STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

April 19, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Louis John Del Giorno, M.D.
630 Winchester Avenue
Martinsburg, West Virginia 25401

Louis John Del Giorno, M.D.
11238 Eastwood Drive
Hagerstown, MD 21742

Law Offices of Eric M. Davis, P.C.
Eric M. Davis, Esq. and
Felix Nihamin, Esq.
180 West 80th Street
Suite 215
New York, New York 10024

Marcia A. Kaplan, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

RE: In the Matter of Louis John Del Giorno, M.D.

Dear Dr. Del Giorno, Mr. Davis and Ms. Kaplan:

Enclosed please find the Determination and Order (No. 96-92) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 all action 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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

COPY

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

IN THE MATTER

OF

LOUIS JOHN DEL GIORNO, M.D.

DETERMINATION
AND
ORDER

BPMC-96-92

EDMUND O. ROTHSCHILD, M.D., (Chair), **ROBERT B. BERGMANN, M.D.** and **MICHAEL A. GONZALEZ, R.P.A.** 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, served as the Administrative Officer.

The Department of Health appeared by **MARCIA A. KAPLAN, ESQ.**, Associate Counsel.

Respondent, **LOUIS JOHN DEL GIORNO, M.D.**, appeared personally and was represented by the **LAW OFFICES OF ERIC M. DAVIS, P.C., ERIC M. DAVIS, ESQ.** and **FELIX NIHAMIN, ESQ.**, of counsel.

A Hearing was held on February 27, 1996. Evidence was received and examined, including a witness who was sworn or affirmed. A Transcript of the proceeding was made. After consideration and review of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

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 [hereinafter "**P.H.L.**"]).

This case, brought pursuant to P.H.L. § 230(10)(p), is also referred to as an "expedited hearing". The scope of an expedited hearing is strictly limited to evidence or sworn testimony relating to the nature and severity of the penalty (if any) to be imposed on the licensee[1] (Respondent).

Respondent, LOUIS JOHN DEL GIORNO, M.D. is charged with professional misconduct within the meaning of § 6530(9)(d) of the Education Law of the State of New York ("**Education Law**"), to wit: "professional misconduct ... by reason of having disciplinary action taken by a duly authorized professional disciplinary agency of another state, for conduct, which conduct, would, if committed in New York State constitute professional misconduct under the Laws of New York State. (Petitioner's Exhibit # 1 and § 6530[9][d] of the Education Law).

In order to find that Respondent committed professional misconduct, the Hearing Committee, pursuant to § 6530(9)(d) of the Education Law, must determine: (1) whether Respondent had some disciplinary action taken or instituted against him by a duly authorized professional disciplinary agency of another state and (2) whether Respondent's conduct on which the disciplinary action was taken would, if committed in New York State, constitute professional misconduct under the laws of New York State.

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[1] P.H.L. § 230(10)(p), fifth sentence.

A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. All Findings and Conclusions herein were unanimous. The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. 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 October 29, 1984 by the issuance of license number 160592 by the New York State Education Department (Petitioner's Exhibits # 1 & # 2)[2].

2. Respondent is currently registered with the New York State Education Department to practice medicine, effective December, 1995 [T-19-20][3].

3. The Florida Board of Medicine, through the Florida Agency of Health Care Administration of the State of Florida, ("**Florida Board**") is a state agency charged with regulating the practice of medicine pursuant to the laws of the State of Florida (Petitioner's Exhibit # 3).

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[2] refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit) or by Dr. Del Giorno (Respondents Exhibit).

[3] Numbers in brackets refer to transcript page numbers [T-].

4. On February 24, 1992, Larry G. McPherson, Jr., Chief Medical Attorney, of the Florida Department of Professional Regulation filed an Administrative Complaint (Case No. 8911367) (**"Complaint 1"**) with the Florida Board charging Respondent with "gross or repeated malpractice or the failure to practice medicine with that level of care, skill and treatment which is recognized by a reasonable prudent similar physician as being acceptable under similar conditions and circumstances" in violation of § 458.331(1)(t) of Florida Statutes (Petitioner's Exhibit # 3).

5. Under Complaint 1, Respondent was also charged with failure to "keep written medical records justifying the course of treatment of the patient" in violation of § 458.331(1)(m) of Florida Statutes (Petitioner's Exhibit # 3).

6. Complaint 1 is annexed hereto as Appendix II. The allegations contained in Complaint 1 are not repeated at length in these Findings but are accepted by the Hearing Committee as the conduct of Respondent in the State of Florida and are fully incorporated herein (Petitioner's Exhibit # 3).

7. On May 15, 1992, Larry G. McPherson, Jr., Chief Medical Attorney, of the Florida Department of Professional Regulation filed an Administrative Complaint (Case No. 8905851) (**"Complaint 2"**) with the Florida Board charging Respondent with "gross or repeated malpractice or the failure to practice medicine with that level of care, skill and treatment which is recognized by a reasonable prudent similar physician as being acceptable under similar conditions and circumstances", involving 4 separate patients, in violation of § 458.331(1)(t) of Florida Statutes (Petitioner's Exhibit # 3).

8. Under Complaint 2, Respondent was also charged with failure to "keep written medical records justifying the physician's course of treatment" (Patient # 1 only) in violation of § 458.331(1)(m) of Florida Statutes (Petitioner's Exhibit # 3).

9. Complaint 2 is annexed hereto as Appendix III. The allegations contained in Complaint 2 are not repeated at length in these Findings but are accepted by the Hearing Committee as the conduct of Respondent in the State of Florida and are fully incorporated herein (Petitioner's Exhibit # 3).

10. On February 7, 1995, Respondent signed and agreed to the terms of a voluntary relinquishment of his license as a medical doctor in the State of Florida (Petitioner's Exhibit # 3); [T-31-32].

11. The terms of the voluntary relinquishment include: (a) Respondent agrees never again to apply for licensure in Florida; (b) the voluntary relinquishment is considered to be disciplinary action and as such it will be reported to the Federation of State Medical Boards and the National Practitioner's Data Bank; and (c) Respondent waives judicial review or challenge to the validity of the voluntary relinquishment (Petitioner's Exhibit # 3); [T-44-48].

12. As a result of the voluntary relinquishment under Complaints 1 and 2, the Florida Board issued a Final Order, dated, June 9, 1995, which accepted Respondent's voluntary relinquishment of his license to practice medicine in the State of Florida (Petitioner's Exhibit # 3).

13. Humana Hospital Northside ("**Humana**") issued findings in January 19, 1989 that the care rendered by Respondent on three cases[4] was well below the community standard and that several other cases presented were "borderline or questionable" (Respondent's Exhibit # B).

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[4] The Hearing Committee presumes that these are 3 of the same patients that were involved in the Administrative Complaints.

14. The Humana Hearing Committee indicated that Respondent was reluctant to accept the fact that he made errors in judgment (Respondent's Exhibit # B).

15. An Executive Committee of Humana, on January 31, 1989, recommended to the Board of Trustees of Humana that Respondent's privileges at Humana be suspended based on the report of the Hearing Committee, dated January 19, 1989 (Respondent's Exhibit # C).

16. On July 6, 1989, the Board of Trustees of Humana voted unanimously to revoke Respondent's membership on the medical staff and all clinical privileges at Humana (Respondent's Exhibit # D).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the December 29, 1995 Statement of Charges, are SUSTAINED [5]:

Paragraphs A., A.1., A.2., A.3., A.4., A.5., A.6. & A.7.: (3 - 16)

The Hearing Committee further concludes, based on the above Factual Conclusion, that the SPECIFICATION OF CHARGES in the Statement of Charges is SUSTAINED

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[5] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation.

The Hearing Committee concludes that the Department of Health has shown by a preponderance of the evidence that Respondent had disciplinary action taken or instituted against him by an authorized professional disciplinary agency of the State of Florida. The Department of health has also proved, by a preponderance of the evidence, that Respondent's conduct, as alleged in the Florida disciplinary action, would, if committed in New York, constitute professional misconduct under the laws of New York State. The Department of Health has met its burden of proof.

DISCUSSION

I. Professional Misconduct under § 6530(9)(d) of the Education Law.

The Florida Board is a duly authorized professional disciplinary agency. In February and May 1992, the State of Florida, through the Florida Board instituted disciplinary action against Respondent.

The record establishes that Respondent committed professional misconduct pursuant to § 6530(3)[6] and § 6530(32)[7] of the Education Law.

The course of conduct contained in Complaints 1 and 2 and the Humana Exhibits presented by Respondent, establish Respondent's negligence. In New York, negligence, in a Medical Misconduct proceeding, is the failure to exercise the care that would be exercised by a reasonably prudent licensee (physician) under the circumstances. Negligence must occur on more than one occasion for a physician to be disciplined.

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[6] Each of the following is professional misconduct... Practicing the profession with negligence on more than one occasion;

[7] Each of the following is professional misconduct... Failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. ...

It is clear, from the Complaints and the Humana Exhibits, that Respondent's care, treatment and management of 5 Patients were a significant deviation of acceptable standards of medical care required of a licensed physician. Respondent was negligent in the medical care he provided to 5 Patients.

Therefore, Respondent was negligent on more than one occasion and would be guilty of professional misconduct under the laws of the State of New York.

In New York, the charge of practicing the profession with negligence on more than one occasion would be sustained.

The Hearing Committee determines that the information contained in the Complaints and the Humana Exhibits was sufficient to show that at least several records of Respondent's patients were not maintained accurately or properly.

With regard to the testimony presented by Respondent, the Hearing Committee evaluated and assessed it according to training, experience, credentials, demeanor and credibility. The Hearing Committee found Respondent to have very little credibility. For example, Respondent's assertions that the Florida surrender was not voluntary and that he was not on notice that his surrender may have consequences in other jurisdictions flies in the face of the plain language contained in the document that Respondent signed.

Respondent's conduct as to at least 5 patients shows negligence and a lack of fitness to practice medicine.

The Hearing Committee finds that there is insufficient evidence to determine whether Respondent's conduct would have constituted Gross Negligence under New York law. The Hearing Committee can not conclude that Respondent's acts rose to the level of being egregious or conspicuously bad conduct.

Therefore, a charge of practicing the profession with gross negligence, within the meaning of § 6530(4) would not be sustained.

The Hearing Committee finds and determines that Respondent's conduct in Florida, would, if committed in New York State, constitute professional misconduct under § 6530(3) and § 6530(32) of the Education Law and therefore Respondent has violated § 6530(9)(d) of the Education Law, as indicated above.

DETERMINATION

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

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 record clearly establishes that Respondent's conduct would be significant violations of Florida Laws. Respondent's lack of complete honesty and fitness to practice medicine is evident in his course of conduct, as established by the Florida Board, the Humana Hospital Exhibits and Respondent's appearance before the Hearing Committee.

The Hearing Committee concludes that if this case had been held in New York, on the facts presented about the pattern of negligence and inadequate records, it would have resulted in a unanimous vote for revocation of Respondent's license.

The Hearing Committee has noted that the State of Florida has accepted the surrender of Respondent's license with the condition that Respondent never reapplies for licensure as a medical doctor in the State of Florida.

Although the Administrative Officer indicated at the Hearing that the Hearing Committee would not consider Respondent's argument as to dismissal in the interest of justice, the Hearing Committee did review the record and the testimony in that regard. The only reason it is even mentioned here is that the Hearing Committee is of the strong opinion that this case is definitely not the kind of case which merits dismissal of the Charges in the interest of justice. Respondent's alleged conduct as to the care and treatment given to at least 5 patients was well below acceptable standards of medical care required of a licensed physician. Even his peers at Humana Hospital found Respondent's care to be deficient. Respondent continues to refuse to accept his continuing errors in judgment. In addition, the seven year time frame is of no consequence to this misconduct proceeding. The Hearing Committee finds absolutely no reason or justification present to grant or to even seriously consider a request for dismissal in the interest of justice under § 6530 of the Education Law.

The Hearing Committee considers Respondent's misconduct to be very serious. With a concern for the health and welfare of patients in New York State, the Hearing Committee determines that revocation of Respondent's license in New York is the appropriate sanction to impose 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 professional misconduct contained within the Statement of Charges (Petitioner's Exhibit # 1) is **SUSTAINED**, and

2. Respondent's license to practice medicine in the State of New York is hereby **REVOKED.**

DATED: New York, New York
April 9 , 1996

EDMUND O. ROTHSCHILD, M.D., (Chair),

ROBERT B. BERGMANN, M.D.
MICHAEL A. GONZALEZ, R.P.A.

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Marcia A. Kaplan, Esq.
Associate Counsel,
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor

APPENDIX I

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

IN THE MATTER OF LOUIS JOHN DEL GIORNO, M.D.	STATEMENT OF CHARGES

Louis John Del Giorno, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 29, 1984, by the issuance of license number 160592 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about June 9, 1995, the Florida Board of Medicine issued an Order accepting Respondent's surrender of his Florida medical license in order to avoid further administrative prosecution pursuant to Florida Administrative Complaints AHCA Case Numbers 89-11367 (filed February 25, 1992) and 89-05851 (filed May 15, 1992), with the provision that Respondent agrees never again to apply for a Florida license. The Complaints alleged that Respondent violated Section 458.331(1)(t), Florida Statutes, which sets forth as grounds for disciplinary action gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, and Sections 458.331(1)(m), Florida Statutes, failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, as follows:

1. Respondent violated Sec. 458.331(1)(t) in his treatment of Patient #1, an eighty-one year old female, from on or about February 6, 1989 through on or about July 20, 1989, in that he failed to conduct an exhaustive workup of Patient #1's rectal bleeding, failed to ascertain the cause of her rectal bleeding, delayed five months after the onset of bleeding to conduct a rigid sigmoidoscopy, failed to conduct a definitive colonoscopy after rigid sigmoidoscopy proved negative, and failed to obtain the consultation of a gastroenterologist in his diagnosis and treatment of Patient #1 (Case No. 89-11367);
2. Respondent violated Section 458.331(1)(m) in his treatment of Patient #1, an eighty-one year old female, from on or about February 6, 1989 through on or about July 20, 1989, in that he failed to record adequately the history of rectal bleeding in his medical records and failed to justify why he rendered conservative treatment to a patient in need of a full workup in response to her complaints of rectal bleeding (Case No. 89-11367);
3. Respondent violated Sec. 458.331(1)(t) in his treatment of Patient #1, a 70 year old male with a history of acute myocardial infarction with unstable angina, on or about September 2, 1988 at Humana Hospital-Northside, in that he failed to examine him or to ensure that a cardiologist examine him until four hours after the patient's admission to the CCU, when the patient suffered a cardiac arrest and expired (Case No. 89-05851);

4. Respondent violated Section 458.331(1)(m) in that he treated Patient #1 at Humana Hospital - Northside's CCU from on or about July 25, 1988 through on or about August 1, 1988 for acute myocardial infarction and thereafter failed to keep written medical records justifying his course of treatment of Patient #1 by failing to dictate a complete history and physical of Patient #1 until thirty days after the patient had been discharged (Case No. 89-05851);

5. Respondent violated Sec. 458.331(1)(t) in his treatment of Patient #2, an eighty year old female, in that from on or about July 30, 1988 to September 5, 1988, Respondent treated Patient #2 , who had a history of CVA's and had been on Coumadin for three years, during two hospitalizations at Humana Hospital-Northside and at Parkway Nursing Home, and failed to address and or treat Patient #2's GI bleeding after discontinuing Coumadin; failed to order indicated repeat CBC's after the second day of her first admission; and failed to pay attention to Patient #2's declining hemoglobin and the blood in her stool prior to her respiratory arrest during her second admission (Case No. 89-05851);

6. Respondent violated Sec. 458.331(1)(t) in his treatment of Patient #3, an 86 year old female, from on or about August 13, 1988 to on or about August 17, 1988, at Humana Hospital-Northside where she was admitted with a fever of 102 degrees, confusion and ataxia and diagnosed by Respondent with dementia and possible pleural effusion in that Respondent failed to find out Patient #3's usual mental status, usual state of mobility and activity; failed to perform an adequate neurological

examination that would justify his diagnosis of dementia; failed to order an indicated neurological consultation; failed to sedate Patient #3 to allow her to undergo an indicated CT scan; and failed to order a VDRL test, thyroid studies and or liver enzymes to rule out other metabolic or disease causes of dementia (Case No. 89-05851);

7. Respondent violated Sec. 458.331(1)(t) in his treatment of Patient #4, an 82 year old female, from on or about October 11, 1988, to on or about October 13, 1988, at Humana Hospital-Northside, in that he failed to respond, treat, and/or authorize treatment in a timely manner when he instructed the ER nurse to discharge Patient #4, who was hypotensive, had unstable vital signs and cardiac dysrhythmia, and when he waited four to five hours before authorizing treatment and or seeing the patient (Case No. 89-05851).

The conduct resulting in the disciplinary action involving the surrender of Respondent's license would, if committed in New York state, constitute professional misconduct under the laws of New York state (namely N.Y. Educ. Law §6530(3); i.e. practicing the profession with negligence on more than one occasion; and/or 6530(4); i.e. practicing the profession with gross negligence on a particular occasion; and/or 6530(32); i.e. failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient).

SPECIFICATION OF CHARGES

HAVING HAD DISCIPLINARY ACTION TAKEN

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(d) (McKinney Supp. 1995) by having his license to practice medicine revoked, suspended or having other disciplinary action taken, or having voluntarily or otherwise surrendered his license after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the revocation, suspension or other disciplinary action involving the license or the surrender of the license would, if committed in New York state, constitute professional misconduct under the laws of New York state [namely N.Y. Educ. Law §6530(3)(4) and/or (32)] as alleged in the facts of the following:

1. Paragraph A.

DATED: December 29, 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

PETITIONER,

vs.

CASE NO. 8911367

LOUIS J. DELGIORNO, M.D.

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against LOUIS J. DELGIORNO, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0047967. Respondent's last known address is 5880 49th Street North, St. Petersburg, Florida 33709.

3. Respondent, a board certified family practitioner, treated Patient #1, an eighty-one (81) year old female, for rectal bleeding from on or about February 6, 1989, to on or about July 20, 1989.

4. Prior to seeing Respondent, Patient #1 began experiencing rectal bleeding in November, 1988, and was treated by Respondent's associates.

5. On or about February 6, 1989, when Patient #1 initially complained of rectal bleeding to Respondent, he diagnosed Irritable Bowel Syndrome reassured her that this was not an indication of a serious problem, and prescribed to Patient #1 Fibrocon 1gd and Anusol H.C. suppositories 1 bid #30.

6. By on or about April 20, 1989, Patient #1 continued to have rectal bleeding and Respondent conducted a rigid sigmoidoscopy in which he inserted the sigmoidoscope 22 cm before encountering a stool which prevented him from continuing 4 cm further. Respondent noted the sigmoidoscopy revealed no apparent lesions, no evidence of bleeding, and no thrombosis.

7. On or about May 4, 1989, Respondent signed his initials on a complaint from Patient #1 in which she stated that she was "still having rectal bleeding with bowel movements" and having bad cramping before reaching B.M. (bowel movement). Below Patient #1's complaint, Respondent noted "No problem, will resolve."

8. On or about July 20, 1989, Respondent conducted an anuscopy on Patient #1, which revealed squamous cell papilloma.

9. Based on the foregoing, Respondent diagnosed Patient #1 with diverticulitis, and advised her that nothing more could be done about her rectal bleeding.

10. On or about July 21, 1989, Respondent signed his initial on a complaint from Patient #1 in which she stated that she had

suffered rectal bleeding through the previous night and inquired as to why Respondent had not referred her to a specialist.

11. Patient #1 subsequently sought treatment, on her own, other physicians who discovered she had adenocarcinoma and successfully performed a resection of the rectosigmoid colon.

12. Persistent rectal bleeding is a serious medical complaint that demands that the treating practitioner search for the cause until it is explained or an exhaustive workup has been completed.

13. Respondent was unable to ascertain the cause of Patient #1's rectal bleeding and he failed to conduct an exhaustive workup of her condition in that Respondent: should not have waited five (5) months after the onset of Patient #1's rectal bleeding to conduct a rigid sigmoidoscopy; should have conducted a definitive colonoscopy after rigid sigmoidoscopy proved negative; and should have obtained the consultation of a gastroenterologist in his diagnosis and treatment of Patient #1.

14. Respondent inadequately recorded the history of Patient #1's rectal bleeding in his medical records; furthermore, these records do not justify why he rendered conservative treatment to a patient in need of a full workup in response to her complaints of rectal bleeding.

COUNT ONE

15. Petitioner realleges and incorporates paragraphs one (1) through fourteen (14), as if fully set forth herein this Count One.

16. Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill,

and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in that Respondent; inappropriately waited five (5) months after the onset of Patient #1's rectal bleeding to conduct a rigid sigmoidoscopy; did not conduct a definitive colonoscopy after the rigid sigmoidoscopy proved negative; and did not obtain the consultation of a gastroenterologist in his diagnosis and treatment of Patient #1.

17. Based on the preceding allegations, Respondent violated Section 458.331(1)(t), Florida Statutes, gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

18. Petitioner reallges and incorporates paragraphs one (1) through fourteen (14), and sixteen (16), as if fully set forth herein this Count Two.

19. Respondent failed to keep written medical records justifying the course of treatment of the patient in that his medical records of Patient #1 inadequately document the history of Patient #1's rectal bleeding; and his records of Patient #1 failed to justify why he rendered conservative treatment to a patient in need of a full workup in response to her complaints of rectal bleeding.

20. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 24 day of February, 1992.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Larry G. McPherson, Jr.
Chief Medical Attorney
Department of Professional Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-0750
Florida Bar #788643
CJR/DPB/tb
PCP: February 17, 1992
McEwen and Kaiser

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK _____

DATE 2-25-92

APPENDIX III

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

PETITIONER,

vs.

CASE NO. 8905851

LOUIS J. DELGIORNO, M.D.

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against LOUIS J. DELGIORNO, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0047967. Respondent's last known address is 630 Winchester Avenue, Martinsburg, West Virginia, 25401.

3. At all times material hereto, Respondent, a board certified physician in family practice, rendered medical care to patients at Humana Hospital-Northside in Saint Petersburg, Florida.

Facts Pertaining to Patient # 1

4. From on or about July 25, 1988, to on or about September 5, 1988, Respondent admitted and treated Patient #1 during two hospitalizations at Humana Hospital-Northside.

5. On or about July 25,1988, Patient #1, a seventy (70) year old male, suffered a respiratory arrest at Respondent's office, and Respondent admitted Patient #1 to Humana Hospital-Northside's Coronary Care Unit (CCU) with a diagnosis of acute myocardial infarction.

6. From July 25, 1988, to on or about August 1, 1988, Patient #1 underwent an uncomplicated course and recovery at the hospital; however, during this hospitalization Respondent wrote a brief and inadequate admission note and failed to dictate a complete history and physical until on or about August 30, 1988.

7. The standard practice requires that a physician dictate a complete history and physical within one to two days after admission.

8. On or about September 2, 1988, around 2:00 a.m., Patient #1 presented to Humana Hospital-Northside's Emergency Room (ER), complaining of shortness of breath and chest pains. The ER physician examined Patient #1 and diagnosed congestive heart failure and unstable angina.

9. Tests done at the ER revealed that Patient #1's cardiac enzymes were elevated around 3:15 a.m., and an electrocardiogram revealed significant lateral wall ischemia.

10. Around 4:00 a.m., the ER physician admitted Patient #1 to the CCU after contacting Respondent and informing him of Patient #1's condition.

11. From around 4:00 a.m. until around 8:00 a.m., Respondent failed to examine Patient #1 and failed to order a cardiac consultation until the patient had suffered a cardiac arrest. A cardiac consultation was not performed.

12. Around 8:00 a.m. Patient #1 suffered a cardiac arrest, and after unsuccessful attempts at resuscitation, Respondent pronounced Patient #1 dead around 8:24 a.m.

13. Patients like Patient #1, who have a history of acute myocardial infarction with unstable angina, require immediate attention and aggressive intervention.

14. Respondent failed to see Patient #1 until the patient suffered a cardiac arrest and thereby failed to adequately assess and/or treat Patient #1 in a timely manner.

COUNT ONE

15. Respondent realleges and incorporates paragraphs one (1) through fourteen (14), as if fully alleged herein this Count One.

16. Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in that he failed to examine and or ensure that a cardiologist examine Patient #1 until four hours later when the patient suffered a cardiac arrest and expired.

17. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, in that he is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

18. Respondent realleges and incorporates paragraphs one (1) through fourteen (14), and sixteen (16), as if fully alleged herein this Count Two.

19. Respondent failed to keep written medical records justifying the physician's course of treatment in that he failed to dictate a complete history and physical of Patient #1 until thirty days after the patient had been discharged.

20. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, by failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

Facts Pertaining to Patient #2

21. From on or about July 30, 1988 to September 5, 1988, Respondent treated Patient #2 during two hospitalizations at Humana Hospital-Northside and at Parkway Nursing Home.

22. On or about July 30, 1988, Respondent's associate, Dr. Edward Popick, admitted Patient #2, an eighty year old female, to

Humana Hospital-Northside due to a cerebral vascular accident (CVA). Patient #2 had a history of CVA's and had been on Coumadin (an anticoagulant drug) for three years.

23. Upon admission, Patient #2's prothrombin time was 25 seconds with a normal hemoglobin. At this time, Respondent discontinued Patient #2's intake of Coumadin.

24. On or about July 31, 1988, the nurses noted that Patient #2 had vomited coffee ground material and that the same substance appeared through a nasogastric tube.

25. After July 31, 1988, Respondent failed to order a complete blood count on Patient #2 in spite of positive results for blood in her stool on or about August 3, 1988, and the nurses noting a large, tarry, black stool on or about August 4, 1988.

26. On or about August 5, 1988, Respondent discharged Patient #2 from Humana Hospital-Northside to Parkway Nursing Home, and although he listed gastritis as one of the discharging diagnoses, he failed to address the patient's gastrointestinal (GI) bleeding.

27. On or about September 3, 1988, Patient #2 presented to Humana Hospital-Northside's ER due to abdominal pain. Laboratory tests revealed that Patient #2's hemoglobin was 12 gm./100 ml. and that she had blood in her stool. The ER physician examined and admitted Patient #2.

28. On or about September 4, 1988, Respondent saw Patient #2 around 9:00 a.m. and that same day around 9:00 p.m. the nurses noted a dark brown to black, liquid stool.

29. On or about September 5, 1988, Patient #2's hemoglobin dropped to 9.3 gm./100 ml. and hemocult tests continued to reveal blood in the patient's stool. That same day, Patient #2 suffered a respiratory arrest. After being intubated and transferred to the intensive care unit, she suffered a cardiac arrest and expired.

30. Although Patient #2's GI bleeding on the first admission could have been explained due to anticoagulation with Coumadin, Respondent failed to adequately address and/or explain the GI bleeding after the Coumadin had been discontinued.

31. Although Patient #2 suffered from melena (passage of dark colored, tarry stools due to the presence of blood) prior to being discharged to the nursing home, Respondent failed to order indicated repeat CBC's after the second day of Patient #2's first hospitalization.

COUNT THREE

32. Petitioner realleges and incorporates paragraphs one (1) through three (3), and twenty-one (21) through thirty-one (31), as if fully alleged herein this Count Three.

33. Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in that he failed to do the following: address and or treat Patient #2's GI bleeding after the Coumadin had been discontinued; order indicated repeat CBC's after the second day of her first admission; and pay attention to Patient #2's declining

hemoglobin and the blood in her stool prior to her respiratory arrest during her second admission.

34. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, in that he is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

Facts Pertaining to Patient #3

35. From on or about August 13, 1988, to on or about August 17, 1988, Respondent treated Patient #3 at Humana Hospital-Northside.

36. On or about August 13, 1988, Patient #3, an eighty-six year old female, presented to Humana Hospital-Northside's ER and around 10:17 p.m., the ER physician admitted her with a fever of 102 degrees, confusion, and being unable to coordinate her muscles in the execution of voluntary muscle movement (ataxia).

37. On or about August 14, 1988, Respondent saw Patient #3 for the first time and diagnosed dementia and possible pleural effusion. Respondent also ordered a computerized axial tomography (CT) scan.

38. During this admission, Respondent ordered Haldol for Patient #3's confusion and intravenous Unasyn, an antibiotic. Due to Patient #3's involuntary muscle movement, no CT scan was performed.

39. On or about August 17, 1988, Respondent discharged Patient #3 to her home with a diagnosis of viral syndrome and senile dementia.

40. At all times material hereto, Respondent failed to find out Patient #3's usual mental status, usual state of mobility and activity, and his neurological examination failed to justify Respondent's diagnosis of dementia.

41. At all times material hereto, Respondent failed to obtain a neurological consultation and to sedate Patient #3 to allow her to undergo an indicated CT scan.

42. During this admission, Respondent failed to order a Venereal Disease Research Laboratory (VDRL) test, thyroid studies or liver enzymes to rule out other metabolic or disease causes of dementia.

COUNT FOUR

43. Petitioner realleges and incorporates paragraphs one (1) through three (3), and thirty-five (35) through forty-two (42), as if fully alleged herein this Count Four.

44. Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in that he failed to do the following: find out Patient #3's usual mental status, usual state of mobility and activity; perform an adequate neurological examination that would justify his diagnosis of dementia; order an indicated neurological

consultation; sedate Patient #3 to allow her to undergo an indicated CT scan; order a VDRL test, thyroid studies and or liver enzymes to rule out other metabolic or disease causes of dementia.

45. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, by being guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

Facts Pertaining to Patient #4

46. From on or about October 11, 1988, to on or about October 13, 1988, Respondent rendered treatment to Patient #4 as her attending physician at Humana Hospital-Northside.

47. On or about October 11, 1988, around 4:00 a.m., a rescue squad brought Patient #4 into Humana Hospital-Northside's ER. Patient #4's, an eighty-two year old female, complained of palpitations, dizziness, and near syncope.

48. Upon admission Patient #4's blood pressure was 66 over 33; her cardiac monitor revealed rapid atrial fibrillation; her heart rate was between 120 and 130; and she was hypotensive.

49. Around 4:05 a.m., the ER nurse called Respondent and informed him of Patient #4's condition. Respondent denied treatment and told the ER nurse to discharge the patient.

50. Around 4:10 a.m., due to Patient #4's condition, the ER physician examined her, and the nurse contacted Respondent again.

At this time Respondent ordered intravenous fluids and advised that he would be in to see the patient in the morning.

51. From around 4:10 a.m. until 7:25 a.m., the ER physician treated Patient #4 without Respondent's authorization and or cooperation.

52. Around 7:25 a.m., the ER physician contacted Respondent and informed him of Patient #4's condition. At this time Respondent authorized ER treatment.

53. Around 8:50 a.m., Respondent finally came in to see Patient #4 and admitted her.

54. A patient in Patient #4's condition with unstable vital signs and cardiac dysrhythmia should be examined and treated immediately.

55. Respondent failed to respond, treat, and/or authorize treatment for Patient #4 in a timely manner.

COUNT FIVE

56. Petitioner realleges and incorporates paragraphs one (1) through three (3), and forty-six (46) through fifty-five (55), as if fully alleged herein this Count Five.

57. Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in that Respondent failed to respond, treat, and/or authorize treatment in a timely manner when he instructed the ER nurse to discharge Patient #4, who was hypotensive, had unstable

vital signs and cardiac dysrhythmia, and when he waited four to five hours before authorizing treatment and or seeing the patient.

58. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, by being guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 15 day of May, 1992.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

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FILED
Department of Professional Regulation
AGENCY CLERK

CLERK

DATE 5-15-92