

FILED

January 8, 2014

**NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS**

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In the Matter of:

RICHARD H. ALTAMURA, M.D.

CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon receipt of a report from the Medical Practitioner Review Panel (the "Panel"), setting forth findings and recommendations made by the Panel upon the conclusion of an investigation of respondent Richard Altamura, M.D. Specifically, the Panel commenced an investigation after receiving notification that a payment of \$135,000 was made on Dr. Altamura's behalf to settle a civil malpractice action wherein it had been alleged that Dr. Altamura failed to properly manage care that he provided to patient G.W. during an emergency room visit and delayed ordering necessary laboratory testing, resulting in G.W.'s death.

Dr. Altamura appeared before the Panel on September 20, 2013, represented by Dominic DeLaurentis, Esq., and then testified regarding the G.W. case. Upon review of available information, to include hospital records and Dr. Altamura's testimony, the Panel

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found that G.W., a 70 year old woman, presented to the emergency department at Virtua-Memorial Hospital on July 7, 2005 with complaints of near syncope and severe abdominal pain. G.W. was found to be hypotensive on arrival to the emergency department, with an initial blood pressure reading of 79/51. G.W. had undergone a colonoscopy earlier that day, and developed severe gas pains following the procedure.

Dr. Altamura first evaluated G.W. approximately 90 minutes after she arrived at the emergency department, at which time he noted that her blood pressure had risen, without any intervention, to 114/56. After examining G.W., Dr. Altamura's dictated chart note included a differential diagnosis of (1) abdominal pain secondary to gas and insufflation from the colonoscopy and (2) perforation. Respondent ordered an obstruction series and upright chest x-ray, both of which were unremarkable. Dr. Altamura then re-examined G.W., at which time he noted improvement in her abdominal discomfort and that her systolic blood pressure remained in the 90-100 range. Upon speaking with the covering gastroenterologist, respondent planned to discharge G.W. with a final diagnosis of dehydration.

G.W. was then asked to stand up and walk, at which time she had a near fainting episode and her blood pressure dropped

markedly to a systolic reading in the 50s. Dr. Altumara then first ordered a CBC and intravenous fluids, however G.W. remained hypotensive thereafter and, approximately one hour later, became unresponsive and expired. On autopsy, her cause of death was determined to be a retroperitoneal hemorrhage.

While the Panel recognized that the retroperitoneal bleed was a rare complication of colonoscopy, the Panel concluded that respondent provided grossly negligent care to G.W., for reasons including:

(1) Respondent failed to adequately investigate and/or establish a basis for the substantial differences between G.W.'s initial abnormal blood pressure measurements (i.e., the blood pressure reading of 79/51 on initial presentation to the emergency department) and those obtained at the time of his examination (i.e., approximately 90 minutes after admission), and failed to determine or consider whether the disparity could have been attributed to orthostatic hypotension (to include a failure to obtain any blood pressure reading in an orthostatic position);

(2) Respondent failed to order any laboratory testing (to specifically include a Complete Blood Count) to investigate G.W.'s initial low blood pressure reading, the suspected perforation and/or

to check for any evidence of bleeding or infection;

(3) Respondent failed to adequately develop a differential diagnosis and treatment plan; and

(4) Despite concluding that G.W.'s symptoms were caused by dehydration, respondent was prepared to discharge G.W. without ever having administered any IV fluids.

The Board adopted all findings and recommendations made by the Panel, and thus specifically finds that bases for disciplinary sanction against respondent exists pursuant to N.J.S.A. 45:1-21 (c) (based on findings that Dr. Altamura engaged in gross negligence). The parties desiring to resolve this matter without the need for further administrative proceedings, and the Board being satisfied that good cause exists for the entry of the within Order,

IT IS on this 8th day of January, 2014

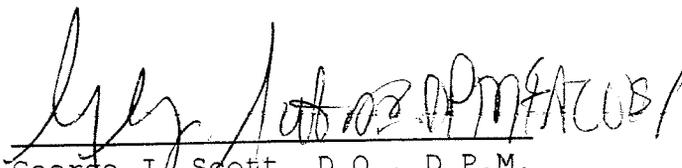
ORDERED and AGREED:

1. Respondent Richard Altamura, M.D. is hereby formally reprimanded for having engaged in gross negligence in his care of patient G.W., for the reasons set forth in greater detail above.

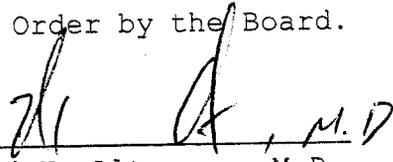
2. Respondent is hereby assessed a civil penalty in the amount of \$7,500, to be paid as follows: \$2,500 at time of entry of the Order, \$2,500 not later than three months from the date of entry

of the Order, and \$2,500 not later than six months from the date of entry of the Order.

NEW JERSEY STATE BOARD OF
MEDICAL EXAMINERS

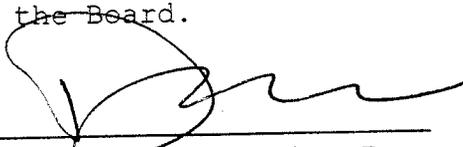
By: 
George J. Scott, D.O., D.P.M.
Board President

I represent that I have carefully read and considered this Order, understand its terms and consent to the entry of the Order by the Board.

, M.D.
Richard H. Altamura, M.D.

Dated: 12-4-13

Consent to form of Order and entry of Order by the Board.


Dominic DeLaurentis, Esq.
Counsel for Respondent

Dated: 12-16-13

**NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which revokes or suspends (or otherwise restricts) a license,
- (2) Which censures, reprimands or places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.