STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Dennis P. Whalen
Executive Deputy Commissioner

January 28, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Karen E. Carlson, Esq.
NYS Department of Health
Corning Tower Room 2503
Empire State Plaza
Albany, New York 12237

Antony Reddy, M.D.
104 Park Street
P.O. Box 507
Malone, New York 12953-0507

Anthony Scher, Esq.
Wood & Scher
The Harwood Building
Scarsdale, New York 10583

RE: In the Matter of Antony Reddy, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-19) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

COPY

IN THE MATTER

OF

ANTONY REDDY, M.D.

DETERMINATION

AND

ORDER

BPMC-98-19

A Notice of Hearing and a Statement of Charges, dated June 27, 1997, were served upon the Respondent, Antony Reddy, M.D. **STEPHEN A. GETTINGER, M.D. (Chair), AARON B. STEVENS, M.D. and TRENA DeFRANCO**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee (hereinafter "the Committee") in this matter pursuant to Section 230(10)(e) of the Public Health Law. **JEFFREY W. KIMMER, ADMINISTRATIVE LAW JUDGE,** served as the Administrative Officer. The Department of Health appeared by Karen E. Carlson, Esq., Associate Counsel. The Respondent appeared by Wood & Scher, Anthony Z. Scher, Esq. of counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Service of Notice of Hearing and Statement of Charges:	July 2, 1997
Answer to Statement of Charges:	July 15, 1997

Dates of Hearing:	July 29, 1997 September 10, 1997 September 16, 1997 September 22, 1997 September 23, 1997 September 29, 1997
Witnesses for Department of Health:	Patient A Patient B Cathy Kourofsky James W. Fitzgerald, M.D. Robert O'Keefe John Antkowiak, M.D.
Witnesses for Respondent:	Gerald Cahill, M.D. Marilyn Stevens Donna Brockway Melissa Bero Sally Trippany Kaolpano Reddy Antony Reddy Hon. Robert Main, Jr. Maryclaire Sherwin Mark Siegler, M.D.
Deliberations Held:	November 3, 1997

STATEMENT OF CASE

The Statement of Charges alleged ten specifications of professional misconduct, including allegations of willfully abusing a patient, engaging in conduct which evidences moral unfitness to practice the profession, the fraudulent practiee of medicine, gross negligence, negligence on more than one occasion and a failure to keep accurate records.

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. Unless noted by an asterisk, all Findings and Conclusions herein are the unanimous determination of the Committee. Having heard testimony and considered evidence presented by the Department of Health and the Respondent respectively, the Committee hereby makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. All Findings of Fact made by the Committee were established by at least a preponderance of the evidence.

1. ANTONY REDDY, M.D., (hereinafter " Respondent"), was authorized to practice medicine in New York State on or about June 3, 1976, by the issuance of license number 127706 by the New York State Education Department. (Department's Exhibit [hereinafter "Dept.Ex."] 1) Patient A

2. Respondent provided medical care to Patient A at his urological practice office at 104 Park Street, Malone, New York, between late 1983 and 1991. (T. 23-24, 45, 54) Patient A , then nineteen years old, was also Respondent's employee in his medical practice between 1983 and 1996. Patient A was Respondent's patient. (T. 684)

3. In approximately late 1983 Respondent provided Patient A with a routine

gynecological examination including a pelvic examination. The pelvic examination of Patient A was painful for her. Respondent rubbed the genitals of Patient A. This was not medically indicated. No one else was present for that examination. Patient A had never had any sexual experiences nor had she had a gynecological examination and Respondent was aware of these facts. (T. 20-22, 27-28, 80, 407-408) *

4. At the end of that examination Respondent exposed his genitals to Patient A telling her it was for her own education that he do so. (T. 29) *

5. At an examination of Patient A Respondent performed a hymenotomy of Patient A. Such procedure was not requested nor was it indicated. Respondent performed this procedure in his examining room in his office with no one else present. (T. 30-33, 89-90, 412-413) *

6. Respondent initiated a subsequent examination of Patient A for the alleged purpose of examining the incision from the hymenotomy. Respondent suggested this examination take place on the floor of his personal office so that Patient A would be more relaxed. (T. 33-35, 92) *

7. Respondent at this examination inserted his penis into the vagina of Patient A. (T. 37-38,) *

8. For an approximate two to two and one half year period following that examination and incident, Respondent engaged in sexual activity with Patient A at Respondent's office and/or Respondent's home and/or a motel. The Respondent told her that the purpose of this was to educate her and teach her the ways of the

world. (T. 46-47, 52. 144)

9. Patient A continued to be employed by Respondent and did not tell anyone about the sexual encounter nor about the subsequent sexual activity. (T. 43-44,57)

10. Sometime after the sexual encounter Respondent injected Patient A with Valium in conjunction with the sexual activity with her. This occurred on several occasions. (T. 50-52) *

11. Respondent treated Patient A as his patient providing her with her only annual gynecological check-ups in his office. (T. 54, 632-633, 692-693, 698)

12. Respondent did not continue engaging in sexual activity with Patient A after late 1986 or early 1987, when Patient A began dating. (T. 53)

13. Respondent last examined Patient A in approximately 1991. (Dept. Ex. 4)

14. Patient A was employed by Respondent until June of 1996. (T. 55)

15. Respondent did not make any referrals to a gynecologist for Patient A. (T. 22-23, 54-55,)

16. Respondent maintained no physician's notes for the medical care he provided to Patient A. (T. 659,692)

Patient B

17. Respondent provided medical care to Patient B in his urological practice office at 104 Park Street, Malone, New York on at least three occasions between February or March 1995 and June of 1996. (T. .211- 212, 214-216, 221, 746-748,757)

18. Patient B was also Respondent's employee in his urological medical office. Patient B was Respondent's patient. (T. 210-217, 224-225, 745-747)

19. Respondent in late February or early March of 1995 examined Patient B while another employee was present in the examining room. (T. 210-212)

20. Respondent performed a pelvic examination of Patient B in his office in March of 1995. No one else was present in the examining room. (T. 214-216)

21. Respondent performed a pelvic examination on Patient B on June 18, 1997, in his office. No one else was present. (T. 221-223)

22. Respondent told Patient B that he was examining for trichomoniasis as he touched her clitoris. (T. 217-218, 227, 819, 832)

23. Respondent placed both hands around the neck of Patient B telling her he was examining her for a mass. (T. 776)

24. Respondent did not maintain any medical records for Patient B. (T. 750, 755, 798)

CONCLUSIONS

The following conclusions were made pursuant to the Findings of Fact listed above. The Committee concluded that the following Factual Allegations were proven by a preponderance of the evidence (the paragraphs noted refer to those set forth in the Statement of Charges, Factual Allegations). The citations in parentheses refer to the Findings of Fact (supra), which support each Factual Allegation:

Paragraph A: (2);

Paragraph A.3.a.: (3);

Paragraph A.3.b.: (4)

Paragraph A.3.c.: (7)

Paragraph A.4.: (5), as amended to read " hymenectomy or hymenotomy

Paragraph A.5.: (5)

Paragraph A.6.: (10), except for that part of the allegation which states that the injection of valium was for Respondent's personal sexual purposes and/or was not medically indicated.

Paragraph A.7.: (16)

Paragraph B.: (17,18)

Paragraph B.5.: (24)

The Committee further concluded that the following Specifications should **be sustained**. The citations in parentheses refer to the Factual Allegations from the Statement of Charges, which support each specification:

ENGAGING IN CONDUCT IN THE PRACTICE OF MEDICINE WHICH EVIDENCES MORAL UNFITNESS TO PRACTICE MEDICINE

First Specification: (Paragraphs A.,A.3.a.,A.3.b., A.3.c., A.5. and A.6 (with the exception noted above);

WILLFULLY HARASSING, ABUSING OR INTIMIDATING A PATIENT EITHER PHYSICALLY OR VERBALLY

Third Specification: (Paragraphs A.,A.3.a.,A.3.b., A.3.c.);

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Sixth Specification: (Paragraphs A., A.4., A.6., A.7. and B.5.);

FAILURE TO MAINTAIN ACCURATE RECORDS

Ninth Specification: (Paragraphs A. and A.7) and

Tenth Specification: (Paragraphs B. and B.5.).

The Committee determined that the Second, Fourth, Fifth, Seventh and Eighth Specifications should **not be sustained**.

Discussion

Respondent was charged with ten specifications alleging professional misconduct within the meaning of Education Law §6530. This statute sets forth numerous forms of conduct which constitute professional misconduct. During the course of its deliberations on these

charges, the Committee consulted a memorandum prepared by General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for, among other conduct, gross negligence, negligence, and fraud in the practice of medicine.

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

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

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Fraudulent Practice of the Profession is an intentional misrepresentation or concealment of a known fact. An individual's knowledge that he/she is making a misrepresentation or concealing a known fact with the intention to mislead may properly be inferred from certain facts.

Using the above-referenced definitions as a framework for its deliberations, the Committee unanimously concluded, by a preponderance of the evidence, that the first, third, sixth, ninth and tenth specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions is set forth below.

The Committee concluded that both Patient A and B were "medical patients" of the Respondent. The fact that they were employees and that they were not charged for the services provided does not change their status. In both cases there were multiple examinations

performed on these persons and in one case drugs were dispensed. A medical service was provided and a physician-patient relationship existed.

Patient A

The Committee found Patient A's testimony credible in part and in part not supported by the documentary evidence. The Committee determined that although Patient A's testimony regarding certain details was disproven, her general description of a 2 and 1/2 year sexual relationship with the Respondent was credible. The Committee found that the initial incident of sexual relations was coercive but subsequent sexual relations were consensual (the latter conclusion was not unanimous).

The Committee also found that the Respondent inappropriately rubbed Patient A's clitoris and/or genital area and exposed himself to her. This conduct and that of inserting his penis in Patient A's vagina in conjunction with an examination amounts to moral unfitness in the practice of medicine and willful physical or verbal abuse of a patient (this conclusion was not unanimous).

Patient A reported a Pap smear being performed during the initial examination of her by the Respondent. Yet the hospital records where the patient alleged the sample was taken for analysis showed no record of this and the parties stipulated to this. Patient A also alleged that the Respondent injected her with Valium 20 or more times prior to their having sexual relations. The documentary evidence does not support that testimony. The Committee did find that the Respondent injected Patient A with valium on several occasions in connection with their having sexual relations in order to reduce or relieve any anxiety she may have been suffering from. The Respondent then left her in his office while the effects of the drug had

not worn off. Such conduct was found to constitute negligence.

Patient A also testified that the Respondent performed a hymenectomy/hymenotomy on her. Based on the patient's detailed testimony relating to this procedure the Committee found that such a procedure was performed on her. Given that and the testimony of the Petitioner's expert witness, which the Committee found credible, that the performance of this procedure was not necessary, the Respondent's conduct with respect the performance of the hymenotomy amounted to negligence.

However, the Committee did not find the Respondent's conduct with respect to the injection of valium or the performance of a hymenotomy amounted to gross negligence under the definition noted above.

The Respondent admitted he never kept any record of his treatment of Patient A. Since she was his patient the failure to do this amounted to misconduct.

Patient B

A majority of the Committee concluded that Patient B misunderstood the Respondent's actions during his treatment of her. They found the Respondent's explanations of his conduct was credible yet his actions could have been misconstrued by the Respondent. It was the unanimous conclusion of the Committee that the Respondent did not urge the patient to allow him to treat her. However the Committee was not unanimous in its conclusion that the Respondent did not inappropriately touch the patient during the second and third examinations of her. A majority of the Committee determined that the Petitioner had not met its burden of proof with respect to those allegations. The Committee was unanimous in its conclusion that

the Respondent failed to maintain adequate records for the treatment of this patient. The Committee disagreed with the Respondent's assumption that the treatment of Patient B was akin to treatment of a family member for whom a record need not be maintained.

DETERMINATION AS TO PENALTY

The Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, determined that Respondent's license to practice medicine as a physician in New York State should revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The Committee considered and determined that revocation was appropriate in this case. The Respondent's misconduct represents an egregious breach of the public trust and warrants such a sanction. The Committee believes that the Respondent's conduct with respect to Patient A dictates revocation of his license. This determination was not unanimous.

A minority of the Committee determined that a period of actual suspension, followed by a lengthy term of probation, with a permanent restriction on the Respondent's license requiring him to have a chaperon present whenever he sees a female patient for physical examination or consultation and permanently prohibiting from treating any employee would provide adequate punishment while protecting the public.

ORDER

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

1. The First, Third, Sixth, Ninth and Tenth Specifications of professional misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**;

2. The Second, Fourth, Fifth, Seventh and Eighth Specifications are **DISMISSED**;

3. Respondent's license to practice medicine as a physician in New York State be and hereby is **REVOKED**.

4. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at Respondent's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: Albany, New York
January 30, **1998**

Stephen A. Gettinger, MD
STEPHEN A. GETTINGER, M.D. (CHAIR)

Aaron B. Stevens, M.D.
Trena DeFranco

REDDY.DAO

TO: Karen E. Carlson, Esq.
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Antony Reddy, M.D.
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Anthony Z. Scher, Esq.
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The Harwood Building
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APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ANTONY REDDY, M.D.	:	CHARGES

----------X

Antony Reddy, M.D., the Respondent, was authorized to practice medicine in New York State on June 3, 1976 by the issuance of license number 127706 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period June 1, 1996 through May 31, 1998 with a registration address of 104 Park Street, P.O. Box 507, Malone, New York 12953-0507.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A [patients are identified in the Appendix] at his office at 104 Park Street Malone, New York [hereafter "Respondent's office"] at various times from approximately 1983 through approximately 1988. Respondent also employed Patient A in his office from approximately November 1983 through June 1996.

1. Respondent repeatedly urged Patient A to receive medical care from him when Patient A first began working for Respondent.

2. Respondent repeatedly urged Patient A to receive medical care from him when Patient A first began working for Respondent for Respondent's personal sexual purposes.

3. Respondent, between approximately November 1983 and January 1984, during the course of providing medical care to Patient A at Respondent's office, engaged in the following conduct which was not medically justified:

   a. Respondent rubbed Patient A's clitoris and/or genital area.
   b. Respondent exposed his penis to Patient A and/or told her that she needed to learn about male genitals or words to such effect.
   c. Respondent put his penis in Patient A's vagina.

4. Respondent, between approximately November 1983 and January 1984 while providing medical care to Patient A at Respondent's office, performed a hymenectomy on Patient A which was not medically indicated.

5. Respondent, on several occasions, had sexual intercourse with Patient A at, among other places, Respondent's office and/or Respondent's home and/or a motel, during the time period that Respondent was providing medical care to Patient A.

6. Respondent, on several occasions, injected Patient A with Valium for Respondent's personal sexual purposes and/or which was not medically indicated.

7. Respondent failed to maintain adequate records for Patient A.

B. Respondent provided medical care to Patient B at Respondent's office at various times from approximately March 1995 through approximately June 1996. Respondent also employed Patient B in his office from approximately January 1994 through June 1996.

1. Respondent repeatedly urged Patient B to receive medical care from him during the approximate first year that Patient B worked for him.

2. Respondent repeatedly urged Patient B to receive medical care from him for Respondent's personal sexual purposes.

3. Respondent, during the course of providing medical care to Patient B on or about March 1995, rubbed Patient B's clitoris and/or genital area which was not medically justified.

4. Respondent, during the course of providing medical care

to Patient B on or about June 18, 1996, engaged in the following conduct which was not medically justified:

a. Respondent rubbed Patient B's clitoral and/or vaginal area.

b. Respondent put his hands around Patient B's waist and/or leaned toward Patient B attempting to kiss Patient B.

c. Respondent, when Patient B confronted him regarding the aforesaid attempted kiss, placed his hands on Patient B's neck and stated that he was checking her for endometriosis.

5. Respondent failed to maintain any medical records for Patient B.

SPECIFICATIONS

FIRST THROUGH SECOND SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law section 6530(20) (McKinney Supp. 1997) by reason of his conduct in the practice of medicine which evidences moral unfitness to practice medicine in that Petitioner charges:

1. The facts in Paragraphs A and A.2, A and A.3.a, A and A.3.b, A and A.3.c, A and A.5 and/or A and A.6.
2. The facts in Paragraphs B and B.2, B and B.3, B and B.4.a, B and B.4.b and/or B and B.4.c.

THIRD THROUGH FOURTH SPECIFICATIONS

WILLFUL PHYSICAL AND/OR VERBAL ABUSE

Respondent is charged with professional misconduct under N. Y. Educ. Law section 6530(31) (McKinney Supp. 1997) by reason of his willfully abusing a patient, either physical or verbally, in that Petitioner charges:

3. The facts in Paragraphs A and A.3.a, A and A.3.b and/or A and A.3.c.
4. The facts in Paragraphs B and B.3, B and B.4.a, B and B.4.b and/or B and B.4.c.

FIFTH SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law section 6530(4) by reason of his practicing the profession with gross negligence on a particular occasion in that Petitioner charges:

5. The facts in Paragraphs A and A.4 and/or A and A.6.

SIXTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law section 6530(3)(McKinney Supp. 1997) by reason of his practicing the profession with negligence on more than one occasion in that Petitioner charges two or more of the following:

6. The facts in paragraphs A and A.1, A and A.4, A and A.6, A and A.7, B and B.1 and/or B and B.5.

SEVENTH THROUGH EIGHTH SPECIFICATIONS

FRAUD

Respondent is charged with professional misconduct under N.Y. Educ. Law section 6530(2)(McKinney Supp. 1997) by reason of his practicing the profession fraudulently in that Petitioner charges:

7. The facts in Paragraphs A and A.6.

8. The facts in Paragraphs B and B.4.c.

NINTH THROUGH TENTH SPECIFICATIONS

RECORDKEEPING

Respondent is charged with professional misconduct under N.Y. Educ. Law section 6530(32)(McKinney Supp. 1997) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of each patient in that Petitioner charges:

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

10. The facts in Paragraphs B and B.5.

DATED: June 27, 1997
Albany, New York

Peter D. Van Buren

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