expert. Dr. Darrigo's credentials are set forth in Findings # 1, # 3, and # 4 above. Respondent has the most at stake in this proceeding. Dr. Darrigo's testimony was sometimes believable but not necessarily supported by the medical records (which he created). Respondent's insight in his shortcomings is lacking and he still does not appreciate or understand the reasons for maintaining good medical records.

Summary

Respondent's medical records maintained for each patients were wholly inadequate in all cases. For Patients A, C, D, E, and F Respondent failed to obtain and/or document adequate medical histories. For Patients A, B, C, D, E, and F Respondent failed to perform and/or document adequate physical examinations. Respondent's failure to perform and/or document a thorough physical examination had a direct impact on patient care, especially as to Patient B. For Patients A, B, C, D, E, and F Respondent failed to maintain a medical record which accurately reflected the care and treatment rendered to those patients.

Patient A

Respondent had the responsibility to attend to this patient and failed to do so in a timely fashion. The Hearing Committee was concerned about the other specialists that were involved and asked to consult and also failed to do so. The Hearing Committee had also some concern regarding the hospital protocols or policy. However, these matters do not negate Respondent's responsibilities towards his care of his patients. Given Patient A presentation, Respondent should have gone to the hospital.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient A deviated from minimum accepted standards of medical care and constituted negligence but not incompetence.

Patient B

The Hearing Committee determined that Respondent did consult with appropriate specialist regarding Patient B's care. Respondent's orders to obtain glycemic control for Patient B was not ideal but we concluded that Patient B's glycemic problems were addressed by the consultants which were involved in his care. Respondent's failure to perform and/or document thorough physical examinations during Patient B's hospitalization had a direct impact on patient care.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient B deviated from minimum accepted standards of medical care and constituted negligence but not incompetence.

Patient C

Again Respondent failed to attend to this patient in a timely fashion. We concluded that the blood transfusion for Patient C was appropriate. The negligence by Respondent was ordering the transfusion without evaluating the patient's anemia. Finally, although the antibiotic chosen by Respondent was questionable, we do not conclude that it was inappropriate.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient C deviated from minimum accepted standards of medical care and constituted negligence but not incompetence.

Patient D

There is no note in the medical records for this patient to show what Respondent's thought process was in the diagnosis or treatment. The Hearing Committee, by a majority, believed that this patient's diabetes was not adequately evaluated. The Hearing Committee unanimously agreed that Patient D was not ready to be discharged, regardless of "hospital policy", when Respondent approved/ordered him to be discharged.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient D deviated from minimum accepted standards of medical care and constituted negligence and incompetence. Respondent lacked understanding that the discharge of this patient was wholly inappropriate.

Patient E

Patient E had an abnormal EKG. When in doubt Respondent should have obtained a cardiac consult. Again, the antibiotic chosen by Respondent was questionable, but we do not conclude that it was inappropriate. Unfortunately, Respondent's reasoning during the Hearing was not contained in the medical records for this patient.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient E deviated from minimum accepted standards of medical care and constituted negligence and incompetence. Respondent lacked the skills necessary to know when to obtain a consultation for this patient.

Patient F

We agree with Respondent that giving Valium or Librium to this patient was a judgment call considering the patient's COPD. Again the medical records do not reflect Respondent's thought process and we sustained the charges that Respondent failed to address the possibility of alcohol withdrawal. Again, the antibiotic chosen by Respondent was questionable, but we do not conclude that it was inappropriate.

We conclude that the Department has shown, by a preponderance of the evidence, that Respondent's care of Patient F deviated from minimum accepted standards of medical care and constituted negligence and incompetence. Respondent failed to understand the need to address the possibility of Patient F's alcohol withdrawal.

Although Respondent, on his own, deviated from minimum accepted standards of medical care for each patient listed above, the Hearing Committee notes that in a number of the cases presented, the hospital and the consultants contributed to the below minimum accepted standard of care provided to the patients.

DETERMINATION AS TO PENALTY

After a full and complete review of all of the evidence presented and pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, the Hearing Committee, by a vote of 2 to 1, determines that Respondent's license to practice medicine in New York State should be suspended for three (3) years but that the three (3) year suspension should be stayed.

The Hearing Committee, unanimously agree, that Respondent should not practice in an Article 28 Facility for five (5) years. The Hearing Committee, unanimously agree, that Respondent should be required to be on probation for three (3) years and have a Practice Monitor review 10% of Respondent's medical records, on a quarterly basis, as indicated in the annexed Terms of Probation. During the three (3) year term of probation Respondent must successfully complete at least fifty (50) hours (per year) of Continuing Medical Education ("CME") including ten (10) hours of Medical Documentation and/or Medical Record Keeping. These fifty (50) hours of CME are inclusive of any other required CME (which are taken to stay current in the practice of medicine) and must be pre-approved by the Director of the Office of Professional Medical Conduct (or his designee).

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including: (1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

The Hearing Committee discussed the appropriate penalties necessary to address Respondent's misconduct in this case. The Hearing Committee believes that Respondent does not appear to be suited to practice in a structured environment such as a hospital setting. Respondent

no longer has admitting privileges and indicated that he does not intend to reapply for same. The Hearing Committee concludes that Respondent is sloppy in his record keeping practices and sometimes that attitude reflects itself in his attention to his patients. Respondent does not seem to understand that medical records are more than just secretarial work. Respondent indicated that he is more interested in patient care than worrying about paperwork. Respondent needs to understand that good medical records are part and parcel of patient care.

Respondent received a letter of reprimand regarding his medical record keeping practices in April of 2003. Three of the six cases presented to the Hearing Committee occurred after this letter of reprimand. We believe that a practice monitor who reviews quarterly, 10% of Respondent medical records will quickly determine if Respondent has changed his habits. We do not believe that Respondent's license should be revoked. Generally the actual treatment rendered by Respondent to these patients was not bad. The overall inferior care these patients received was in part provided by Respondent but also in part provided by the hospital and the consultants. Whether other practitioners were charged or not is not known to the Hearing Committee and in any event is not relevant to determining if Respondent provided below the minimum standard of care.

The Hearing Committee generally agrees with Dr. Ostrander's conclusion in regards to the six (6) patients reviewed:

> "Dr. Darrigo's initial work-ups are generally substandard. He fails to obtain a history of present illness, explore pertinent past medical, family and social history. His physical exams are incomplete and lack detail. His diagnostic and treatment plans do not adequately address a differential diagnosis in complex patients, and the treatment plans are not well thought out. The 'doctor's orders' and subsequent patient care suggest that this is not simply a matter of inadequate documentation. ... Dr. Darrigo's progress notes reflect care which is lacking in detail, organization and likely knowledge. He fails to describe his interpretation of data, awareness of potential problems and rationale for tests and treatments ordered." (Respondent's Exhibit # B).

After hearing from Respondent we do recognize that a majority of Dr. Darrigo's misconduct involves failure to document. We believe that Respondent should keep practicing and that he provides a service which can be improved with Department of Health oversight. Respondent can continue to provide benefits to his patients with his medical license and with appropriate safeguards.

The Hearing Committee believes that the penalty imposed should help prevent future lapses in record keeping practices by Respondent. Respondent's medical record keeping practices must be monitored for a period of time in order to verify that he can practice medicine in compliance with generally accepted standards of record keeping practices. The medical records maintained by Respondent should be reviewed by the Practice Monitor for accuracy and completeness.

No additional fines or sanctions were deemed appropriate under the circumstances presented. Taking all of the facts, details, circumstances, and particulars in this matter into consideration, the Hearing Committee determines that the above is the appropriate action under the circumstances. All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

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

1. The Specification of Negligence On More Than One Occasion, contained in the Statement of Charges (Department's Exhibit # 1), is **SUSTAINED**; and

2. The Specification of Incompetence On More Than One Occasion, contained in the Statement of Charges (Department's Exhibit # 1), is **SUSTAINED**; and

3. The Specification of Failure To Maintain Records, contained in the Statement of Charges (Department's Exhibit # 1), is **SUSTAINED**; and

4. The Specification of Gross Negligence, contained in the Statement of Charges (Department's Exhibit # 1), is **NOT SUSTAINED**; and

5. The Specification of Gross Incompetence, contained in the Statement of Charges (Department's Exhibit # 1), is **NOT SUSTAINED**; and

6. Respondent's license to practice medicine in the State of New York is hereby SUSPENDED for THREE (3) YEARS; and

7. The THREE (3) YEAR SUSPENSION is STAYED; and

8. Respondent shall be on PROBATION for THREE (3) YEARS and have a Practice Monitor review his medical records as indicated in the annexed terms of probation (Appendix 3) which terms are fully incorporated in this Determination and Order; and

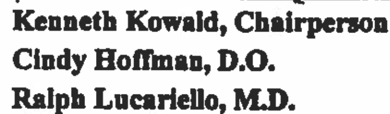
9. Respondent's license to practice is Limited in that he may not practice in an Article 28 Facility; and

10. The period of probation shall begin when this Determination and Order becomes effective (as described in paragraph # 12 below); and

11. During the three (3) year term of suspension Respondent must successfully complete at least fifty (50) hours of Continuing Medical Education ("CME") including courses in medical documentation and/or medical record keeping. These 50 hours of CME are inclusive of any other required CME (which are taken to stay current in the practice of medicine) and must be pre-approved by the Director of the Office of Professional Medical Conduct (or his designee); and

12. This Order shall be effective on personal service on the Respondent or seven (7) days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York**
July, 25 2006



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APPENDIX 1

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

IN THE MATTER OF JAMES DARRIGO, D.O.	STATEMENT OF CHARGES

JAMES DARRIGO, D.O., the Respondent, was authorized to practice medicine in New York State on or about September 6, 1991, by the issuance of license number 186808 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about and between May 18 and 19, 2003, Respondent treated Patient A, who was a 42 year-old man at the time of treatment. Respondent treated Patient A at St. Luke's Cornwall Hospital in Cornwall, New York. Respondent's care of Patient A deviated from minimum accepted standards of medical care in that:

1. Respondent failed to attend Patient A in a timely fashion.
2. Respondent failed to attend Patient A upon deterioration of his condition.
3. Respondent failed to obtain an adequate medical history concerning Patient A.
4. Respondent failed to perform adequate physical examinations of Patient A.
5. Respondent failed to maintain a record which accurately reflected the care and treatment of Patient A.

B. On or about and between February 5 and 22, 2002, Respondent treated

Patient B, who was a 43 year old man at the time of treatment. Respondent treated Patient B at St. Luke's Cornwall Hospital in Cornwall, New York. Respondent's care of Patient B deviated from minimum accepted standards of medical care in that:

1. Respondent failed to consult in a timely manner with the appropriate specialists regarding Patient B's care.
2. Respondent failed to perform adequate physical examinations and evaluations of Patient B throughout Patient B's hospitalization.
3. Respondent failed to adequately address the need to obtain glycemic control in Patient B.
4. Respondent failed to maintain a record which accurately reflected the care and treatment of Patient B.

C. On or about and between July 1 and 11, 2002, Respondent treated Patient C, who was a 74 year old man at the time of treatment. Respondent treated Patient C at St. Luke's Cornwall Hospital in Newburgh, New York. Respondent's care of Patient C deviated from minimum accepted standards of medical care in that:

1. Respondent failed to attend Patient C in a timely fashion.
2. Respondent failed to appropriately evaluate Patient C's anemia prior to transfusing Patient C with packed red blood cells.
3. Respondent inappropriately ordered antibiotics for Patient C.
4. Respondent failed to obtain an adequate medical history concerning Patient C.
5. Respondent failed to perform adequate physical examinations of Patient C.
6. Respondent failed to maintain a record which accurately

reflected the care and treatment of Patient C.

D. On or about May 20, 2003, Respondent treated Patient D, who was a 24 year old man at the time of treatment. Respondent treated Patient D at St. Luke's Cornwall Hospital in Newburgh, New York. Respondent's care of Patient D deviated from minimum accepted standards of medical care in that:

1. Respondent failed to adequately evaluate Patient D's diabetes and discharged Patient D from the hospital prematurely and with an inadequate discharge plan.
2. Respondent failed to obtain an adequate medical history concerning Patient D.
3. Respondent failed to perform adequate physical examinations of Patient D.
4. Respondent failed to maintain a record which accurately reflected the care and treatment of Patient D.

E. On or about and between June 4 and 7, 2002, Respondent treated Patient E, who was a 41 year old man at the time of treatment. Respondent treated Patient E at St. Luke's Cornwall Hospital in Newburgh, New York. Respondent's care of Patient E deviated from minimum accepted standards of medical care in that:

1. Respondent failed to appropriately evaluate Patient E's cardiac condition.
2. Respondent inappropriately ordered antibiotics for Patient E.
3. Respondent failed to obtain an adequate medical history concerning Patient E.
4. Respondent failed to perform adequate physical examinations

of Patient E.

5. Respondent failed to maintain a record which accurately reflected the care and treatment of Patient E.

F. On or about and between July 11 and 18, 2003, Respondent treated Patient F, who was a 83 year old man at the time of treatment. Respondent treated Patient F at St. Luke's Cornwall Hospital in Newburgh, New York. Respondent's care of Patient F deviated from minimum accepted standards of medical care in that:

1. Respondent failed to address the possibility of alcohol withdrawal in Patient F.
2. Respondent inappropriately ordered antibiotics for Patient F.
3. Respondent failed to obtain an adequate medical history concerning Patient F.
4. Respondent failed to perform adequate physical examinations of Patient F.
5. Respondent failed to maintain a record which accurately reflected the care and treatment of Patient F.

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 facts of the following:

1. Paragraphs A, A1 and A2; B, B1 through B3; C and C1.

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

2. Paragraphs A, A1 and A2; B, B1 through B3; C and C1.

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:

3. Paragraphs A, A1 through A4; B, B1 through B4; C, C1 through C5; D, D1 through D3; E, E1 through E4; F, and F1 through F4.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

4. Paragraphs A, A1 through A4; B, B1 through B4; C, C1 through C5; D, D1 through D3; E, E1 through E4; F, and F1 through F4.

THIRD SPECIFICATION

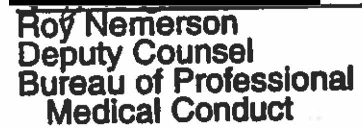
FAILURE TO MAINTAIN RECORDS

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:

5. Paragraphs A, A5, B, B4, C, C6, D, D4, E, E5, F, and F5.

DATED: November 23, 2005
New York, New York



Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX 2

Respondent A 12-27-05

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PATRICIA A. RAMOS
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PARALEGALS

PLEASE REPLY TO: (X) POUGHKEEPSIE
( ) RHINEBECK

December 27, 2005

State of New York
Department of Health
90 Church Street
New York, New York 10007

Attn: Nancy Strohmeyer, Esq.

NYS DEPT OF HEALTH
DEC 29 2005
DIVISION OF LEGAL AFFAIRS
BUREAU OF ADJUDICATION

RE: DOH v. Darrigo
Our File No. 2321

Dear Ms. Strohmeyer:

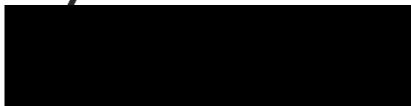
Kindly accept this letter as Dr. Darrigo's Answer with respect to the underlying factual allegations and the specific specifications that the Department of Health has lodged against him.

Please be advised that with respect to the underlying facts, except for the identity of the patients, and the dates and location of treatment, Dr. Darrigo denies those factual allegations in their entirety.

Furthermore, be advised please that the specification of charges are denied, also in their entirety.

Very truly yours,

The Law Offices of
STEINBERG & SYMER, LLP



JAMES A. STEINBERG

JAS/yg
cc: Hon. Marc P. Zylberberg
122705 subs

APPENDIX 3

Terms of Probation for James Darrigo, D.O.

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Determination and Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

5. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

6. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

7. Respondent shall enroll in and successfully complete at least fifty (50) hours of Continuing Medical Education ("CME") including courses in medical documentation and/or medical record keeping. These 50 hours of CME are inclusive of any other required CME (which are taken to stay current in the practice of medicine). Said continuing education program shall be subject to the prior written approval of the Director of OPMC and the CME in medical documentation and/or medical record keeping must be completed during the first year of probation.

8. Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("Practice Monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

9. Respondent shall make available to the Practice Monitor any and all records or access to the practice requested by the monitor, including on-site observation. The Practice Monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least quarterly and shall examine a selection (no less than 10%) of records maintained by Respondent, including patient records and prescribing information. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

10. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the Practice Monitor physician.

11. Respondent shall cause the Practice Monitor to report quarterly, in writing, to the Director of OPMC.

12. Respondent shall maintain or be covered by medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order

13. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to the Order and shall assume and bear all costs related to compliance. On receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.