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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
DAVID A. DEANGELES, M.D., RESPONDENT.	:	LS # 0803031 MED

[Division of Enforcement Case # 05 MED 27]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

David A. DeAngeles, M.D.
Dean Medical Center
1313 Fish Hatchery Rd.
Madison, WI 53715

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Medical Examining Board
Department of Regulation & Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

A formal disciplinary complaint was filed in this matter on March 3, 2008, and assigned to Administrative Law Judge Jacquelynn B. Rothstein. Ms. Rothstein presided over two prehearing conferences, during which the parties informed her that settlement discussions were underway. The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Medical Examining Board. The Board has reviewed the attached Stipulation and considers it acceptable, and therefore makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. David A. DeAngeles, M.D. ("Respondent") was born on August 30, 1963, and is licensed in medicine and surgery in the state of Wisconsin (license # 33483). This license was first granted on July 23, 1992.

2. Respondent's most recent address on file with the Wisconsin Medical Examining Board is Dean Medical Center, 1313 Fish Hatchery Road, Madison, Wisconsin 53715.

3. At all times relevant to this action, Respondent was working as a physician at Madison, Wisconsin. Respondent is a surgeon.

4. On July 6, 2003, a 74 year old female patient ("Patient AP") was seen in the emergency room at St. Mary's Hospital and evaluated for severe abdominal pain, nausea, and emesis.

5. Multiple tests were ordered including an abdominal and pelvic CT with IV and enteric contrast. The radiologist's report identified a dilated and inflamed gall-bladder, severe left-sided hydronephrosis with complete dilation of the left collecting system and an abnormal soft tissue density at the left bladder base, and mild to moderate hydronephrosis down to the ureteropelvic junction on the right with some questionable soft tissue density. A diagnosis of acute cholecystitis was made.

6. Respondent performed a laparoscopic cholecystectomy on Patient AP, which was uneventful. Pathology reports confirmed cholelithiasis associated with acute suppurative cholecystitis with benign cystic duct lymph node.

7. On July 7, 2003, Patient AP was discharged. Respondent's discharge instructions and discharge summary recommended follow-up with Respondent. Respondent documented his secondary diagnosis of hydronephrosis and his recommendation for follow-up with an urologist in his clinical progress notes, but neither Respondent's secondary diagnosis nor his referral to a urologist appeared in the discharge instructions to the patient, or in the discharge summary.

8. A physician's assistant had dictated the discharge summary and had noted the CT findings, but failed to document Respondent's recommendation for a urological follow-up. Respondent did not recognize this error during his document review.

9. On July 14, 2003, Respondent saw Patient AP for follow-up. Patient AP was doing well, exam noted no complaints or pain, and she was instructed to return as needed.

10. On March 22, 2004, Patient AP presented to a gynecologist complaining of vaginal bleeding, despite having had a hysterectomy in 1988. Patient AP was thereafter referred to a urologist.

11. At the April 21, 2004, urology visit, Patient AP was diagnosed with cancer of the bladder.

12. Respondent met with the patient and her family and apologized for the failure of follow through.

13. In June of 2005, Patient AP was placed in hospice, and she died of metastasized bladder cancer on September 28, 2005.

14. Following this incident, Respondent, as chair of the surgery department, worked to expand a program of hospitalists, physicians whose practice is limited to hospitalized patients, to ensure continuity of patient care between and among specialists in the hospital setting, and to assist with the transition of and continuity of care through the transition from in-patient to out-patient status. The hospitalist program now provides constant coverage by hospitalists.

14. Respondent was also heavily involved in the implementation and integration of a system of electronic medical records, designed to improve continuity of care for patients throughout the Dean Health system.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction to act in this matter, pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).

2. The failure to follow-up on the diagnosis of hydronephrosis and the abnormal soft tissue density at or near the bladder that was noted in the July 6, 2003, CT as described in paragraphs five through nine, above, constitutes a violation of Wisconsin Administrative Code § MED 10.02(2)(h).

ORDER

The Board recognizes Respondent's conduct in working on a system wide basis to prevent any recurrence of a similar loss of continuity of care as significant mitigation of the need for the imposition of discipline against Respondent.

1. Respondent shall, within ONE HUNDRED EIGHTY (180) days from the date of this Order, pay costs of this proceeding in the amount of $2,976.00 (two thousand nine hundred seventy-six dollars). Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817
Fax (608) 266-2264

2. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to pay costs as ordered, the Respondent's license (# 33483) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.

3. This Order is effective on the date of its signing.

Wisconsin Medical Examining Board

By: Gene Musser MD 8/20/08
A Member of the Board Date