STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 25, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy M. Fascia, Esq.
NYS Department of Health
Corning Tower Room 2509
Empire State Plaza
Albany, New York 12237

William L. Wood, Jr., Esq.
Wood & Scher
The Harwood Building
14 Harwood Court
Scarsdale, New York 10583

Gaetano V. Cavallaro, M.D.
113 Hooker Avenue
Poughkeepsie, New York 12601

RE: In the Matter of Gaetano Cavallaro, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-123) 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.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

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 licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

GAETANO V. CAVALLARO, M.D.

DETERMINATION

AND

ORDER

BPMC- - 98-123

DAVID T. LYON, M.D., Chairperson, **ROBERT M. KOHN, M.D.** and **GEORGE C. SIMMONS, JR., ED.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(1)(e) and 230(12) of the Public Health Law. **PHILIP J. LODICO, ESQ.**, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with gross negligence and gross incompetence, with negligence and incompetence, each on more than one occasion, and with failure to maintain accurate records.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Commissioner's Order and Notice of Hearing Date:	February 2, 1998
Amendment to Statement of Charges Dated:	
Prehearing Conference:	February 5, 1998
Hearing Dates:	February 26, 1998 March 12, 1998 March 16, 1998 March 23, 1998
Deliberation Date:	April 21, 1998
Place of Hearing:	February 26, 1998 N.Y.S. Department of Health Corning Tower Building Empire State Plaza Albany, New York 12237 March 12, 16 and 23, 1998 Office of Professional Medical Conduct Hedley Park Place 433 River Street Troy, New York 12180
Petitioner Appeared By:	Henry M. Greenberg, Esq. General Counsel N.Y.S. Department of Health By: Cindy M. Fascia, Esq.
Respondent Appeared By:	Wood & Scher The Harwood Building 14 Harwood Court Scarsdale, New York 10583 By: William L. Wood, Jr., Esq.

WITNESSES

For the Petitioner:	William A. Busino, Jr., M.D. Patient B's Mother
For the Respondent:	Arnold L. Abrams, M.D. Jesus L. Floresca, M.D.

FINDINGS OF FACT

Numbers in parentheses refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Gaetano V. Cavallaro, M.D., the Respondent, received his Medical Doctor degree from the University of Bologna Medical School in 1962 and was licensed to practice as a physician in New York State in October 1964. (T. 242; Resp. Ex.C)

2. Before opening a practice in the City of Poughkeepsie in 1970, the Respondent had post graduate training in internal medicine at Albany Medical Center and a fellowship in gastroenterology at the Albany Medical College for one year and one year at The Lahey Clinic in Boston in 1968. (T. 242, 243)

3. The Respondent has practiced continuously since 1970 in Poughkeepsie. (T. 243)

FINDINGS AS TO PATIENT A

1. Patient A was a 75 year old man admitted to Vassar Brothers Hospital in Poughkeepsie, New York on the evening of April 16, 1988. On admission, Patient A had a temperature of 105.3 degrees rectally, pulse of 140, and a blood pressure of 112/60. He was confused, restless, incontinent of urine, and spitting up large amounts of foamy secretions. (Pet. Ex. 3, pp. 3-4;

T. 35-36)

2. Respondent was Patient A's attending physician throughout the course of the patient's hospitalization at Vassar Brothers Hospital. (Pet. Ex. 3, pp. 6-17; T. 34)

3. Respondent, on April 16, 1988, requested a consultation from Dr. Ray, a urologist, regarding hematuria in this patient. Respondent also requested a consultation regarding Patient A's urethral bleeding and Respondent's inability to pass a Foley catheter. (Pet. Ex. 3, pp. 9-10) Dr. Ray saw Patient A and wrote his consultation report at 1:00 a.m. on April 17, 1988. Dr. Ray inserted a Foley catheter and left it in place. He ordered urinalysis and urine cultures. In his consultation note, he advised "IV garamycin x 48 hours, and BUN and creatinine monitoring." (Pet. Ex. 3, p. 10; T. 37) Dr. Ray ordered garamycin 80 mg IV stat and q.8 hours x 48 hours at 1:00 a.m. on April 17, 1988. (Pet. Ex. 3, p. 53)

4. Respondent read Dr. Ray's written consultation report on April 17, 1988, the day it was written. He also read the April 17 order written by Dr. Ray. Respondent read this order on April 17 or 18. Respondent also wrote orders for Patient A on April 17. Those orders are written on the same page as Dr. Ray's orders for Patient A. When Respondent wrote his April 17 orders for Patient A, he read Dr. Ray's orders as well. (T. 337-339; Pet. Ex. 3, pp. 10, 53)

5. Respondent had ordered blood cultures for Patient A on admission. On April 18, Respondent received results from those cultures indicating gram-positive organisms in clusters. (Pet. Ex. 3, p. 19) Respondent knew that the presence of gram-positive organisms in clusters indicated a serious disease (T. 336-337; Pet. Ex. 3, pp.19, 123) On April 19, the results of the blood cultures indicated the presence of staphylococcus aureus. (Pet. Ex. 3,

pp. 19, 122-123) This was a significant finding indicating a very serious, highly lethal infection was present, and that this virulent bacteria had invaded the patient's blood stream. (T. 39-41)

6. When staphylococcus aureus is identified in a patient's blood, a reasonably prudent physician must ask: where is the infection coming from, what is its primary source, and have there been any identified complications of the infection? Most importantly, the physician must ensure that the patient receive immediate treatment for the infection. (T. 39-41) In the absence of an identifiable source of infection that is clearly treatable, such as a large abscess that could be drained, the treatment of staphylococcal bacteremia would require at least two weeks of intravenous antibiotic therapy, and as long as six weeks of such therapy, to adequately treat the infection. (T. 41, 54)

7. Untreated staphylococcus aureus bacteremia would in most cases result in death. This infection, if not timely or adequately treated, can also produce secondary infections, such as heart valve infections, and can spread to the lung, bone, skin, joints, and kidneys. (T. 40-41)

8. Respondent, as Patient A's attending physician, had overall responsibility for Patient A's care throughout his hospitalization. Respondent was responsible for examining the patient every day, reviewing his progress every day, and ensuring on a daily basis that the patient was receiving proper treatment. Respondent, as Patient A's attending physician, was responsible for ensuring that the correct drugs were ordered for Patient A, that the drugs were properly administered, and that the patient was monitored for adverse effects. (T. 34, 41-42)

9. Pursuant to Dr. Ray's order, Patient A received his first dose of Garamycin at 8:00 a.m. on April 17, and received his last dose of that antibiotic at 12:00 a.m., on April 20. Subsequently, the drug was discontinued because Dr. Ray's order had expired. (Pet. Ex. 3, pp. 100-102; T. 43-44)

10. Respondent failed to note in a timely manner that the antibiotic order for Patient A had expired. (Resp. Ex. A-2) After Patient A received his last dose of Garamycin at midnight on April 20, he was on no antibiotics whatsoever until midnight on April 25. (Pet. Ex. 3, pp. 102-107; T. 360-361) Respondent did not take any action to address the fact that the order for Garamycin had expired, and that Patient A was no longer receiving that antibiotic (T. 359-361; Pet. Ex. 3, pp. 6, 20), despite the fact that a consultant on April 22 had recommended the institution of Cipro. (Pet. Ex. 3, p. 20)

11. Respondent admitted the factual allegations pertaining to Patient A contained in the Statement of Charges, paragraph A.2., as amended; to wit: the Respondent failed to note in a timely manner that the antibiotic order for Patient A had expired. (T. 9-10)

12. Patient A's white blood cell count rose from 26,000 on his admission on April 16, to over 47,000 on April 25. (T. 70-71; Pet. Ex. 3, pp. 30, 33)

13. Progress notes for hospitalized patients, such as Patient A, provide a method for outlining the rationale for the patient's care, for describing the care, and for setting out the progress of the patient's care. (T. 76-77) Progress notes should record the physical examination performed by the physician. The hospital records for this patient do not describe any elements of any physical examinations that may have been performed, other than to note fever. (T. 75-76)

14. Respondent admitted all Factual Allegations regarding Patient A in his amended answer. (Pet. Ex. 1, as amended by stipulation between the parties at T. 9-10; Resp. Ex. A-2)

FINDINGS AS TO PATIENT B

15. Patient B was a 31 year old woman who sought for the first time the Respondent's care on November 6, 1990. (Pet. Ex. 4; T. 185-187; T. 251)

16. In November 1990, Patient B began losing weight, complaining of feeling very tired and very weak. She began drinking a lot of water and juices. She was noted to be pale, and the area around her mouth and inside of her mouth appeared blistered. (T. 182-183, 186-189) Up until such time, she was a generally healthy young woman with no history of any problems. (T. 181-182)

17. On Tuesday, November 6, Patient B felt worse, her symptoms had increased, and she was unable to work. (T. 183-184, 204-205)

18. On the evening of Tuesday, November 6, a conversation occurred between the Respondent and Patient B and Patient B's mother in which the Respondent was informed of several symptoms, including that Patient B was not feeling good, she was feeling weak and tired, she was drinking a lot of juice and water, and she was urinating a lot. (T. 186-187; T. 237-239)

19. During Patient B's appointment with Respondent on the morning of Wednesday, November 7, blood was drawn for purposes of a CBC, but no blood glucose was performed. (Pet. Ex. 4; T. 255-256)

20. Patient B continued to deteriorate. (T. 190-191) Patient B's mother telephoned the Respondent and advised him of Patient B's continued symptomatology. (T. 192-195; T. 281) Respondent took no action, made no further recommendations other than telling her that nothing could be done and her daughter would have to wait until the next day. (T. 191-195, 231-232)

21. Respondent did not document in Patient B's medical records his telephone conversation with Patient B's mother on the evening of November 7. (Pet. Ex. 4; Pet Ex. 5; T. 283-284)

22. Sometime in the early morning hours of November 8, Patient B's mother found Patient B unresponsive on the couch. Patient B's mother called 911. The ambulance came and Patient B was taken to Vassar Brothers Hospital. (T. 196-197; 206-209)

23. Patient B arrived at Vassar Brothers Hospital at 3:23 a.m. on November 8. A diagnosis of diabetic ketoacidosis was made. Despite attempts to resuscitate her, Patient B was pronounced dead at 12:10 p.m. on November 8, 1990 at Vassar Brothers Hospital. (Pet. Ex. 5)

24. Respondent's office record for Patient B contains no recorded features of a physical examination other than vital signs. (T. 85-86) For a patient such as Patient B, the standard of care for a general physical examination at an initial office visit would include many more elements. (T. 85-86; Pet. Ex. 4)

25. Respondent's expert, Dr. Abrams, testified that it is not acceptable medical practice to not document the findings of a physical examination you have performed. (T. 585-586)

26. Respondent was informed by both Patient B's mother and Patient B herself that Patient B was feeling weak, was drinking large amounts of fluid, and was urinating frequently. (T. 186-187) For a patient such as Patient B, such symptoms should raise in the mind of a reasonably prudent physician a diagnosis of diabetes. (T. 89-91)

27. In the context of these symptoms of excess thirst and frequent urination, a reasonably prudent physician would consider Patient B's diagnosis to be uncontrolled diabetes. In a person such as Patient B, uncontrolled diabetes can lead rapidly to diabetic ketoacidosis which, if untreated, can cause death. For this reason, it is important to make or exclude a diagnosis of diabetic ketoacidosis in patients such as Patient B. (T. 92-95)

28. In patients such as Patient B, a physician can easily confirm or exclude, and should do so, the diagnosis of diabetes. (T. 91-95)

29. In patients such as Patient B, a reasonably prudent physician would be expected to obtain and document a history, and record that history. (T. 90-91) Respondent failed to perform or document an adequate physical examination of Patient B in his office on November 7, 1990. Respondent failed to elicit or document an adequate history from Patient B in his office. Respondent, despite being aware of symptoms that would have led a reasonably prudent physician to suspect uncontrolled diabetes in this patient, failed to test Patient B's blood sugar to either confirm or exclude this diagnosis, irrespective of the fact that Patient B had not fasted. (T.89-103)

30. If Respondent had made the diagnosis of diabetes when Patient B was seen in his office and treatment had been instituted, there is a high likelihood that this patient would have survived. (T. 137) Respondent's failure to timely diagnose and treat Patient B's progressive uncontrolled diabetes led to cardiac arrest and death. (T. 106-107; Pet. Ex. 5)

FINDINGS AS TO PATIENT C

31. Patient C was a thirty year old man who presented to Respondent's office for an initial office visit on January 13, 1995. (Pet. Ex. 6)

32. Notwithstanding the absence of a chief complaint, accepted standards of care require that, on a patient's initial office visit, a reasonably prudent physician must ascertain the reason why the patient has presented at the physician's office, pertinent elements of past medical history, including past surgical history and other elements. The physician should also perform and document a physical examination, and form and document an impression which might list diagnoses or problems, and a plan to address them. (T. 143)

33. The only documentation in Respondent's medical record for Patient C regarding any physical examination performed by Respondent on that visit includes vital signs, pulse, blood pressure, weight, and the notation "WNL," meaning "within normal limits." (Pet. Ex. 6, p.5)

34. A notation "WNL" to document the physical examination performed on a patient does not meet accepted standards of medical practice. (T. 143-144) Dr. Abrams agreed that from the notation "WNL" he could not tell what, if any, physical examination was performed, and that without further conversation with Respondent to determine the meaning of "WNL," Dr. Abrams had no idea what, if any, components of a physical examination were included. (T. 621-622; 594-595)

35. Respondent's office record for Patient C does not describe or document any of the elements of a physical examination, which makes it impossible to ascertain whether a complete, incomplete or indeed any physical examination was performed beyond vital signs, pulse, blood pressure and weight. It is impossible to tell from reviewing the patient's record whether or not a physical examination was performed or what it included. (T.143-146)

36. It is important for a physician to document the components of even a completely normal physical examination of a patient. These components must be recorded both as a tool for the examining physician to recall what was examined, and to document for future use and reference the extent of the examination performed. (T. 171) Respondent's expert witness, Dr. Abrams, agreed that reducing documentation of a normal history and physical examination on an initial patient visit to "WNL" is inadequate, and does not meet accepted standards of medical practice. (T. 592-593)

37. It is essential for a physician to keep complete and accurate medical records. A physician should avoid having to rely upon his or her memory from one office visit to the next or between encounters with any given patient, because the physician may have seen hundreds of patients with countless physical findings. If a practitioner does not keep complete and accurate medical records, there is a real risk of confusion as to which patient had which

physical finding. To be adequate, medical records must provide this valuable, essential information for the practitioner to rely on and reference over time. (T.167-169)

38. Respondent failed to adequately evaluate Patient C's complaint of abdominal pain on the January 13 office visit. Respondent did not describe any of the characteristics of the patient's abdominal pain, and did not describe at all the current status of the patient's abdominal pain. The description of the patient's abdominal pain is inadequate and incomplete. There is no description of any relevant physical examination performed to evaluate the complaint. (T. 144-145, 161-162)

39. Respondent's office record for the patient's initial office visit on January 13 contains internal inconsistencies. (T. 169-170) Respondent, in his review of systems, put a line through all the listed items, indicating they were all negative. (T. 364; Pet Ex. 6, p. 4) The list of systems described as negative, however, included abdominal pain, which Respondent also lists as the patient's chief complaint. (T. 160-161, 169-170; Pet. Ex. 6, p. 4)

40. Respondent did not appropriately follow up on previously identified symptoms during the May 17 visit. Respondent did not document having performed any physical examination other than vital signs, and his failure to perform or record such follow up and examination in that visit deviates from accepted medical standards. (T.147-151)

41. Respondent's medical record for Patient C fails to describe the patient's symptoms in sufficient detail and contains no recorded impressions or treatment plans. (T 150-151; Pet. Ex. 6)

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee. The citations in parentheses refer to the Findings of Fact which support each Factual Allegations.

CONCLUSIONS AS TO PATIENT A

The Hearing Committee determined that the following Factual Allegations should be sustained.

A. Respondent provided medical care to Patient A on various occasions including from approximately April 16, 1988 through approximately April 27, 1988 at Vassar Brothers Hospital, Poughkeepsie, New York. (1-14)

A.1. Respondent failed to appropriately and/or in a timely manner treat Patient A with antibiotics. (1-12 and 14)

A.2. Respondent failed to note in a timely manner that the antibiotic order for Patient A had expired. (2-12 and 14)

A.3. Respondent, on numerous occasions during Patient A's hospitalization, failed to recognize that Patient A was not receiving antibiotic therapy for bacteremia, and failed to correct the situation. (2-12 and 14)

A.4. Respondent failed to adequately monitor Patient A's treatment and/or condition during his hospitalization. (2-12 and 14)

A.5. Respondent failed to make adequate progress notes in Patient A's hospital record. (2, 13 and 14)

CONCLUSIONS AS TO PATIENT B

The Hearing Committee determined that the following Factual Allegations should be sustained.

B. Respondent provided medical care to Patient B on or about November 7, 1990 at Respondent's office at 113 Hooker Avenue, Poughkeepsie, New York, in a telephone conversation on November 7, 1990, and at Vassar Brothers Hospital on or about November 8, 1990. (15-30)

B.1. Respondent failed to perform and/or document an adequate physical examination of Patient B in his office. (15-19 and 24-30)

B.2. Respondent failed to elicit and/or document an adequate history from Patient B in his office. (15 and 29)

B.3. Respondent failed to diagnose and/or treat Patient B's diabetes in a timely manner. (15-30)

CONCLUSIONS AS TO PATIENT C

The Hearing Committee determined that the following Factual Allegations should be sustained.

C. Respondent provided medical care to Patient C on various occasions from approximately January 13, 1995 through approximately June 20, 1995 at Respondent's office. (31-41)

C.1. Respondent failed to perform and/or document an adequate initial physical examination of Patient C on or about January 13, 1995. (31-36)

C.2. Respondent failed to adequately evaluate Patient C's complaints and/or symptoms on or about January 13, 1995 and/or on or about May 17, 1995, and/or failed to adequately document said evaluation. (31-36)

C.3. Respondent failed to maintain adequate medical records regarding Respondent's treatment of Patient C. (31-36) For purposes of this Factual Allegation, the Hearing Committee construed the term "treatment" to mean care or management of a patient.

DISCUSSION

General -- Respondent is charged with multiple specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of actions which constitute professional misconduct, but does not provide definitions of such categories of misconduct. During the course of its deliberations on these charges, the Hearing

Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law," sets forth suggested definitions for certain types of professional misconduct.

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

"Negligence" is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

"Gross negligence" is 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.

"Incompetence" is a lack of the skill or knowledge necessary to practice the profession.

"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.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the Petitioner sustained its burden of proof regarding six of the nine charges brought against Respondent. The rationale for the Hearing Committee's conclusions is set forth below.

Credibility of Witnesses -- The Hearing Committee made determinations as to the credibility of the various witnesses presented by the parties. Each side presented an expert witness. The Petitioner presented William A. Busino, Jr., M.D., who is board certified in internal medicine, and has added qualifications in geriatric medicine. Dr. Busino is Associate Professor of Clinical Medicine, Department of Medicine, at Albany Medical College. Currently, Dr. Busino practices general internal medicine full-time as part of a group practice. Dr. Busino is an attending physician at two general care acute service hospitals in Schenectady, New York.

The Respondent presented Arnold L. Abrams, M.D., who is board certified in internal medicine. For the past 29 years, Dr. Abrams has been a solo practitioner. Dr. Abrams is a senior

attending physician in medicine and cardiology at White Plains Hospital in White Plains, New York.

Neither of the expert witnesses has a demonstrated stake in the outcome of this case. Neither Dr. Busino nor Dr. Abrams had ever met Respondent prior to the commencement of this proceeding.

Each side also presented a fact witness relating to the medical care Respondent provided to Patient B. Petitioner presented the mother of Patient B. The Respondent presented Jesus L. Floresca, M.D., who was assigned as an emergency room physician at Vassar Brothers Hospital on November 8, 1990.

In addition, the Respondent testified on his own behalf during these proceedings.

The Hearing Committee's determination regarding the credibility of the witnesses rested on the quality of their testimony. The Hearing Committee found the Petitioner's expert witness, Dr. Busino to be more objective, fair-minded in his opinions than the Respondent's witness, Dr. Abrams. The Hearing Committee found Patient B's mother to be a credible witness. In recounting events, Patient B's mother was deemed to be honest and forthcoming, and not evasive, in contrast to the Respondent whom Hearing Committee found not to be credible. The Hearing Committee deemed Dr. Floresca's testimony not to be relevant to the misconduct charged.

Gross Negligence and Gross Incompetence -- Petitioner has charged Respondent with gross negligence, negligence, gross incompetence, and incompetence in connection with his care and treatment of Patient A. The Hearing Committee found overwhelming evidence to sustain the charge of "simple" or "ordinary" negligence regarding Respondent's care and treatment of Patient A, but not of gross negligence. The Respondent admitted the Factual Allegations pertaining to Patient A. Moreover, the Respondent presented no expert testimony concerning Patient A. Respondent's expert witness, Dr. Abrams, reviewed Patient A's record and discussed his review of it with Respondent's attorney. However, the Respondent chose not to offer any testimony from Dr. Abrams with regard to Patient A. Since the Respondent presented no expert testimony to the

contrary, Dr. Busino's testimony stands uncontroverted regarding Patient A.

Notwithstanding clear evidence of negligent conduct, the record also shows that the Respondent obtained appropriate consultations during Patient A's hospitalization. In view of such evidence, the Hearing Committee was unable to conclude that Respondent's negligent conduct was "egregious or conspicuously bad."

The Hearing Committee determined not to sustain the charges of incompetence and gross incompetence against Respondent in connection with his care and treatment of Patient A. The evidence pertaining to Respondent's care and treatment of Patient A supports a determination of negligence, but does not show that Respondent lacks the skill or knowledge necessary to practice the profession. Having found the evidence insufficient to sustain the charge of incompetence, a priori the Respondent is not guilty of gross incompetence.

Negligence on More than One Occasion and Incompetence on More than One Occasion -- Petitioner also has charged Respondent with negligence in connection with his care and treatment of Patients B and C. With respect to Patient B, there was compelling evidence that Respondent failed to perform and/or document an adequate physical examination, to elicit and/or document an adequate history, and to diagnose and/or treat her diabetes in a timely manner. As such, the Respondent failed to exercise the care that would be exercised by a reasonably prudent physician under the circumstances. Indeed, the Hearing Committee believed Respondent's failure with respect to Patient B was so egregious and conspicuously bad as to justify a charge of gross negligence. In the absence of a charge of gross negligence with respect to Patient B, the Hearing Committee was limited to finding Respondent guilty of negligence.

The Hearing Committee also found ample evidence to sustain a charge of negligence regarding Respondent's care and treatment of Patient C. Petitioner proved by a preponderance of the evidence that Respondent failed to perform and/or document an adequate physical examination, to adequately evaluate his complaints and/or symptoms, and to adequately document such

evaluation.

Having concluded that Respondent is guilty of negligence in connection with his care and treatment of Patients A, B, and C, the Hearing Committee voted to sustain the charge of negligence on more than one occasion.

Respondent also has been charged with incompetence in connection with his treatment of Patients B and C. As noted above, to sustain such a charge, it must be shown by a preponderance of the evidence that Respondent lacked the requisite skill or knowledge necessary to practice the profession. With respect to Respondent's care and treatment of Patient C, the Hearing Committee concluded that Petitioner did not satisfy such burden of proof. With respect to Patient B, however, the evidence clearly established Respondent's incompetence. Respondent failed to diagnose and/or treat Patient B's diabetes in a timely manner during the November 7, 1990 office visit. Respondent failed a second time to diagnose and/or treat Patient B's diabetes that evening when her mother called Respondent to inform him of Patient B's continued symptomatology. The Hearing Committee concluded that such repeated acts of incompetence were sufficient to sustain the charge of incompetence on more than one occasion.

Failure to Maintain Accurate Records -- Respondent also was charged with failing to maintain accurate records for Patients A, B and C. The evidence clearly showed that Respondent's record keeping for these patients was wholly inadequate. Respondent's hospital progress notes for Patient A fail to provide a method for outlining the rationale for Patient A's care, for describing that care, and for setting out the progress of Patient A's care. Respondent's progress notes also fail to record any physical examination of Patient A that he performed.

Respondent's record keeping was equally bad with respect to Patient B. Respondent's office record for Patient B fails to document that an adequate history was elicited from the patient and contains no recorded features of a physical examination other than vital signs.

Respondent's poor record keeping also is clearly evident in his failure to adequately document Patient C's initial office visit on January 13, 1995. Other than Respondent's recollection, there is no clear evidence that a complete physical examination took place on that date. In addition, Patient C's history, as documented by Respondent, is incomplete.

In view of the findings noted above, the Hearing Committee determined that Respondent's record keeping failed to meet accepted standards of medical practice. Accordingly, the Hearing Committee voted to sustain Specifications Seven, Eight, and Nine.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously as follows:

FIRST SPECIFICATION (GROSS NEGLIGENCE)

1. NOT SUSTAINED

SECOND SPECIFICATION (GROSS INCOMPETENCE)

2. NOT SUSTAINED

THIRD AND FOURTH SPECIFICATIONS (NEGLIGENCE ON MORE THAN ONE OCCASION)

3. SUSTAINED
4. SUSTAINED

FIFTH AND SIXTH SPECIFICATIONS (INCOMPETENCE ON MORE THAN ONE OCCASION)

5. NOT SUSTAINED

6. SUSTAINED as to Factual Allegations B.1, B.2 and B.3.

SEVENTH SPECIFICATION (FAILURE TO MAINTAIN ACCURATE RECORDS)

7. SUSTAINED

8. SUSTAINED

9. SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee determined, by a vote of two to one, that Respondent's license to practice medicine as a physician in New York State should be revoked. This determination was reached after due consideration of the full range of available penalties.

The evidence produced during this hearing proved several instances of serious professional misconduct. The Hearing Committee found Respondent guilty of negligence in connection with his care and treatment of Patient A. Blood cultures for Patient A revealed staphylococcus aureus, indicating the presence of a very serious, highly lethal infection and requiring immediate antibiotic treatment. The record shows that Respondent allowed Patient A's antibiotic order for garamycin

to expire. Moreover, for five days following the expiration of such order, Respondent failed to order antibiotic treatment for Patient A, despite the fact that during such five day period a consultant had recommended the institution of Cipro.

The Hearing Committee also found Respondent guilty of negligence and incompetence with regard to his care and treatment of Patient B. Respondent failed to perform and/or document an adequate physical examination, to elicit and/or document an adequate history, and to diagnose and/or treat her diabetes in a timely manner. Indeed, Respondent's failure with respect to Patient B was so egregious and conspicuously bad as to justify a charge of gross negligence.

With regard to Respondent's care and treatment of Patient C, the Hearing Committee also found abundant evidence to sustain a charge of negligence. Respondent failed to perform and/or document an adequate physical examination, to adequately evaluate his complaints and/or symptoms, and to adequately document such evaluation.

The Hearing Committee concluded that Respondent is a poor candidate for rehabilitative sanctions, such as retraining and/or supervised practice. Respondent resigned his privileges at Vassar Brothers Hospital in 1991, rather than undergo medical reeducation and attempt to qualify for the Board examination in internal medicine. In 1996, St. Francis Hospital required Respondent to attend continuing medical education emphasizing risk assessment and medical record keeping as a condition to restoring any of his clinical privileges. Respondent instead resigned his clinical privileges at the hospital. Therefore, the Hearing Committee determined that revocation is the only appropriate sanction that will adequately punish Respondent and protect the public.

ORDER

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

1. The license to practice medicine of **GAETANO V. CAVALLARO** is hereby **REVOKED**.

2. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

Dated: **Schenectady, New York**
June 22, 1998

David T. Lyon, M.D. **(Chairperson)**

Robert M. Kohn, M.D.
George C. Simmons, Jr., Ed.D.

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
GAETANO CAVALLARO, M.D.	:	CHARGES

----------X

GAETANO CAVALLARO, M.D., the Respondent, was authorized to practice medicine in New York State on October 14, 1964, by the issuance of license number 093132 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1997, through December 31, 1998, with a registration address of 113 Hooker Avenue, Poughkeepsie, New York 12601.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (patients are identified in Appendix) on various occasions including from approximately April 16, 1988 through approximately April 27, 1988 at Vassar Brothers Hospital, Poughkeepsie, New York.

1. Respondent failed to appropriately and/or in a timely manner treat Patient A with antibiotics.

2. Respondent inappropriately discontinued antibiotics for Patient A, and/or failed to note in a timely manner that the antibiotic order for Patient A had expired.

3. Respondent, on numerous occasions during Patient A's hospitalization, failed to recognize that Patient A was not receiving antibiotic therapy for bacteremia, and failed to correct the situation.

4. Respondent failed to adequately monitor Patient A's treatment and/or condition during his hospitalization.

5. Respondent failed to make adequate progress notes in Patient A's hospital record.

B. Respondent provided medical care to Patient B on or about November 7, 1990 at Respondent's office at 113 Hooker Avenue, Poughkeepsie, New York [hereinafter Respondent's office], in a telephone conversation on November 7, 1990, and at Vassar Brothers Hospital on or about November 8, 1990.

1. Respondent failed to perform and/or document an adequate physical examination of Patient B in his office.

2. Respondent failed to elicit and/or document an adequate history from Patient B in his office.

3. Respondent failed to diagnose and/or treat Patient B's diabetes in a timely manner.

4. Respondent failed to appropriately respond to and/or

document in Patient B's medical record his November 7, 1990 telephone conversation with Patient B's mother regarding Patient B's condition.

C. Respondent provided medical care to Patient C on various occasions from approximately January 13, 1995 through approximately June 20, 1995 at Respondent's office.

1. Respondent failed to perform and/or document an adequate initial physical examination of Patient C on or about January 13, 1995.

2. Respondent failed to adequately evaluate Patient C's complaints and/or symptoms on or about January 13, 1995 and/or on or about May 17, 1995, and/or failed to adequately document said evaluation.

3. Respondent failed to maintain adequate medical records regarding Respondent's treatment of Patient C.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with practicing medicine with gross negligence on a particular occasion, in violation of New York Education Law §6530(4) (McKinney Supp. 1997), in that Petitioner charges:

1. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4.

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with practicing medicine with gross incompetence in violation of New York Education Law §6530(6) (McKinney Supp. 1997), in that Petitioner charges:

2. The facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4.

THIRD AND FOURTH SPECIFICATIONS

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with negligence on more than one occasion in violation of New York Education Law §6530(3) (McKinney Supp. 1997), in that Petitioner charges that Respondent committed:

3. The facts in Paragraphs A and A.3.
4. Two or more of the following: the facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or C and C.1 and/or C.2 and/or C.3.

FIFTH AND SIXTH SPECIFICATIONS

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing medicine with incompetence on more than one occasion in violation of New York Education Law §6530(5) (McKinney Supp. 1997) in that Petitioner charges that Respondent committed:

5. The facts in Paragraphs A and A.3.
6. Two or more of the following: the facts in Paragraphs A and A.1 and/or A.2 and/or A.3 and/or A.4 and/or A.5 and/or B and B.1 and/or B.2 and/or B.3 and/or B.4 and/or C and C.1 and/or C.2 and/or C.3.

SEVENTH THROUGH NINTH SPECIFICATIONS

FAILURE TO MAINTAIN ACCURATE RECORDS

Respondent is charged with professional misconduct under New York Education Law §6530(32) (McKinney Supp. 1997) by reason of his failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

7. The facts in Paragraphs A and A.5.

8. The facts in Paragraphs B and B.1 and/or B.2 and/or B.4.

9. The facts in Paragraphs C and C.1 and/or C.2 and/or C.3.

DATED: February 2, 1998
Albany, New York

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