THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, N.Y. 12234

OFFICE OF PROFESSIONAL DISCIPLINE
ONE PARK AVENUE, NEW YORK, NEW YORK 10016-5802

Giovanni Del Gizzo, Physician
400 Ocean Boulevard
Highland, New Jersey 07732

July 24, 1992

Re: License No. 107205

Dear Dr. Del Gizzo:

Enclosed please find Commissioner's Order No. 12839. This Order goes into effect five (5) days after the date of this letter.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you must deliver your license and registration to this Department within ten (10) days after the date of this letter. Your penalty goes into effect five (5) days after the date of this letter even if you fail to meet the time requirement of delivering your license and registration to this Department. In the event you are also served with this Order by personal service, the effective date of the Order is the date of personal service.

If the penalty imposed by the Order in your case is a revocation or a surrender of your license, you may, pursuant to Rule 24.7 (b) of the Rules of the Board of Regents, a copy of which is attached, apply for restoration of your license after one year has elapsed from the effective date of the Order and the penalty; but said application is not granted automatically.

Very truly yours,

DANIEL J. KELLEHER
Director of Investigations
By:

GUSTAVE MARTINE
Supervisor

DJK/GM/er

CERTIFIED MAIL - RRR
cc: Martin Paul Solomon, Esq.
286 5th Avenue
New York, New York 10001

REPORT OF THE
REGENTS REVIEW COMMITTEE

GIOVANNI DEL GIZZO

CALENDAR NO. 12839

The University of the State of New York

IN THE MATTER

of the

Disciplinary Proceeding

against

GIOVANNI DEL GIZZO **No. 12839**

who is currently licensed to practice
as a physician in the State of New York.

REPORT OF THE REGENTS REVIEW COMMITTEE

Between November 13, 1990 and May 17, 1991 a hearing was held in the instant matter on nine sessions before a hearing committee of the State Board for Professional Medical Conduct which subsequently rendered a report of its findings, conclusions, and recommendation, a copy of which is annexed hereto, made a part hereof, and marked as Exhibit "A". The statement of charges and amendment to statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "B".

The hearing committee concluded that respondent, Giovanni Del Gizzo, was guilty of gross negligence, negligence on more than one occasion, incompetence on more than one occasion, practicing fraudulently, unprofessional conduct for record-keeping violations, and unprofessional conduct for excessive tests and treatments not

warranted by the conditions of the patients involving: respondent prescribing various medications without medical indication; ordering diagnostic tests; failing to do and note any work-up or follow-up; failing to evaluate and note the causes of findings; failing to take and record an adequate history of patient complaints and failing to indicate the reasons for visits or for therapeutic treatment rendered; failing to perform and note an adequate physical examination and noting only "WNL" for physical examination; failing to evaluate and follow-up laboratory results or to comment upon them; and failing to maintain medical records which accurately reflect his evaluation, examination, and treatment of the patient. The hearing committee recommended that respondent's license to practice medicine be revoked.

The Commissioner of Health, by designee, recommended to the Board of Regents that the findings, conclusions, and recommendation of the hearing committee be accepted, and several apparent typographical errors appearing on page 3 of the hearing committee report be corrected. A copy of the recommendation of the Commissioner of Health is annexed hereto, made a part hereof, and marked as Exhibit "C".

On March 24, 1992, respondent appeared in person and was represented by Martin Paul Solomon, Esq. Roy Nemerson, Esq. presented oral argument on behalf of the Department of Health.

Petitioner's written recommendation as to the penalty to be imposed, should respondent be found guilty, was the same as that of the Commissioner of Health that respondent's license be revoked.

Respondent's written recommendation was for a remand to conduct a hearing with an expert who is aware that respondent prescribed medication for the treatment of substance abuse. Respondent also recommended in writing that the findings of the hearing committee and Health Commissioner's designee be reversed and no penalty be imposed.

We have considered the record in this matter as transferred by the Department of Health, respondent's March 10, 1992 submission to us, and, as to the issue of penalty, the two attachments to respondent's March 10, 1992 submission.

This matter concerns 52 specifications brought against respondent as to 10 different patients. Each specification relates to various paragraphs of separate factual allegations, many of which are repeated in several specifications. Furthermore, these factual allegations relate to the multiple visits each patient had with respondent. The record contains 1,661 pages of hearing transcripts and various exhibits, including the medical records of patients having more than one chief complaint or condition.

The hearing committee report and designee's recommendation do not separately and clearly show the extent of respondent's guilt. Their conclusions do not identify which individual or combination of paragraphs of allegations were sustained for each definition of professional misconduct. While pages 38-41 of the hearing committee report generally indicate groups of specifications which were sustained therein, they do not state the specifications which

are sustained, in whole or in part, for gross negligence and do not specify the conclusions as to each charge in terms of both the particular specifications and paragraphs involved. Thus, in order to understand the determination reached, we will hereafter provide a chart breaking-down our conclusions as to respondent's guilt.

Petitioner's case consisted of its producing respondent's office medical records for each patient and the review and evaluation of these records by petitioner's expert witness. No patient or subsequent treating physician testified at the hearing. Moreover, petitioner did not call any witness to testify, whether professional or lay or factual or expert, who personally observed respondent's treatment of these patients or knew about whether respondent's records actually reflected his treatment of the patients. Petitioner's expert had no knowledge of these patient cases and the care and treatment respondent provided, other than the information he could discern from the patient records.

Early in the hearing, respondent's attorney objected to testimony which went beyond the terms of the patient records. Transcript page (hereafter T. ___) 23, 39. He asserted that while the witness may testify as to the patient records, the witness was not permitted to testify about factual occurrences beyond those records. T. 24, 39. Petitioner understood that its sole witness was "only testifying as to what the record says". T. 49; See also, T. 185, 281. In fact, petitioner conceded that the testimony of its witness, who did not examine any of the patients, would be

"confined" to his review and evaluation of what was written in the patient records. T. 41. During the hearing, petitioner even objected to a question which was not based upon the record. T. 122. Accordingly, petitioner's expert's testimony was based solely upon and was limited to his reading of these records.

The attorneys for petitioner and respondent agreed that even if the questions asked of the witness do not expressly indicate that they are based upon the records, everyone will understand the nature of the testimony elicited. T. 41. In view of the agreement between and course charted by the parties, the Administrative officer specifically told the hearing committee that, beyond the contents of the patient records, they do not know whether or not respondent committed any act because, as "a matter of fact, it may have been done and not recorded". T. 50. Earlier the Administrative Officer had declared; "all questions raised ... are directed with regard to purely the records". T. 40.

RECORD-KEEPING

We agree with the hearing committee's analysis that respondent's record-keeping practices "systematically mislead, rather than inform, any other physician who might undertake the subsequent evaluation and treatment of the patient, denying that practitioner meaningful medical information." Hearing committee report page 37. The purpose behind the requirement that a proper record be kept for each patient (8 N.Y.C.R.R. §29.2(a)(3)) "is in part to provide meaningful medical information to other

practitioners should the patient transfer to a new physician or should the treating practitioner be unavailable". Schwarz v. Board of Regents of University of State of New York, 89 A.D.2d 711 (3rd Dept. 1982). In our unanimous opinion, respondent is guilty of serious record-keeping deficiencies affecting different patients over a course of visits. The record discloses a pervasive pattern of terrible and confusing patient records. Between 1986 and 1988, respondent failed to maintain accurate medical records of the history, physical examination, follow-up, evaluation, and treatment provided by respondent as hereafter set forth. Much necessary information is not mentioned or described in respondent's very sparse medical records. They are not only lacking in detail and quality, but also do not convey meaningful and true information. These inadequate records, which respondent had to interpret, are deficient as they are inaccurate and incomplete and fail to provide objective meaningful medical information. See, Schwarz, supra; and Revici v. Commissioner of Education of the State of New York, 154 A.D.2d 797 (3rd Dept. 1989).

Respondent admitted that he used an assistant to prepare charts for him and that he did not spend time "writing pieces of paper to accommodate somebody else's desire." T. 907. Because of his interest in the clinical part of his practice, he deliberately established a routine record-keeping process whereby these unlicensed individuals, prior to the performance of any physical examination, charted the record of the physical examination which

was later to be reviewed by respondent after he examined the patient. T. 907, 908, 919, 920, 921. These assistants "handled the findings on the chart". T. 1248, 1249. In respondent's practice, pro forma and improper charts were prepared in order to save time. T. 921.

When respondent made entries in the medical records, they were often written in codes or signals. T. 812, 813, 867, 897, 1244, 1259. To understand those records, one has to deduce what must have occurred with the patient from respondent's earlier patient records or from what respondent must have considered on an earlier occasion. T. 874, 903, 1244, 1245, 1445, 1446. For example, the patient's diagnosis was discerned by respondent looking at the prescriptions listed in the patient records. T. 1446, 1447.

On cross-examination, respondent acknowledged that in the case of Patient D, he "no doubt about it" failed to enter on the patient record an "upper respiratory situation" because he was "concentrating" on the patient. T. 1245. In the case of Patient J, respondent's chart indicates that the physical examination is within normal limits, but respondent did not write anything about the patient's condition for which he was still ordering medications. T. 903, 904. Furthermore, respondent's usage of the term "within normal limits" was idiosyncratic in documenting the present findings as to the patient's condition in the context of the past condition rather than reflecting the patient's present condition is truly within normal limits. Hearing committee report

practitioners should the patient transfer to a new physician or should the treating practitioner be unavailable". Schwarz v. Board of Regents of University of State of New York, 89 A.D.2d 711 (3rd Dept. 1982). In our unanimous opinion, respondent is guilty of serious record-keeping deficiencies affecting different patients over a course of visits. The record discloses a pervasive pattern of terrible and confusing patient records. Between 1986 and 1988, respondent failed to maintain accurate medical records of the history, physical examination, follow-up, evaluation, and treatment provided by respondent as hereafter set forth. Much necessary information is not mentioned or described in respondent's very sparse medical records. They are not only lacking in detail and quality, but also do not convey meaningful and true information. These inadequate records, which respondent had to interpret, are deficient as they are inaccurate and incomplete and fail to provide objective meaningful medical information. See, Schwarz, supra; and Revici v. Commissioner of Education of the State of New York, 154 A.D.2d 797 (3rd Dept. 1989).

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page 37. However, even using respondent's meaning for the term, his records were inaccurate because the term was used to describe a condition the patient no longer had. T. 1445, 1446, 1447, 903, 904.

We reject respondent's incredible defense that his "charts reflect all information necessary for treatment", respondent's exception to hearing committee report page 39, and that the patient records in question were clear and adequate. A preponderance of the evidence establishes that respondent failed to maintain patient records which accurately reflect his evaluation and treatment of Patients A, B, C, D, F, G, H, I, and J.

We also reject respondent's defenses regarding the lack of credible evidence being produced from petitioner's witness and regarding that witness not being qualified or not possessing sufficient expertise. We agree with the ruling that petitioner's witness was an expert qualified for the hearing. T. 21; see also, T. 20-21. Although that witness was aware that various patients had drug or alcohol problems, any claimed unawareness by the witness that respondent's treatments were principally for these purposes is attributable to respondent's fault for not maintaining proper records. The witness was qualified to review and evaluate the adequacy and accuracy of the records relating to the noted arthritis, asthma, inflammations, infections, etc. In our unanimous opinion, a remand for the purpose, advanced by respondent, of petitioner producing a new expert witness is not

accepted inasmuch as both parties had the opportunity at the hearing to produce expert testimony and as our decision is based on an assessment of the evidence adduced by the parties in the record.

With respect to respondent's challenge of this witness regarding practicing on Medicaid, minority, and poor patients, petitioner's expert adequately set forth the standards for record-keeping, regardless of the patient's economic or ethnic background. We cannot accept respondent's position that his record-keeping practices were appropriate in view of the limited payments received from his patients. In our view, petitioner's witness was far more credible than respondent. In weighing the testimony of record, we note that although respondent reserved the right to call expert witnesses of his own to testify, he did not produce any witness other than himself. We find, as implicitly did the hearing committee and designee, that petitioner's evidence as to the record-keeping charges is more credible and of greater weight than is respondent's testimony.

Respondent is thus guilty of record-keeping violations insofar as is shown in our additional findings of fact. A great expenditure of time and effort has been made to review the hearing committee's findings in relation to the record and the instant report and, as shown on pages 3 and 4 supra, to understand and review their conclusions. It is sufficient to state that the hearing committee report is woeful and leaves much to be desired. Among other things, its findings do not consistently and

sufficiently show: the basis for sustaining the violations charged; which visit and for which condition does the conduct relate; what is not adequate about respondent's records; whether, as required for record-keeping charges, the failures relate to evaluation or to treatment; that the guilt found and concluded is grounded on patient records which should have been kept as to those acts performed by respondent; and that they accurately support the conclusions. By basically mirroring general charges, the hearing committee's findings do not provide specific details and elements needed to define and depict the guilt found.

Moreover, the findings, by simply referring to the exhibits as the sole support of the charges, appear to be based upon the patient records without regard to the testimony of the expert witness. Although references to the transcript are provided on other pages in the conclusions portions of the report, these references are not always accurate. Significantly, the hearing panel report, to support its findings, relies on testimony given as to patients other than those who are the subject of the records referred to in those findings. This occurs for Patient E entirely and for Patients F, H, I, and J substantially. It is unacceptable to support conclusions of guilt as to a patient's records with testimony relating to separate conditions, treatments, and records, and to different circumstances regarding another distinct patient.

The last charge for each patient was sustained by the hearing committee and designee without findings and also with the same

general conclusion as to each patient citing page 133 of the transcript. The testimony on that page relates to Patient A and to particular prescriptions prescribed for that patient. The guilt sustained for each patient must be based upon findings as to each specific failure to maintain a medical record applicable to each patient.

Our additional findings, which are hereafter set forth, develop, complete, and clarify our recommended determination in regard to the following charges:

SPECIFICATION	PARAGRAPH	GUILT
33	A(3)	Guilty to extent indicated
	A(4)	Guilty to extent indicated
	A(5)	Guilty to extent indicated
	A(6)	Guilty to extent indicated
	A(7)	Guilty
34	B(4)	Guilty
	B(5)	Guilty to extent indicated
	B(6)	Guilty to extent indicated
	B(7)	Guilty
35	C(3)	Guilty
	C(5)	Guilty to extent indicated
	C(6)	Guilty to extent indicated
	C(7)	Guilty

GIOVANNI DEL GIZZO (12839)

SPECIFICATION	PARAGRAPH	GUILT
36	D(3)	Guilty to extent indicated
	D(4)	Guilty
	D(5)	Guilty to extent indicated
	D(6)	Guilty to extent indicated
	D(7)	Guilty
38	F(5)	Guilty
39	G(3)	Guilty to extent indicated
	G(5)	Guilty to extent indicated
	G(7)	Guilty
40	H(3)	Guilty to extent indicated
	H(7)	Guilty
41	I(3)	Guilty to extent indicated
	I(7)	Guilty
42	J(7)	Guilty

CHARGES OTHER THAN RECORD-KEEPING

Respondent raises various assertions that the charges other than record-keeping have not been proven and were improperly

sustained by the hearing committee and designee. We shall address the reasons why we recommend that such charges, referred to in the first through thirty-second and forty-third through fifty-second specifications, be dismissed on the merits.

According to the hearing committee, fraud is established by the failures in the charts to reveal that the prescriptions were not medically indicated. This is insufficient as a matter of law. The hearing committee rendered no findings as to the issue of respondent's knowledge, even though the charges refer to this consideration. There are no findings or proof of respondent's intent. It is noted that petitioner's expert testified that he was not supposed to evaluate what was in respondent's mind and what occurred in respondent's clinical practice. T. 433, 630, 282, 283. Again, petitioner's aforesaid limited approach in this case did not permit an expert opinion as to what transpired in respondent's office apart from the records.

Petitioner's attorney correctly argued to the designee that the courts have made it clear that, in order to sustain charges of fraudulent practice, explicit findings, that respondent engaged in the conduct in an intentional and knowing fashion, are required. The Commissioner's designee, without explanation, sustained all specifications of fraud, (twenty-third through thirty-second), but did not accept petitioner's argument and proposed findings and did not address the elements of fraud. In spite of the long-standing judicial guidance of numerous decisions such as Amarnick v. Sobol,

173 A.D.2d 914 (3rd Dept. 1991); Tompkins v. Board of Regents of University of State of New York, 299 N.Y. 469 (1949); Sherman v. Board of Regents of University of State of New York, 24 A.D.2d 315 (3rd Dept. 1966); Radnay v. Sobol, ___ A.D.2d ___, 572 N.Y.S.2d 489 (3rd Dept. 1991); and Brestin v. Commissioner of Education of the State of New York, 116 A.D.2d 357 (3rd Dept. 1986), the hearing committee's and designee's conclusions as to fraud are deficient and erroneous.

The hearing committee and designee also sustain all specifications of unprofessional conduct (forty-third through fifty-second) for excessive tests and treatments not warranted by the conditions of the patient. We disagree.

No findings were made as to excessive tests and the hearing committee and designee do not find or conclude that, as charged, the tests were performed without medical indication. Instead, they recite the, at best, awkward conclusion that there was "no probative evidence to sustain the ordering of a test" or there was "no probative evidence for the necessity of ordering a test." The mere ordering of diagnostic tests does not constitute professional misconduct. Compare, conclusions H.4 and I.4 (where the lack of probative evidence means respondent is not guilty of the charges). Such conclusions are not adequate and clear. Nor is the sustaining of charges adequate where no conclusions are rendered as to such charges. Compare the sustaining of charges A(1)(c),(e), and (i) (hearing committee report page 6) with the lack of conclusions as

to those charges regarding Elavil, Proventil, and Zantac. Furthermore, these specifications cannot be sustained in view of the lack of proof as to the actual treatment and conditions of the patients. In this matter, proof that the medical records do not show the justification for particular treatment and tests, does not establish that such treatment and tests were not justified. We note, in this regard, the Administrative Officer instructed the hearing committee, as shown on page 5 of this report, that the hearing committee does not know whether or not respondent committed any act because, as "a matter of fact, it may have been done and not recorded". This instruction was particularly necessary because petitioner's expert could not read or understand various parts of the medical records and respondent's testimony as to the treatment he claimed he provided was unrebutted.

The hearing committee and designee conclude that respondent is guilty of gross negligence as defined on page 39 of the hearing committee report. That definition refers to gross negligence as being "something more" than ordinary negligence and there being no New York cases specifically applying the meaning of gross negligence to a medical context. Therefore, the hearing committee and designee ignored specific cases and judicial guidance as to gross negligence in this context. They did not consider or conclude that the requisite egregious negligent act or acts were committed. See, Rho v. Ambach, 74 N.Y.2d 318 (1989); Spero v. Ross, 158 A.D.2d 763 (3rd Dept. 1990); and Gandianco v. Sobol, 171

A.D.2d 965 (3rd Dept. 1991). Accordingly, the appropriate standard for determining whether respondent's conduct rose to the level of gross negligence has not been applied.

The hearing committee's and designee's conclusions that respondent committed gross negligence and negligence on more than one occasion, both relating to respondent's care and treatment and not his record-keeping practices, suffer from the same infirmities. The opinion testimony of an expert must be based on facts in the record or personally known to the witness. Cassano v. Hagstrom, 5 N.Y.2d 643 (1959). An expert may not reach a conclusion by assuming material facts not supported by the evidence and may not guess or speculate in drawing a conclusion. Cassano, supra; Hambsch v. New York City Transit Authority, 63 N.Y.2d 723 (1984). While petitioner's witness was an expert who could provide appropriate expert testimony, his testimony as to the care and treatment not reflected in respondent's records was not based upon facts either contained in the record or within his personal knowledge and was not competent proof. Therefore, there could not be a basis for such opinion and the testimony was insufficient to support the conclusions that respondent was guilty of gross negligence and negligence on more than one occasion as to such care and treatment.

The same rationale as to the lack of evidentiary support in this record also applies to the hearing committee's and designee's conclusions regarding incompetence on more than one occasion.

Furthermore, we do not accept the hearing committee's and designee's conclusion that respondent was guilty of incompetence on more than one occasion based upon his devising treatment which does not fit into accepted methods. Hearing committee report page 40. In view of the absence of any such charges having been brought against respondent, these conclusions are beyond the charges and, therefore, may not be sustained. Moreover, petitioner's expert did not have knowledge of respondent's competency to practice and understood that he was not supposed to testify about what was going on in respondent's mind and could not "tell" what was in his mind. Eg., T. 433, 434.

We recognize that, in some cases, charges of gross negligence, negligence on more than one occasion, and/or incompetence on more than one occasion may be established regarding poor record-keeping practices, in addition to charges of unprofessional conduct pursuant to 8 N.Y.C.R.R. §29.2(a)(3). However, the hearing committee report and designee's recommendation do not develop these issues for review of their findings and conclusions, and do not show us the portions of the record upon which they rely to satisfy the requirements for proving such charges. Under our recommendation as to penalty based solely upon the unprofessional conduct we sustain, it is not necessary to delay the final determination of this matter.

In our unanimous opinion, for the aforesaid 27 paragraphs contained in the nine specifications we sustained, the penalty of

revocation is warranted due to respondent's serious record-keeping deficiencies, reflective of repeated deliberate conduct antithetical to the needs of the patients and of a pattern of complete disdain for fulfilling professional requirements and accounting for his care and treatment of patients. This record demonstrates the potential harm to which respondent's patients were exposed as a result of his inadequate record-keeping practices. Cf., Koh v. Perales, 173 A.D.2d 477 (2nd Dept. 1991).

We note that we do not accept the hearing committee's and designee's recommendation regarding respondent's "attitude" during the course of the hearings. Hearing committee report page 42. Our recommendation is not based upon respondent's conduct during the hearing.

While we have considered the possibility of recommending a remand for the purpose of having the hearing committee address the aforesaid deficiencies in its report, as the Board of Regents may consider, we do not, as previously pointed out, feel that it is necessary to remand this matter.

We unanimously recommend the following:

1. The findings of fact of the hearing committee and the recommendation of the Health Commissioner's designee as to those findings of fact be accepted, except the last sentence of findings of fact A.3, A.4, B.5, B.6, C.3, C.5, C.6, D.5, and D.6 not be accepted and findings of fact A.5, A.6, B.4, D.3, D.4, F.3, F.4, G.3, G.5, G.6, H.3, H.5, H.6, I.3, I.5, I.6, J.3, J.5, and J.6 not be accepted.

2. The following additional findings of fact, referable to Patients A through D and F through J, be accepted:

A.7 Respondent did not indicate in Patient A's medical records, for the 10 visits after respondent noted on Patient A's record for February 4, 1987 to "Rule Out Pneumonia", whether x-rays were taken and whether anything else was done diagnostically. (T. 49).

A.8 Regarding the February 19, 1987 visit, respondent did not indicate in Patient A's medical record whether pneumonia, based on respondent's follow-up, was ruled in or out for this patient and whether the x-rays were followed. (T. 54, 55).

A.9 Respondent failed on the medical records for the 10 visits following the February 4, 1987 visit, including the February 19, 1987 visit, with Patient A to accurately reflect the evaluation and treatment as to the follow-up for the note to "Rule Out Pneumonia". (Paragraph A(3)).

A.10 Respondent did not indicate on the medical records for the August 25, 1987 and October 28, 1987 visits with Patient A the reasons

why Patient A was losing weight and the laboratory results. (T. 67, 68, 69).

A.11 Respondent failed on the medical records for the August 25, 1987 and October 28, 1987 visits with Patient A to accurately reflect the evaluation of the causes of the findings as to the patient's weight loss and laboratory results. (Paragraph A(4)).

A.12 Respondent did not indicate on Patient A's medical records for the December 11, 1986 visit an adequate history taken from the patient elaborating on the complaints of constipation and coughing and amplifying the social history in terms of what kind of IV drugs the patient had been using and of the drug history. (T. 27, 28, 31).

A.13 Respondent did not indicate on Patient A's medical records for the April 24, 1987 visit, the reasons for the visit and why the patient was treated with ampicillin. (T. 58).

A.14 Respondent failed on the medical records for the December 11, 1986 visit with Patient A to accurately reflect the evaluation of an adequate history of the patient's complaints

and failed on the medical records for the April 24, 1987 visit with Patient A to accurately reflect the evaluation of the reasons for the visit and of the reason why the patient was treated with ampicillin. (Paragraph A(5)).

A.15 On Patient A's medical records, for the December 11, 1986 visit, respondent's note of the physical examination was inadequate because no neurological examination was mentioned. (T. 31, 32, 121, 122, 131).

A.16 Respondent failed on the medical records for the December 11, 1986 visit with Patient A to accurately reflect the evaluation of the physical examination. (Paragraph A(6)).

A.17 Respondent did not indicate on Patient A's medical records for all visits after the first visit a clear and accurate evaluation of the patient's condition. (T. 128, 129).

A.18 Respondent did not indicate on Patient A's medical records, regarding the prescriptions of Valium referred to in finding A.1(a) and the prescriptions of Ativan referred to in finding A.1(b), why the patient was prescribed the medication for prolonged

periods of time. (T. 132, 133, 134, 135).

A.19 Respondent failed on the medical records relating to the prescriptions in finding A.18 herein above to accurately reflect the evaluation and treatment of the patient. (Paragraph A(7)).

A.20 Regarding the possibility of Patient A having pneumonia, respondent did not record Patient A's temperature and blood count. (T. 51).

A.21 Respondent failed in the medical record for Patient A to accurately reflect the evaluation as to the possibility of the patient having pneumonia. (Paragraph A(7)).

A.22 Parts of respondent's medical records for Patient A were not clear so that the reader could be sure he was correctly reading it. (T. 28, 56, 57, 58).

A.23 Respondent's records for Patient A are not adequate to allow a subsequent physician to effectively continue the treatment of the patient. (T. 128).

B.7 The medical records for Patient B's October 17, 1988 visit indicates the impression of

arthritis right knee and the complaint of pain in the right knee, but says the examination was negative for the extremities. The impression is inconsistent with the physical examination. (T. 186, 187, 189).

B.8 Respondent failed to substantiate the diagnosis of arthritis found in the chart, especially in light of the physical examination finding of extremities negative. (T. 189).

B.9 Respondent failed in the medical records for Patient B to accurately reflect the evaluation as to the impression of arthritis and the physical examination finding of extremities negative. (Paragraph B(4).

B.10 Respondent did not indicate on Patient A's medical records for the October 17, 1986 visit an adequate history elaborating on the chief complaints listed therein and as to some detail about the drugs used by the patient. (T. 183, 184, 185, 254).

B.11 Respondent failed on the medical records for the October 17, 1986 visit to accurately reflect the evaluation of an adequate

history of the patient's chief complaints and of the drugs used by the patient. (Paragraph B(5)).

B.12 On Patient B's medical records for the October 17, 1986 visit, respondent's note for the physical examination was not adequate because there was no neurological evaluation mentioned, because there was no indication in the physical examination note that the patient, who was prescribed trihemic, was coughing, and because there are no physical findings described on the physical examination with respect to asthma. (T. 185, 188, 193).

B.13 Respondent failed on the medical records for the October 17, 1986 visit with Patient B to accurately reflect the evaluation of the physical examination. (Paragraph B(6)).

B.14 The medical records for Patient B do not describe what is meant by the patient's chief complaints. Therefore, respondent's list reference to "nervousness" can mean anything from insomnia to seizure. (T. 184, 185).

B.15 Respondent failed in the medical record for

Patient B to accurately reflect the evaluation as to what was meant by the chief complaints. (Paragraph B(7)).

B.16 Parts of respondent's medical records for Patient B were not clear so that the reader could be sure he was reading it correctly. (T. 185, 193).

C.7 The laboratory report of March 19, 1987 indicates that Patient C had a hematocrit of 29.7 and a sedimentation rate of 53. The hematocrit level was quite low and indicates that the patient was significantly anemic. The sedimentation was elevated and suggests that there was some inflammatory process occurring in this patient. (Exhibit 3C; T. 293, 294.)

C.8 The medical records for Patient C do not indicate that any action was taken by respondent in following-up on these laboratory results or that these results were noted by respondent (T. 293, 294, 295).

C.9 Respondent failed in the medical records for Patient C to accurately reflect the evaluation as to the follow-up on the

laboratory results or to comment upon them. (Paragraph C(3)).

C.10 Respondent did not indicate on Patient C's medical records for the March 10, 1987 visit an adequate history as to the chief complaints listed therein. (T. 284, 285, 286, 307).

C.11 Respondent failed in the medical records for the March 19, 1987 visit to accurately reflect the evaluation of an adequate history of the patient's chief complaints. (Paragraph C(5)).

C.12 On Patient C's medical records for the March 19, 1987 visit, respondent's note for the physical examination was not adequate because there was no neurological examination mentioned and no supplementation by a more careful neurological examination for this patient, and because there was no indication in the physical examination note of the pulse rate and of what was going on with the patient. (T. 287, 288, 302).

C.13 Respondent failed on the medical records for the March 19, 1987 visit with Patient C to accurately reflect the evaluation of the

physical examination. (Paragraph C(6)).

C.14 Respondent's specific assessment/impression for Patient C on the first visit are not legible (T. 300).

C.15 Nothing is shown in the medical records for Patient C on the second visit that explains the reason for the prescribing of Clinoril or that records the patient's blood pressure. (T. 304).

C.16 Respondent failed to maintain a record for Patient C which accurately reflects his evaluation and treatment of the patient. (Paragraph C(7)).

C.17 Parts of respondent's medical records for Patient C were not clear so that the reader could be sure he was correctly reading it. (T. 284, 285, 286, 289, 300, 302, 303, 306).

D.7 On February 11, 1987, respondent made a diagnosis of "ulcer" for Patient D without noting a history as to such "ulcer" and without indicating why this assessment was made. (T. 432, 433, 434, 460).

D.8 Respondent failed in the medical records for the February 11, 1986 visit to accurately

reflect the evaluation of an adequate history as to the assessment of an ulcer. (Paragraph D(3)).

D.9 The laboratory report of November 20, 1987 indicated that Patient D had a low hematocrit and an elevated LDH and SGOT. Nowhere in the medical records for Patient D is there any comment about these laboratory results or any showing that respondent searched for the cause of the abnormality. There is no evidence of any medical response by respondent to the abnormal laboratory findings. (T. 386, 387, 388, 449, 454).

D.13 Respondent failed in the medical records for Patient D to accurately reflect the evaluation of the laboratory results, his follow-up, and his comments upon these laboratory results (Paragraph D(4)).

D.14 Respondent did not indicate on Patient D's medical records for the February 11, 1987 visit an adequate history taken from the patient elaborating on the complaint of epigastric pain, the past medical history of asthma, and the social history which mostly cannot be read. A careful description of

what is wrong with the patient is absent in these records. (T. 372, 373, 375, 382).

D.15 Respondent failed in Patient D's medical records for the February 11, 1987 visit to accurately reflect the evaluation of an adequate history of Patient D's complaints. (Paragraph D(5)).

D.16 Respondent did not indicate on Patient D's medical records for the February 11, 1987 visit an adequate physical examination because of the brevity of the record and because of the omission to show, at least, gross neurological findings and to show the gastrointestinal symptoms. (T. 374, 454).

D.17 Respondent failed in Patient D's medical records for the February 11, 1987 visit to accurately reflect the evaluation of an adequate physical examination. (Paragraph D(6)).

D.18 There is no indication in Patient D's medical records of the specific reason to do pulmonary function tests, for the patient to have been treated with Valium and Elavil, for the results of ordered tests, and for prescribing an antibiotic. (T. 374, 375,

377, 382, 383, 384).

D.19 Respondent did not indicate on Patient D's medical records for the third visit that the patient had an upper respiratory situation. (T. 1244, 1245).

D.20 Respondent's assistant handled the findings on the chart. Before respondent examined Patient D, the assistant prepared the chart according to the last visit. (T. 1248, 1249).

D.21 Respondent failed to maintain a medical record for patient D which accurately reflects his evaluation and treatment of the patient. (Paragraph D(7)).

D.22 Parts of respondent's medical records for Patient D were not clear so that the reader could be sure he was correctly reading it. (T. 372, 373, 374, 431).

F.5. Respondent did not indicate in Patient F's medical records for the March 12, 1987 visit any diagnosis for this patient that makes it reasonable to prescribe psychotropic medications. (T. 530, 531).

F.6 Respondent failed on the medical records for

the March 12, 1987 visit to accurately reflect the evaluation as to the patient's condition for which psychotropic medications were prescribed. (Paragraph F(5)).

F.7 Parts of respondent's medical records for Patient F were not clear so that the reader could be sure he was correctly reading it. (T. 530, 537).

G.7 Respondent did not indicate on Patient G's medical records for a 1987 visit the description, size, and characteristics of a left foot infection which is entered in a different handwriting from the adjacent entry that the physical examination is within normal limits. (Department's Exhibit 3G page 5; T. 590, 591, 592).

G.8 Respondent did not indicate on Patient G's medical record for a 1987 visit an investigation of the history of the possible causes for the left foot infection. (T. 593).

G.9 Respondent did not indicate on Patient G's medical record for the next visit after the one referred to in finding G.8 whether there

was a physical examination as to the chief complaint and history of infection left ankle and what was observed during the physical examination of the left ankle. (Department's Exhibit 3G page 5 bottom; T. 593, 594, 595).

G.10 Respondent did not indicate on Patient G's medical records for two undated visits the description of the skin ulcer. (Department's Exhibit 3G page 7; T. 599, 600, 601).

G.11 Respondent did not indicate on Patient G's medical records for the visits referred to in finding G.10 the history of the skin ulcer. (T. 601).

G.12 A reader of respondent's medical records for Patient G cannot tell from his note on the last visit whether the left leg infection is a different infection from the one previously found on the patient's left foot or is an extension from the foot up the leg. (T. 601; Department's Exhibit 3G page 8).

G.13 Respondent failed on the visits, referred to in findings G.7, G.9, and G.10, to accurately reflect the evaluation as to an

adequate history and an adequate physical examination of the complaints of infection left foot, infection left ankle, and skin ulcer. (Paragraph G.3).

G.14 Respondent did not indicate on Patient G's medical records for the July 8, 1987 visit an adequate history as there is no history of complaints indicated other than regarding wine and cocaine, and that history shows that the medications ordered are contraindicated. (T. 566, 586, 587, 588; Department's Exhibit 3G page 4).

G.15 Respondent did not indicate on Patient G's medical records for the visit after July 8, 1987 and the second visit after July 8, 1987 an adequate history as to complaints regarding the course, nature and description of the infections. (T. 566, 592, 593, 594, 628, 629, 630, 637, 638; Department's Exhibit 3G page 5).

G.16 Respondent failed on the visit after July 8, 1987 and the second visit after the July 8, 1987 visit to accurately reflect the evaluation as to an adequate history for Patient G's complaints. (Paragraph G(5)).

GIOVANNI DEL GIZZO (12839)

G.17 On February 4, 1987, respondent performed a barely adequate physical examination of Patient G. (T. 566).

G.18 Respondent did not indicate on Patient G's medical records for February 4, 1987 an adequate assessment of the patient and the reason for ordering a pulmonary function test, and did not indicate in Patient G's medical record for the February 18, 1987 visit the reason why anti-inflammatory medications were prescribed. (T. 566, 567, 569, 570, 571).

G.19 Respondent's medical records for Patient G show on the visit after the February 4, 1987 visit that the physical examination is within normal limits and immediately below it the assessment and impressions is "as above". The reference to "as above" was understood by respondent to pertain to his prior findings regarding the patient. However, "as above" did not relate to the prior finding that Patient D had bronchitis. The true diagnosis is deduced by respondent looking at the prescriptions he wrote (T. 1444, 1445) rather than from reading the

assessment/impression (T. 1446, 1447).

G.20 Respondent failed on the February 4, 1987 and February 18, 1987 visits to accurately reflect the evaluation of the assessment of Patient G or the reason why medications were prescribed. (Paragraph G(7)).

G.21 Parts of respondent's medical records for Patient G were not clear so that the reader could be sure he was correctly reading it. (T. 566, 584, 586, 588, 593, 595, 599, 600, 601).

H.7 Based on a laboratory report of March 24, 1987, Patient H had a positive VDRL, which is a screening test for syphilis, and a positive confirmatory FTA test. (T. 689; Department's Exhibit 3H page 11).

H.8 Respondent did not indicate in Patient H's medical records what evaluation and treatment was done to follow-up these laboratory results. (T. 689, 690, 708).

H.9 Respondent failed on the medical records for Patient H to accurately reflect the follow-up evaluation and treatment as to syphilis. (Paragraph H(3)).

H.10 Respondent did not indicate on Patient H's medical records for the visit on April 10, 1987 the basis for his ordering abdominal, spleen, and renal sonograms, and the results of an examination of the patient's abdomen. (T. 691, 692, 693).

H.11 Respondent failed on Patient H's medical records for the April 10, 1987 visit to accurately reflect the evaluation of his testing orders and of an examination of the patient. (Paragraph H(7)).

I.7 The laboratory report of March 19, 1987 indicates that abnormal test results were obtained for Patient I. The hematology test results show anemia and suggest the possibility that the anemia is due to iron deficiency. (T. 719).

I.8 The medical records for Patient I do not indicate that there was either follow-up on these laboratory results or, at least, a notation that follow-up could not be obtained because the patient did not return for a subsequent visit. (T. 721, 719, 720, 722).

I.9 Respondent failed in the medical records for Patient I to accurately reflect the evaluation as to the follow-up on the laboratory results. (Paragraph I(3)).

I.10 Respondent did not indicate on Patient I's medical records anything which would show any correlation between the timing of the patient's visits and the timing of the sonograms respondent ordered. Almost none of the details of any of the patient's visits are shown in Patient I's medical records. These records did not show the reason why a sonogram of the total abdomen was indicated. (T. 722).

I.11 Respondent failed in the medical records regarding the sonograms respondent ordered on July 7, 1987 to accurately reflect the evaluation of the indications for ordering these sonograms. (Paragraph I(7)).

J.7 Respondent did not note on Patient J's medical records "the real problem" and did not record his observations as to Patient J unless respondent believed they were unique. Respondent used his code on Patient J's

medical records instead of stating the true assessment and impression of the patient (T. 867, 876, 897).

J.8 Respondent's May 6, 1987 medical records for Patient J do not state, as respondent understood must have been the case, that Patient J demonstrated a persistence of an upper respiratory condition and demonstrated symptoms respondent considered to be of a superficial nature. (T. 874, 903).

J.9 Respondent did not note on Patient J's medical records for June 17, 1987 and June 30, 1987 that he examined the patient's nodes about which the patient complained (T. 879, 880).

J.10 Respondent observed Patient J's adenopathy on examinations before June 17, 1987, but did not note this observation for those earlier examinations. (T. 903, 904).

J.11 Before respondent examined Patient J on June 17, 1987, his assistant wrote on Patient J's medical records that the physical examination was "WNL". However, when respondent examined the patient on June 17, 1987 he found enlarged nodes. (T. 907).

J.12 Respondent established his record-keeping procedures because he chose not to write entries "to accommodate somebody else's desire". A pro forma chart was prepared by respondent's assistants in order to save respondent time. A proper chart was not prepared for respondent. (T. 907, 919, 920, 921).

J.13 Respondent failed on Patient J's medical records for the May 6, 1987, June 17, 1987, June 30, 1987, and August 13, 1987 medical records to accurately reflect the evaluation of his examination of the patient. (Paragraph J(7)).

3. The corrections by the Health Commissioner's designee of the typographical errors in the hearing committee report be accepted;

4. The conclusions of the hearing committee and the recommendation of the Health Commissioner's designee as to those conclusions be modified;

5. Respondent be found guilty, by a preponderance of the evidence, of the thirty-third through thirty-sixth and thirty-eighth through forty-second specifications of unprofessional conduct for record-keeping violations to the extent indicated in this report involving

respondent's failing to note any follow-up; failing to note his evaluations and the causes of findings; failing to record an adequate history of patient complaints and failing to indicate the reasons for visits or for therapeutic treatment rendered; failing to note an adequate physical examination and noting only "WNL" for physical examination; failing to note an evaluation and follow-up of laboratory results or to comment upon them; and failing to maintain medical records which accurately reflect his evaluation and treatment of the patient;and respondent be found not guilty of the remaining specifications and charges not covered by the chart on pages 11-12 of this report; and

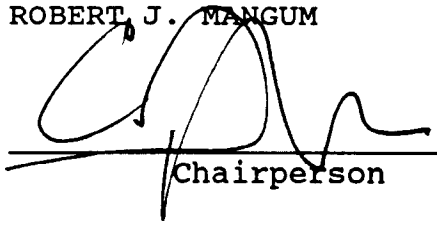
6. The recommendation of the hearing committee and the recommendation of the Health Commissioner's designee as to that recommendation be accepted, and respondent's license to practice medicine in the State of New York be revoked upon each specification of the charges of which respondent has been found guilty, as aforesaid.

Respectfully submitted,

CARL T. HAYDEN

JANE M. BOLIN

ROBERT J. MANGUM



Chairperson

Dated: July 13, 1992

VOTE AND ORDER

GIOVANNI DEL GIZZO

CALENDAR NO. 12839

The University of the State of New York

IN THE MATTER

OF

GIOVANNI DEL GIZZO
(Physician)

DUPLICATE ORIGINAL VOTE AND ORDER NO. 12839

Upon the report of the Regents Review Committee, a copy of which is made a part hereof, the record herein, under Calendar No. 12839, and in accordance with the provisions of Title VIII of the Education Law, it was

VOTED (July 24, 1992): That, in the matter of GIOVANNI DEL GIZZO, respondent, the recommendation of the Regents Review Committee be accepted as follows:

1. The findings of fact of the hearing committee and the recommendation of the Health Commissioner's designee as to those findings of fact be accepted, except the last sentence of findings of fact A.3, A.4, B.5, B.6, C.3, C.5, C.6, D.5, and D.6 not be accepted and findings of fact A.5, A.6, B.4, D.3, D.4, F.3, F.4, G.3, G.5, G.6, H.3, H.5, H.6, I.3, I.5, I.6, J.3, J.5, and J.6 not be accepted;
2. The additional findings of fact, referable to Patients A through D and F through J, be accepted as specifically set forth on pages 19 through 39 of the Regents Review Committee report;
3. The corrections by the Health Commissioner's designee of the typographical errors in the hearing committee report be accepted;
4. The conclusions of the hearing committee and the

recommendation of the Health Commissioner's designee as to those conclusions be modified;

5. Respondent is guilty, by a preponderance of the evidence, of the thirty-third through thirty-sixth and thirty-eighth through forty-second specifications of unprofessional conduct for record-keeping violations to the extent indicated in the report of the Regents Review Committee involving respondent's failing to note any follow-up; failing to note his evaluations and the causes of findings; failing to record an adequate history of patient complaints and failing to indicate the reasons for visits or for therapeutic treatment rendered; failing to note an adequate physical examination and noting only "WNL" for physical examination; failing to note an evaluation and follow-up of laboratory results or to comment upon them; and failing to maintain medical records which accurately reflect his evaluation and treatment of the patient;and respondent is not guilty of the remaining specifications and charges not covered by the chart on pages 11-12 of the report of the Regents Review Committee; and

6. The recommendation of the hearing committee and the recommendation of the Health Commissioner's designee as to that recommendation be accepted, and respondent's license to practice medicine in the State of New York be revoked upon each specification of the charges of which respondent has been found guilty, as aforesaid;

and that Deputy Commissioner Henry A. Fernandez be empowered to execute, for and on behalf of the Board of Regents, all orders necessary to carry out the terms of this vote;

and it is

ORDERED: That, pursuant to the above vote of the Board of Regents, said vote and the provisions thereof are hereby adopted

GIOVANNI DEL GIZZO (12839)

and SO ORDERED, and it is further

ORDERED that this order shall take effect as of the date of the personal service of this order upon the respondent or five days after mailing by certified mail.

IN WITNESS WHEREOF, I, Henry A. Fernandez, Deputy Commissioner, for and on behalf of the State Education Department and the Board of Regents, do hereunto set my hand, at the City of Albany, this 24th day of July, 1992.

HENRY A. FERNANDEZ
DEPUTY COMMISSIONER