



STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 27, 2000

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anthony Benigno, Esq.
NYS Department of Health
433 River Street – Fourth Floor
Troy, New York 12180

Carolyn Shearer, Esq.
Hinman, Straub, Pigors & Manning, P.C.
121 State Street
Albany, New York 12207-1693

Janardhan Bokka Reddy, M.D.
959 Gloucester Place
Schenectady, New York 12309

RE: In the Matter Janardhan Bokka Reddy, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 00-184) 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.

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.

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.

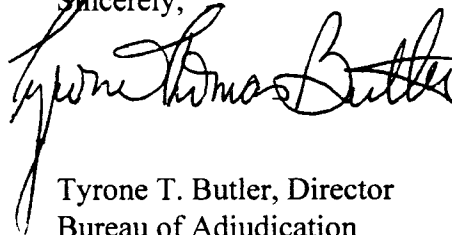
The notice of review served on the Administrative Review Board should be forwarded to:

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,

A handwritten signature in black ink, appearing to read "Tyrone T. Butler". The signature is written in a cursive style with a long, sweeping underline that extends down towards the typed name below.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm

Enclosure

COPY

IN THE MATTER
OF
JANARDHAN BOKKA REDDY, M.D.

DETERMINATION
AND
ORDER

BPMC-00-184

ARSENIO G. AGOPOVICH, M.D., Chairperson, MOHAMMAD GHAZI-MOGHADAM, M.D. and NANCY J. MACINTYRE, R.N., PH.D., duly designated members of the State Board for Professional Medical Conduct, appointed by Commissioner of Health of the State of New York pursuant to section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. MICHAEL P. MCDERMOTT, ESQ., Administrative Law Judge, served as Administrative Officer for the Hearing Committee,

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

SUMMARY OF THE PROCEEDINGS

| | |
|---|--|
| Notice of Hearing and Statement of Charges: | March 17, 2000 |
| Pre-Hearing Conference: | March 21, 2000 |
| Hearing Dates: | March 28, 2000 April 11, 2000 April 24, 2000 |

Place

March 28, 2000
Quality Inn
3 Watervliet Ave
Albany, New York

April 11, 2000
NYS Department of Health
Hedley Park Place
433 River Street
Troy, New York 12180

April 27, 2000
Ramada Inn
1228 Western Ave
Albany, New York

Date of Deliberations:

June 1, 2000

Petitioner appeared by:

Henry M. Greenberg, Esq.
General Counsel
NYS Department of Health
by: Anthony Begnino, Esq.
of Counsel

Respondent appeared by:

Hinman, Straub, Pigors & Manning, P.C.
121 State Street, Albany, N.Y. 12207-1693
by: Carolyn Shearer, Esq., of Counsel

WITNESSES

For the Petitioner:

Wayne Olinzok
Cheryl Ratner
Jean Bursor, L.P.N.
Lois Bezio, R.N.
Robert J. O'Keefe
Oscar C. Lirio, M.D.
Paul A. Skudder, M.D.
Irving H. Goldman, M.D.

For the Respondent:

John R. Valvo, M.D.
Grace Jorgensen, M.D.
Janardhan Bokka Reddy, M.D., the Respondent

STATEMENT OF CHARGES

Essentially, the Statement of Charges, charges the Respondent with negligence on more than one occasion, incompetence on more than one occasion, practicing the profession fraudulently and inadequate record keeping.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

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. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. **JANARDHAN BOKKA REDDY, M.D.** the Respondent, was authorized to practice in New York state on April 10, 1981 by the issuance of license number 145744 by the New York State Education Department (Pet's. Ex. 3)

FINDINGS AS TO BPMC ORDER NO 99-1

2. The New York State Board of Professional Medical Conduct issued BPMC Order No. 99-1, effective January 7, 1999 which contained various conditions of monitoring agreed to by the Respondent. (Ex. "1" of Pet's. Ex. 1, Ex. "B" of Pet's Ex. 4)

3. Condition 7 of the Condition of Monitoring required,

"Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Approval of a monitor or supervisor is a condition precedent to the Respondent's further practice of medicine and any practice of medicine without a pre-approved monitor is unauthorized within the meaning of N.Y. Education Law §6512, and may lead to criminal prosecution." (Ex. "B" of Pet's. Ex. 4)

4. On January 8, 1999, BPMC Order 99-1 was delivered by the U.S. Postal Service to the Respondent's residence, 959 Gloucester Place, Schenectady, New York 12309 and it was signed for by someone at that address. (Pet's, Ex. 5)

5. On January 8, 1999 the Respondent's household consisted of his wife and three children ages 20, 17 and 17. The Respondent was unable to tell the Hearing Committee if any of his holiday guests were still at his home on that date. (Tr. 337)

6. The Respondent testified that he does not recognize the signature on the postal receipt as that of any member of his household. (Pet's. Ex. 5 and 48: Tr. 308-309, 329, 331)

7. The signature on the original postal receipt (Pet's. Ex. 48) is similar to the signature of Kumuda Bokka Reddy as it appear in (Pet's. Ex. 49). Kumuda Bokka Reddy is the Respondent's wife (Pet's. Ex. 48 and 49)

8. BMPC Order 99-1 was effective upon issuance by the Board on January 7, 1999 (Ex. 1 of Pet's. Ex. 1), and was duly served at the Respondent's residence on January 8, 1999. (Pet's. Ex. 5 and 48)

9. By letter, dated January 14, 1999, Nathan P. Reed, M.D., Medical Director, Physicians Monitoring Programs, Office of Professional Medical Conduct, advised the Respondent,

"Monitoring Condition #7 states that you may practice medicine only when monitored by a licensed, board certified physician. I understand that Ms. Ratner is reviewing a proposal to have Dr. Kandasamy Perumal of Troy serve as your practice monitor pursuant to your Order. Until Dr. Perumal is approved as your monitor, any continued practice of medicine would be considered a violation of your Order. Please review the enclosed documents related to practice monitoring and forward to Ms. Ratner documentation that you have the required minimum malpractice insurance."

Dr. Reed's letter was delivered to the Respondent's residence on January 27, 1999 (Pet's. Ex. 6).

10. By letter, dated January 20, 1999, Michael S. Jakubowski, M.D., Vice President for Medical Affairs, Ellis Hospital, Schenectady, New York, advised the Respondent,

" We have received a copy of a Consent Agreement and Order, which was signed by you and the Office of Professional Medical Conduct of the State of New York. This agreement requires a two year period of monitoring during which time you are required to be monitored at all practice sites by a "practice monitor" who must report quarterly, in writing, to the Director of OPMC:

Please send us the name and address of the approved "practice monitor" so that we may contact him/her to make the proper arrangements for him/her to monitor your practice at Ellis Hospital. We will request that we be provided with a copy of each quarterly report that he/she sends to the Director of OPMC. A release form for this report is included for you to sign. ***

Your practice at Ellis Hospital will be contingent upon you compliance with the conditions, which have been placed upon you by the Office of Professional Medical Conduct."

Dr. Jakubowski's letter was delivered to Respondent's residence on January 22, 1999 (Pet's. Exs. 7 and 8).

11. The Respondent practiced medicine at the following locations on the following dates:

- St. Clare's Hospital, Schenectady, New York on January 25, 1999, Respondent performed a procedure on Patient A (Pet's. Ex. 9).
- St. Clare's Hospital, on January 27, 1999, Respondent performed a procedure on Patient A (Pet's. Ex. 10).
- St. Clare's Hospital, on January 28, 1999, Respondent provided a consultation to Patient B (Pet's. Ex. 11).
- St. Clare's Hospital, on February 16, 1999, Respondent performed a procedures on Patient C (Pet's. Ex. 12).
- Ellis Hospital, Schenectady, New York, on January 7, 1999, Respondent performed a procedure on Patient D (Pet's. Ex. 13).
- Ellis Hospital, on January 7, 1999, Respondent performed a procedure on Patient E (Pet's. Ex. 14).

- Ellis Hospital, on January 12, 1999, Respondent performed a procedure on Patient F (Pet's. Ex. 15).
- Ellis Hospital, on January 12, 1999, Respondent performed a procedure on Patient G (Pet's. Ex. 16).
- Ellis Hospital, on January 14, 1999, Respondent performed a procedure on Patient H. (Pet's. Ex. 17).
- Ellis Hospital, on January 21, 1999, Respondent performed a procedure on Patient I (Pet's. Ex. 18).
- Ellis Hospital, on January 21, 1999, Respondent performed a procedure on Patient J (Pet's. Ex. 19).
- Ellis Hospital, on January 21, 1999, Respondent performed a procedure on Patient K (Pet's. Ex. 20).
- Ellis Hospital, on January 25, 1999, Respondent performed a procedure on Patient L (Pet's. Ex. 21).
- Ellis Hospital, on January 28, 1999, Respondent performed a procedure of Patient M (Pet's. Ex. 22).
- Ellis Hospital, on January 29, 1999, Respondent performed a procedure on Patient N (Pet's. Ex. 23).
- Ellis Hospital, on January 29, 1999, Respondent performed a procedure on Patient O (Pet's. Ex. 24).
- Ellis Hospital, on January 29, 1999, Respondent performed a procedure on Patient P (Pet's. Ex. 25).
- Ellis Hospital, on February 1, 1999, Respondent performed a procedure on Patient Q (Pet's. Ex. 26).
- Ellis Hospital, On February 2, 1999, Respondent performed a procedure on Patient R (Pet's. Ex. 27).
- Ellis Hospital, on February 16, 1999, Respondent performed a procedure on Patient S (Pet's. Ex. 28).
- Ellis Hospital, on February 17, 1999, Respondent performed a procedure on Patient P (Pet's. Ex. 29).

- Ellis Hospital, on February 18, 1999, Respondent performed a procedure on Patient T (Pet's. Ex. 30).
- Ellis Hospital, on February 18, 1999, Respondent performed a procedure on Patient U (Pet's. Ex. 31).
- Bellevue Hospital, Schenectady, New York, on January 26, 1999, Respondent performed two procedures on Patient V (Pet's. Ex. 32).
- Bellevue Hospital, on January 26, 1999, Respondent performed two procedures on Patient W (Pet's. Ex. 33).
- Bellevue Hospital, on January 26, 1999, Respondent performed two procedures on Patient X (Pet's. Ex. 34).
- Bellevue Hospital, on February 4, 1999, Respondent performed a procedure on Patient Y (Pet's. Ex. 35)
- Bellevue Hospital, on February 4, 1999, Respondent performed a procedure on Patient Z (Pet's. Ex. 36).
- Bellevue Hospital, on February 4, 1999, Respondent performed a procedure on Patient AA (Pet's. Ex. 37).
- Bellevue Hospital, on February 4, 1999, Respondent performed a procedure on Patient BB (Pet's. Ex. 38).
- Bellevue Hospital, on February 18, 1999, Respondent performed a procedure on Patient CC (Pet's. Ex. 39).
- Bellevue Hospital, on February 18, 1999, Respondent performed a procedure on patient DD (Pet's. Ex. 40).
- Bellevue Hospital, on February 18, 1999, Respondent performed a procedure on Patient EE (Pet's. Ex. 41).

12. The Respondent admits that he treated Patients A through EE, on or about the dates specified. (Resp's. Ex. A)

13. The Respondent's practice monitor was approved by OPMC on February 24, 1999. (Tr. 39)

CONCLUSIONS AS TO BPMC ORDER NO. 99-1

Based on the evidence, the Hearing Committee concludes:

- (a) The Respondent's contention that he did not receive timely actual notice of BPMC Order No. 99-1 is not credible

BPMC Order No. 99-1 was effective January 7, 1999 and was duly served at Respondent's residence on January 8, 1999.

While it appears that the Respondent did not himself sign the postal receipt, someone at his residence, (most probably his wife), did sign for it. In any event it is reasonable to assume that the postal receipt was signed by a person of suitable age and discretion who brought it to the Respondent's attention.

- (b) The Respondent practiced medicine during the period January 25, 1999 through February 18, 1999 (as specified in Finding of Fact No. 11), without a practice monitor as required by BPMC Order No. 99-1.
- (c) The Respondent's practice monitor was not approved by OPMC until February 24, 1999.

FINDING AS TO PATIENT M

14. The Respondent began providing care and treatment to Patient M on or about November 17, 1998 (Resp's. Ex. B; Tr. 279).

15. On November 23, 1998, a biopsy report revealed that Patient M had bladder cancer (Resp's. Ex. B, p. 19).
16. Following the diagnosis, the Respondent discussed the treatment options with Patient M and her son (Resp's. Ex. B, p.1; Tr. 285).
17. On January 28, 1999, Patient M was admitted to Ellis Hospital to undergo a radical cystectomy (Resp's. Ex. B, p. 5).
18. A radical cystectomy includes removal of the uterus, ovaries, and fallopian tubes along with the bladder (Tr. 203(4/27/00), 284).
19. Removal of the uterus is a necessary part of the procedure in a patient such as Patient M because the uterus is densely adherent to the bladder, and attempting to dissect the bladder away from the uterus creates a risk of tumor spillage.
20. Removal of Patient M's uterus was appropriate, in view of the extent of malignancy and the lethality of the disease (Tr. 225-226).
21. It is within the scope of the specialty of urology to perform a radical cystectomy in a patient with a history of aorto-bifemoral graft (Tr. 211).
22. The standard of care does not require that a urologist be assisted by a vascular surgeon in the performance of such procedure on such a patient (Tr. 205 (4/27/00), 220).

23. Respondent selected Dr. Lirio as the co-surgeon for Patient M's procedure because of Dr. Lirio's experience in vascular surgery (Tr. 349).
24. At the time of Patient M's surgery, Dr. Lirio held privileges in vascular surgery at Ellis Hospital (Tr. 105).
25. At the time of Patient A's surgery, Dr. Lirio maintained a listing in the Schenectady, New York yellow pages indicating that his practice included vascular surgery (Tr. 105).
26. The Respondent discussed patient M's history with Dr. Lirio when they were scrubbing for the operation. The Respondent informed Dr. Lirio of the presence of a bypass but did not specify the aorto bi-femoral bypass (Tr. 88).
27. Patient M's history of vascular graft was documented by the Respondent pre-operatively in the hospital record (Pet's. Ex. 42, p. 13; Tr. 289).
28. During the procedure, the aorto bi-femoral bypass was transected by the Respondent (Tr. 58-59, 94-95).
29. When the graft was transected, Dr. Lirio asked that a vascular surgeon be called in, as he "did not want responsibility for it" (Tr. 97).

30. Dr. Paul Skudder, who is board certified in general surgery, vascular surgery and surgical critical care, arrived at the operating room 5 to 10 minutes after being called by the Respondent (Tr. 128, 139).

31. The Respondent failed to maintain a medical record for Patient M that accurately reflects the care and treatment he provided for the patient (Pet's. Ex. 42, pp. 35-37; Tr. 187 (4/11/00), 249-251 (4/27/00)).

HEARING COMMITTEE CONCLUSIONS AS TO PATIENT M

Based on the evidence, the Hearing Committee concludes:

(a) The Respondent did not deviate from the accepted standards of care in his surgical treatment of Patient M.

The radical cystectomy was indicated, a qualified assistant was selected, and the procedure was undertaken appropriately. The transection of the aorto-bifemoral graft was an inauspicious complication which, even in the best of hands, is a recognized surgical risk. The Respondent promptly and appropriately managed the complication by immediately consulting and calling in a vascular surgeon.

(b) The Respondent failed to maintain a medical record which accurately reflected his care and treatment of Patient M.

FINDINGS AND CONCLUSION OF THE ISSUE OF FRAUD
(Respondent's February 19, 1999 interview with OPMC Supervising Medical
Conduct Investigator Cheryl Ratner)

32. The Respondent was interviewed by OPMC Supervising Medical Conduct Investigator Cheryl Ratner on February 19, 1999 (Tr. 36)

33. It has been alleged that at the interview, the Respondent stated that he did not know he could not practice medicine until an approved monitor was in place (Tr. 36)

34. This allegation was contradicted by Cheryl Ratner who testified, "So he acknowledged - - Dr. Reddy acknowledged that he knew he had to have a practice monitor" (Tr. 37).

Conclusion: The allegation that the Respondent made the statement that he did not know he could not practice medicine until an approved monitor was place is not supported by the evidence.

35. The Respondent stated that his lawyer told him that there would be no interruption of his practice (Tr. 36).

36. There is nothing on the record to contradict the Respondent's statement as to what his former attorney told him.

Conclusion: There is nothing in the record to contradict the Respondent's statement as to what his former attorney told him.

37. The Respondent stated he had not read the Order (Tr. 36).

38. The Respondent signed the Consent Agreement on December 28, 1998; he received BPMC Order 99-1 on January 8, 1999; he received Dr. Jakubowski's letter on January 22, 1999 and he received Dr. Reed's letter on January 27, 1999 (Pet's. Exs. 4, 5, 6, 7, 8 and 48).

Conclusion: Given the evidence, the Petitioner's statement that he had not read the Order is not credible.

Respondent's January 11, 2000 interview with Cheryl Ratner

39. The Respondent was interviewed by Cheryl Ratner on January 11, 2000 (Tr. 39).

40. At the interview the Respondent stated that he never signed the receipt for the Order which was delivered to his residence on January 8, 1999 (Tr. 40).

41. The signature on the postal receipt dated, 1/8/99, does not appear to be similar to the Respondent's signature (Pet's. Exs. 5 and 48).

Conclusion: The Respondent's statement was true.

42. The Respondent stated that he does not recognize the signature on the return receipt, does not know who signed the Order and the Order never got to him (Tr. 40).

Conclusion: The Respondent's statement was not credible. (See Findings of Fact 4, 5, 6, 7 and Conclusions as to BMPC Order No. 99-1).

Respondent's January 11, 2000 interview with OPMC Senior Investigator Robert O'Keefe

43. The Respondent was interviewed by OPMC Senior Investigator Robert O'Keefe on January 11, 2000 (Tr. 81).

44. At the interview the Respondent stated that Dr. Lirio transected the aorto bi-femoral graft (Tr. 81-82).

Conclusion: The Respondent's statement was false (See Finding of Fact 28).

45. The Respondent stated that prior to surgery he discussed with Dr. Lirio the patient's history of pre-existing aorto bi-femoral graft.

Conclusion: The Respondent statement was false (See Finding of Fact 26).

**GENERAL CONCLUSION AS TO THE FALSE STATEMENT MADE BY THE
RESPONDENT TO OPMC INVESTIGATORS**

Based on the record, the Hearing Committee concludes that the false statements made by the Respondent to OPMC investigators were made knowingly, willfully and with the intent to mislead, and constitute fraud.

The Hearing Committee is convinced that the Respondent made the false statements in an effort to justify his deliberate violation of BPMC Order No. 99-1.

VOTE OF THE HEARING COMMITTEE
(All votes were unanimous unless otherwise specified)

FIRST SPECIFICATION: (GROSS NEGLIGENCE)

NOT SUSTAINED as to any of the charges.

SECOND SPECIFICATION: (GROSS INCOMPETENCE)

NOT SUSTAINED as to any of the charges.

**THIRD THROUGH THIRTY-FIFTH SPECIFICATIONS
(VIOLATION OF A BOARD ORDER)**

SUSTAINED as to all of the charges

THIRTY-SIXTH THROUGH THIRTY-SEVENTH SPECIFICATIONS
(FRAUDULENT PRACTICE)

PARAGRAPH C **NOT SUSTAINED** as to the allegation that the Respondent stated that he did not know he couldn't practice medicine until an approved monitor was in place.

NOT SUSTAINED as to the allegation that the Respondent stated that his lawyer told him that there would be no interruption in this practice.

SUSTAINED as to the allegation that the Respondent stated that he had not read the Order.

PARAGRAPH D **NOT SUSTAINED** as to the allegation that the Respondent stated that he never signed for the Order which was delivered to his house.

SUSTAINED as to the allegation that the Respondent stated that he does not recognize the signature on the return receipt, does not know who signed for the Order and the Order never got to him.

PARAGRAPH E **SUSTAINED** as to the allegation that the Respondent stated that Dr. Lirio transected the aorta bi-femoral graft.

SUSTAINED as to the allegation that the Respondent stated that prior to surgery he discussed with Dr. Lirio the patient's history of pre-existing aorto bi-femoral graft.

THIRTY-EIGHT SPECIFICATION: (FAILURE TO MAINTAIN RECORDS

SUSTAINED as to those charges specified in paragraphs B, B(9) of the Statement of Charges.

HEARING COMMITTEE DETERMINATION

The Hearing Committee determined that the Respondent was not a credible witness. His testimony was vague, evasive, self serving and it displayed selective recall and an eagerness to assign blame to others. The Hearing Committee came away with the impression that the Respondent lacked moral integrity and would offer any excuse, however transparent, rather than admit that he knowingly and willfully violated BPMC Order No. 99-1.

The Hearing Committee believed that a severe penalty, short of revocation, is warranted in this case.

Based on the entire record, the Hearing Committee determines that the appropriate penalty would be a five (5) year suspension, stay the suspension partially, and place the Respondent on probation for five (5) years under terms and conditions as hereinafter specified in the Order.

The Hearing Committee also determined that a Ten Thousand (\$10,000.00) Dollar fine would be appropriate in this case.

ORDER

THEREFORE: IT IS HEREBY ORDERED THAT:

1. The Respondent's license to practice medicine in the State of New York is **SUSPENDED** for five (5) years, suspension **STAYED** for all but the first six (6) months of the suspension period. **(Six months actual suspension)**

2. The Respondent shall not receive credit against the six (6) months period of actual suspension for any time he was not engaged in the practice of surgery pursuant to a voluntary, non-disciplinary Order of Conditions, effective March 9, 2000.

- The period of actual suspension shall commence on the effective date of this Order and shall continue for six (6) months thereafter unless extended as hereinafter provided.
- During the six (6) months of actual suspension the Respondent shall satisfactorily complete a course in Ethics approved by OPMC and shall file with OPMC a certificate indicating that he has satisfactorily completed the Ethics course.

If the Respondent fails to satisfactorily complete the Ethics course within the six months period of actual suspension, the period of actual suspension shall be extended until such time as the Respondent files with OPMC a certificate indicating that he has satisfactorily completed the Ethics course.

3. The Respondent is placed on probation for a period of five years under the following terms and conditions:

- Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.
- Respondent shall submit written notification of the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Fourth Floor, Troy, New York 12180: said notice is to include a full description of any employment and practice; professional and residential addresses and telephone number within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.
- Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by state rules and regulations.
- Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his staff at practice locations or OPMC offices.

- Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.
- **RESPONDENT SHALL PRACTICE MEDICINE ONLY WHEN MONITORED BY A LICENSED PHYSICIAN, BOARD CERTIFIED IN AN APPROPRIATE SPECIALTY, ("PRACTICE MONITOR") PROPOSED BY RESPONDENT AND SUBJECT TO THE WRITTEN APPROVAL OF THE DIRECTOR OF OPMC. APPROVAL OF A MONITOR OR SUPERVISOR IS A CONDITION PRECEDENT TO THE RESPONDENT'S FURTHER PRACTICE OF MEDICINE AND ANY PRACTICE OF MEDICINE WITHOUT A PRE-APPROVED MONITOR IS UNAUTHORIZED WITHIN THE MEANING OF NEW YORK EDUCATION LAW §6512, AND MAY LEAD TO CRIMINAL PROSECUTION.**
- Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection of records prepared and/or maintained by Respondent, including, but not limited to, all surgeries and records of such surgeries, all prescriptions for controlled substances, patient records, prescribing information and office

records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

- Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.
- Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.
- The period of probation and monitoring shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation and monitoring shall resume and any terms of probation and monitoring which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

- Respondent shall maintain medical malpractice insurance coverage with limits no less than \$2 million per occurrence and \$6 million per policy year, in accordance with Section 230(18)(b) or the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

4. A fine in the amount of Ten Thousand (\$10,000.00) Dollars is assessed against the Respondent. Payment of the fine shall be due within 60 days of the effective date of this ORDER.

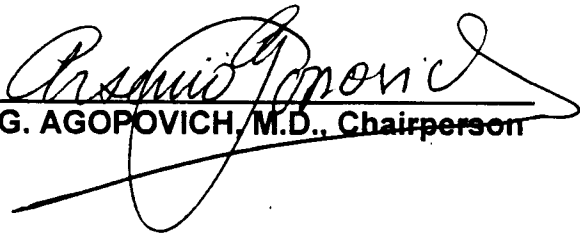
The Respondent shall make payment to the Bureau of Accounts Management, New York Department of Health, Erastus Corning Tower Building, Room 1245, Empire State Plaza, Albany, New York 12237.

Any fine not paid by the prescribed date shall be subject to all provisions of law relating to debt collection by the State of New York. This includes but is not limited to that imposition of interest, late payment charges and collection, and non-renewal of permits of licenses (Tax Law §171(27); State Finance Law §18; CPLR §5001; Executive Law §32).

5. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he is subject pursuant to this Order and shall assume and bear all cost related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or such other proceeding against Respondent as may be authorized pursuant to the law.

6. The **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: *June 21*, 2000
Troy, New York



ARSENIO G. AGOPOVICH, M.D., Chairperson

MOHAMMAD GHAZI-MOGHADAM, M.D.
NANCY J. MACINTYRE, R.N., PH.D.

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

-----X

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

-----X

JANARDHAN B. REDDY, M.D., the Respondent, was authorized to practice medicine in New York State on April 10, 1981 by the issuance of license number 145744 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 July 1, 1999, through June 30, 2000, with a registration address of 1537 Union Street, Schenectady, NY 12309.

FACTUAL ALLEGATIONS

A. Effective on or about January 7, 1999, the New York State Board for Professional Medical Conduct issued BPMC Order No. 99-1, a copy is annexed hereto as Exhibit 1, which among other things, censured and reprimanded Respondent's license and imposed various conditions of monitoring for two years. Paragraph 7 of the Conditions of Monitoring required,

"Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Approval of a monitor or supervisor is a condition precedent to the Respondent's further practice of medicine and any practice of medicine without a pre-approved monitor is unauthorized within the meaning of N.Y. Educ. Law §6512, and may lead to criminal

prosecution."

Respondent's practice monitor was not approved until February 24, 1999. Respondent practiced medicine at the following locations on the following dates prior to his practice monitor being approved:

1. St. Clare's Hospital, Schenectady, New York on January ~~26~~²⁵, 1999, Respondent performed a procedure on Patient A (a list of patient names is included as Exhibit A);
2. St. Clare's Hospital, on January ~~26~~²⁷, 1999, Respondent performed a procedure on Patient A;
3. St. Clare's Hospital, on January ~~28~~²⁸, 1999, Respondent provided a consultation to Patient B;
4. St. Clare's Hospital, on February 16, 1999, Respondent performed a procedure on Patient C;
5. Ellis Hospital, Schenectady, New York, on January 7, 1999, Respondent performed a procedure on Patient D;
6. Ellis Hospital, on January 7, 1999, Respondent performed a procedure on Patient E;
7. Ellis Hospital, on January 12, 1999, Respondent performed a procedure on Patient F;
8. Ellis Hospital, on January 12, 1999, Respondent performed a procedure on Patient G;
9. Ellis Hospital, on January 14, 1999, Respondent performed a procedure on Patient H;
10. Ellis Hospital, on January 21, 1999, Respondent performed a procedure on Patient I;
11. Ellis Hospital, on January 21, 1999, Respondent performed a procedure on Patient J;
12. Ellis Hospital, on January 21, 1999, Respondent performed a procedure on Patient K;
13. Ellis Hospital, on January 25, 1999, Respondent performed a procedure on Patient L;
14. Ellis Hospital, on January 28, 1999, Respondent performed a procedure on Patient M;

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15. Ellis Hospital, on January 29, 1999, Respondent performed a procedure on Patient N;
16. Ellis Hospital, on January 29, 1999, Respondent performed a procedure on Patient O;
17. Ellis Hospital, on January 29, 1999, Respondent performed a procedure on Patient P;
18. Ellis Hospital, on February 1, 1999, Respondent performed a procedure on Patient Q;
19. Ellis Hospital, on February 2, 1999, Respondent performed a procedure on Patient R;
20. Ellis Hospital, on February 16, 1999, Respondent performed a procedure on Patient S;
21. Ellis Hospital, on February 17, 1999, Respondent performed a procedure on Patient P;
22. Ellis Hospital, on February 18, 1999, Respondent performed a procedure on Patient T;
23. Ellis Hospital, on February 18, 1999, Respondent performed a procedure on Patient U;
24. Bellevue Hospital, Schenectady, New York, on January 26, 1999, Respondent performed two procedures on Patient V;
25. Bellevue Hospital, on January 26, 1999, Respondent performed two procedures on Patient W;
26. Bellevue Hospital, on January 26, 1999, Respondent performed two procedures on Patient X;
27. Bellevue Hospital, on February 4, 1999, Respondent performed a procedure on Patient Y;
28. Bellevue Hospital, on February 4, 1999, Respondent performed a procedure on Patient Z;
29. Bellevue Hospital, on February 4, 1999, Respondent performed a procedure on Patient AA;
30. Bellevue Hospital, on February 4, 1999, Respondent performed a procedure on Patient BB;
31. Bellevue Hospital, on February 18, 1999, Respondent performed a procedure on Patient CC;
32. Bellevue Hospital, on February 18, 1999, Respondent performed a procedure on Patient DD;

33. Bellevue Hospital, on February 18, 1999, Respondent performed a procedure on Patient EE;

B. On or about January 28, 1999, at Ellis Hospital, Schenectady, New York, Respondent provided medical care to Patient M consisting of performing a radical cystectomy, hysterectomy, bilateral salpingo-oophorectomy and an ileal conduit. Patient M had a history of an aorto bi-femoral graft since 1997. During the operation Respondent transected the aorto bi-femoral graft. Respondent's care and treatment of Patient M failed to meet acceptable standards of medical care in that:

1. Respondent failed to have a practicing vascular surgeon present at the initiation of the procedure given the patient's history of aorto bi-femoral graft, and lower abdominal pelvic procedure.
2. Respondent failed to adequately discuss the patient's history pre-operatively with his assistant surgeon.
3. Respondent failed to identify, isolate and protect the graft at the initiation of the procedure.
4. Respondent failed to adequately explore the abdominal cavity prior to removing the pelvic organs.
5. Respondent failed to identify the ureters prior to mobilizing the bladder and uterus.
6. Respondent continued with removal of the uterus despite his assistant surgeon's concern over excessive bleeding, scarring and adhesions.
7. Respondent transected the graft without adequate care and caution to previously identify the graft.
8. Respondent exceeded the scope of his specialty by proceeding to transect an area without having identified the graft.

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9. Respondent failed to maintain records which accurately reflected the care and treatment of the patient, including, but not limited to, the operative note.

C. On or about February 19, 1999, Respondent was interviewed by OPMC Supervising Medical Conduct Investigator Cheryl Ratner. At that interview, Respondent stated that he did not know he could not practice medicine until an approved monitor was in place. Respondent stated that his lawyer told him that there would be no interruption of his practice. Respondent stated that he had not read the order.

TO DELETE,

D. On or about January 11, 2000, Respondent was interviewed by OPMC Supervising Medical Conduct Investigator Cheryl Ratner. At that interview, Respondent stated that he never signed for the Order which was delivered to his house on January 8, 1999, does not recognize the signature on the return receipt, does not know who signed for the Order and the Order never got to him.

E. On or about January 11, 2000, Respondent was interviewed by OPMC Senior Investigator Robert O'Keefe. At that interview, Respondent stated that Dr. Lirio transected the aorto bi-femoral graft and that prior to surgery he discussed with Dr. Lirio the patient's history of pre-existing aorto bi-femoral graft.

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SPECIFICATIONS OF MISCONDUCT

FIRST SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(4) by practicing the profession of medicine with gross negligence, in that Petitioner charges:

1. The facts in paragraphs B1, B2, B3, B4, B5, B6, B7 and B8.

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(6) by practicing the profession of medicine with gross incompetence, in that Petitioner charges:

2. The facts in paragraphs B1, B2, B3, B4, B5, B6, B7 and B8.

THIRD THROUGH THIRTY-FIFTH SPECIFICATIONS

VIOLATION OF A BOARD ORDER

Respondent is charged with professional misconduct under N.Y. Education Law section 6530(29) by reason of his having

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violated a condition imposed upon him pursuant to Section 230 of the Public Health Law, by BPMC Order #99-1, in that Petitioner charges:

3. The facts in paragraphs A and A1.
4. The facts in paragraphs A and A2.
5. The facts in paragraphs A and A3.
6. The facts in paragraphs A and A4.
7. The facts in paragraphs A and A5.
8. The facts in paragraphs A and A6.
9. The facts in paragraphs A and A7.
10. The facts in paragraphs A and A8.
11. The facts in paragraphs A and A9.
12. The facts in paragraphs A and A10.
13. The facts in paragraphs A and A11.
14. The facts in paragraphs A and A12.
15. The facts in paragraphs A and A13.
16. The facts in paragraphs A and A14.
17. The facts in paragraphs A and A15.
18. The facts in paragraphs A and A16.
19. The facts in paragraphs A and A17.
20. The facts in paragraphs A and A18.
21. The facts in paragraphs A and A19.
22. The facts in paragraphs A and A20.
23. The facts in paragraphs A and A21.
24. The facts in paragraphs A and A22.
25. The facts in paragraphs A and A23.
26. The facts in paragraphs A and A24.
27. The facts in paragraphs A and A25.

28. The facts in paragraphs A and A26.
29. The facts in paragraphs A and A27.
30. The facts in paragraphs A and A28.
31. The facts in paragraphs A and A29.
32. The facts in paragraphs A and A30.
33. The facts in paragraphs A and A31.
34. The facts in paragraphs A and A32.
35. The facts in paragraphs A and A33.

**THIRTY-SIXTH THROUGH SEVENTH SPECIFICATIONS
FRAUDULENT PRACTICE**

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently, in that Petitioner charges:

36. The facts in paragraphs C and D.
37. The facts in paragraph E.

**THIRTY-EIGHTH SPECIFICATION
FAILURE TO MAINTAIN RECORDS**

Respondent is charged with professional misconduct under N.Y. Education Law section 6530(32) by failing to maintain a record for each patient which accurately reflects the care and

treatment of the patient, in that Petitioner charges:

38. The facts in paragraphs B and B9.

DATED: *March 17*, 2000
Albany, New York

Peter D. Van Buren

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