



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

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Public

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August 20, 2004

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

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Albany, New York 12237-0032

**RE: In the Matter of Vidyadhara Kagali, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 04-185) 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,

  
Sean D. O'Brien, Director  
Bureau of Adjudication

SDO:djh

Enclosure

**COPY**

**IN THE MATTER**  
**OF**  
**VIDYADHARA A. KAGALI, M.D.**

**DETERMINATION**  
**AND**  
**ORDER**

BPMC NO. 04-185

A Notice of hearing, dated January 22, 2004, and a Statement of Charges, dated January 22, 2004, were served upon the Respondent, **VIDYADHARA A. KAGALI, M.D.** (Hereinafter "Respondent"). **LYON M. GREENBERG, M.D.**, Chairperson, **ARSENIO G. AGOPOVICH, M.D.** and **GAIL S. HOMICK**, are duly designated members of the State Board for Professional Medical Conduct. They served as the Hearing Committee ("the Committee") in this matter which was held pursuant to Section 230(10)(e) of the Public Health Law. **JONATHAN M. BRANDES**, Administrative Law Judge, served as the Administrative Officer.

The Department of Health ("the Department") appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, by **ANTHONY M. BENIGNO, ESQ.**, of Counsel. The Respondent appeared by **WOOD AND SCHER, WILLIAM L. WOOD, 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**

Answer Filed	February 20, 2004
Pre-Hearing Conference	February 20, 2004
Witness for Petitioner	Richard Toll, M.D.      Expert Witness
Witnesses for Respondent	Respondent testified in his own behalf and called Somsak Bhitiyakul, M.D. as an expert.
Hearing Date(s)	February 26, 2004 and March 26, 2004.
Deliberation Date(s)	June 3, June 16 and June 23, 2004

**STATEMENT OF CASE**

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter P.H.L.]).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. VIDYADHARA A. KAGALI, M.D. ("Respondent") is charged with five specifications of professional misconduct, as defined in §6530 of the Education Law of the State of New York ("Education Law"). Specifically, Respondent is charged with:

1. One count of Negligence on more than one occasion as defined in §6530(3) of the Education Law;
2. One count of Incompetence on more than one occasion as defined in §6530(5) of the Education Law;
3. One count of gross negligence as defined in §6530(4) of the Education Law;
4. One count of gross incompetence as defined in §6530(6) of the Education Law;
5. One count of failure to maintain records as defined in §6530(32) of the Education Law;

## FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("Tr."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Hearing Committee hereby makes the following findings of fact:

1. Respondent was authorized to practice medicine in New York State on November 18, 1974 by the issuance of license number 122498 by the New York State Education Department (Ex. 3, pg. 2)
2. Respondent, is a board certified pathologist who began treating inmates at the Dutchess County Jail (DCJ) in 2001. Respondent was responsible for the treatment of Patient A from January 10, 2002 until her death on February 16, 2002. Respondent examined Patient A on four occasions, January 23, 2002, February 1, 2002, February 6, 2002 and February 13, 2002. Patient A was a 35-year-old female with a history of smoking, obesity, sedentary lifestyle and was surgically post menopausal.
3. Health professionals at DCJ, other than Respondent, took Patient A's history and performed a physical examination on January 23, 2002 (Ex. 4, pgs. 39, 40).
4. Respondent always reviewed the patient's records prior to seeing the patient (T. at 125).
5. The patient's record shows a weight change of 72 lbs. in the last twelve months. (Ex. 4, pg. 45).

6. During the four examinations and treatment of Patient A, Respondent failed to ask the patient whether her 72 pound weight change was a weight gain or loss (Ex. 4, pg. 45).
7. The medical significance of such a large weight change could be pathologic. It could be the result of edema fluid or weight loss from the onset of diabetes (T. at 36, 191-194). Patient A reported a history of smoking (Ex. 4, pg. 39). Respondent failed to ask her how long she had smoked. He did not ask her how much she smoked per day (T. at 38-39).
8. Accepted standards of medicine require a physician to ascertain the duration and quantity of smoking (T. at 38-39).
9. The incidence and prevalence of cardiovascular disease increases with the duration and quantity of smoking exposure (T. at 38-39)
10. Respondent acknowledged that the "higher the smoking, probably increases the risk [of cardiovascular disease] smoking-wise" (T. at 299).
11. Someone who leads a sedentary lifestyle has an increased risk for cardiac disease (T. at 41).
12. Respondent failed to ask the patient about her level of physical activity (T. at 42).
13. Accepted standards of medicine require a physician to ask patients whether they lead a sedentary lifestyle or are physically active (T. at 42).
14. On February 6, 2002, Patient A reported chest discomfort, neck tightness and numbness in the left arm. No additional history appears. (Ex. 4, pg. 16).
15. Respondent should have elicited additional history to help him rule out whether the complaints were related to musculo-skeletal, gastrointestinal, esophageal, pulmonary or cardiac conditions (T. at 52-53)
16. On February 7, 2002, Patient A complained of respiratory distress, locked jaws, pain in the extremities, and chest wall pain upon palpation (Ex. 4, pg. 13).
17. On February 8, 2002, Patient A complained of chest pain (Ex. 4, pgs. 13-14).

18. On February 13, 2002, Patient A complained of chest wall pain and tightness, burning in the throat area, tingling and pain in left arm, as well as neck pain, numbness in the hands, burning in the chest, stiffness in the chest, and pain in the left shoulder (Ex. 4, pgs. 9, 11-12).
19. No investigation of these symptoms appears in the Patient Record (Ex. 4, pgs. 9, 11-12).
20. Accepted standards of medicine dictate that Respondent should have ascertained whether the pain was continuous or intermittent. (T. at 66-67, 218-220).
21. Accepted standards of medicine dictate that a practitioner ascertain what precipitates the pain; whether it is worse on exertion, moving, taking a deep breath, or lying down and how eating affects it (T. at 66-67, 218-220).
22. On each of these dates, Respondent failed to obtain and record an adequate history regarding the pain.
23. Respondent diagnosed costochondritis-like symptoms on February 6, 2002. He failed to obtain an adequate history to support this diagnosis (Ex. 4, pg. 16; T. at 88-89).

#### **PHYSICAL EXAMINATIONS PERFORMED BY RESPONDENT**

24. On January 23, 2002, Respondent examined Patient A for the first time. Respondent failed to obtain Patient A's blood pressure and pulse. Respondent did not examine Patient A's heart and lungs (T. at 46-47) (Ex. 4, pg. 18)
25. On January 23, 2002, Patient A reported arthritis (Ex. 4, pgs. 39, 40). Arthritis and swelling may be concomitant findings with hypertension (T. at 46-47) (Ex. 4, pg. 18).
26. The patient's blood pressure and pulse are pertinent to the patient's complaints. Patient A's blood pressure and pulse do not appear in the patient record (T. At 46-47 (Ex. 4, pg. 18)

26. The patient's blood pressure and pulse are pertinent to the patient's complaints. Patient A's blood pressure and pulse do not appear in the patient record (T. At 46-47 (Ex. 4, pg. 18)
27. On February 1, 2002, Respondent examined Patient A after she complained of falling backward (Ex. 4, pg. 15).
28. Respondent did not perform a neurological evaluation of the patient. An evaluation consistent with accepted standards of medicine would have included palpation of the back and spine, testing motor strength or sensation and straight leg raising. (T. at 50-51).
29. On February 13, 2002, Respondent examined Patient A. There is no record of her vital signs. There is also no record Respondent had examined her heart and lungs (Ex. 4, pgs. 9, 11-12).
30. Under the protocols of this facility, it was the responsibility of nurses to take histories, perform physical examinations and record this information (Ex. 4).

**FAILURE TO ORDER APPROPRIATE LABORATORY  
AND DIAGNOSTIC STUDIES**

31. Patient A was incarcerated at DCJ on January 10, 2002. When she entered the facility she was taking Vioxx. Vioxx is a non-steroidal anti-inflammatory (NSAID) (Ex. 4, pg 39).
32. On January 10, 2002 Patient A was taking Vioxx 50 mg per day (Ex. 4, pg. 6).
33. On January 23, 2002, Respondent increased the Vioxx dosage to 50 mg twice daily for thirty days. (Ex. 4, pg. 6).
34. Respondent failed to order blood tests of renal function on January 23, 2002 (Ex. 4, pg. 6).
35. On February 6, 2002, Patient A reported chest and other upper body discomfort. Accepted standards of medicine dictated that Respondent should have ordered various tests to aid him in his differential diagnosis including an electrocardiogram (EKG).

37. On February 13, 2002, Patient A continued to complain of chest pain. Accepted standards of medicine required Respondent to have ordered another EKG in addition to the laboratory studies listed above (T. at 68-69).
38. Respondent's expert agreed that Respondent needed to determine what type of arthritis Patient A suffered from (T. at 229-230, 238).

**FAILURE TO ADEQUATELY EVALUATE PATIENT A'S  
CARDIAC AND PULMONARY STATUS**

40. On February 6, 2002, Patient A complained of chest discomfort, neck tightness and numbness in the left arm (Ex. 4, pg. 16).
41. Part of the differential diagnosis in a patient exhibiting these symptoms would include pulmonary and cardiac problems (T. at 53).
42. Respondent did not carefully explore the symptoms reported by Patient A (T. at 53).
43. Respondent should have ordered cardiac enzymes and an EKG as part of his differential diagnosis (T. at 54).
44. On February 7, 2002, Patient A had respiratory distress, locked jaws and pain in extremities (Ex. 4, pg. 13). Respondent's differential diagnosis should have included cardiac and pulmonary causes.
45. On February 8, 2002, Patient A complained of chest pain (Ex. 4, pg. 13). Her complaints of chest pain were ongoing for well over 24 hours, implying that the problem was continuous and unrelenting (T. at 57).
46. Two EKG's done on February 7, 2002 and February 8, 2002 indicated non-specific T wave abnormalities (Ex. 4, pgs. 33-36).
47. A normal EKG or even a non-specifically abnormal EKG does not rule out an active cardiac disease process (T. at 58).

48. On February 12, 2002, Patient A complained of chest pain and difficulty breathing (Ex. 4, pg. 14). These complaints could be from angina, coronary artery disease, or congestive heart failure. A pulmonary embolism could also give chest pain and shortness of breath (T. at 59-60).
49. On February 13, 2002, Patient A complained of chest pain, needle feelings in her arms, pinching and a lump on left shoulder (Ex. 4, pg. 19).
50. Patient A complained of chest wall pain and tightness, burning in the throat area, a lump in the left clavicle area, tingling and pain in her left arm, neck pain, numbness in her hands, and stiffness in her chest. She also complained of pain in her left shoulder (Ex. 4, pgs. 11-12, 9).
51. Based upon these ongoing complaints, accepted standards of medicine dictated that Respondent should have expanded his differential history to include coronary artery disease and various types of lung problems (T. at 65-66).
52. A more thorough history would have assisted Respondent in his differential diagnosis (T. at 66-67).
53. If Respondent was unable to expand his physical examination and if he did not have sufficient resources available he should have noted same in the record and at least attempted to transfer Patient A to another facility where the resources were available (T. at 68).
54. Respondent should have done another EKG, blood tests for renal function, blood tests for cardiac enzymes and an exercise stress test (T. at 68-69).

**RESPONDENT INAPPROPRIATELY PRESCRIBED VIOXX TO PATIENT A  
AT 50MG TWICE DAILY FOR THIRTY DAYS**

55. The typical daily dose of Vioxx for relief of arthritic symptoms is approximately 25mg per day. For relief of acute pain syndromes the approved dose is typically approximately 50mg per day. These dosages should be for a specific number of days and usually are not to exceed five days. The use of 100mg per day for thirty days is excessive in terms of dosage and duration (T. at 48).
56. Vioxx is known to produce renal function abnormalities in some patients. Respondent should have ordered blood tests for assessment of Patient A's renal function at the time he ordered Vioxx 50mg twice daily for thirty days (T. at 48-49, 107).

**CONCLUSIONS**

**CREDIBILITY OF RESPONDENT**

Whether or not a witness has an interest in the case has a bearing upon his or her credibility. A party to a case is an interested witness as a matter of law. Respondent's license to practice medicine is in jeopardy in this proceeding. As a party in this matter, by law, he is an interested witness. Respondent's interest effects the weight to be given his testimony.

Respondent testified in his own defense. His testimony was evasive and self serving and therefore entitled to less weight than that of a straightforward witness. Respondent's evasiveness can be shown by his failure to respond to the questions posed by the Department's Counsel (T. at 281-282, 295-296, 300-301).

Respondent also testified falsely. He asserted that he only worked eight hours per week at DCJ and this placed pressure on him to see as many patients as possible. His point was that he had too little time to give his patients the full benefit of his clinical thought processes. However,

during cross-examination, time records were produced which showed Respondent worked an average of over ten hours per week (Ex. 6, pgs. 180-186). This misrepresentation had a deleterious effect on the credibility of Respondent. It is a basic maxim of law that where a trier of fact finds a witness spoke falsely about an important issue, the trier of fact may find all of the witness' testimony false. The Committee does not find all of Respondent's testimony to be false. However, as will be more fully developed below, there were many areas where the Committee did not believe Respondent.

In addition to his false testimony, Respondent also attempted to lay some of the blame for any lapses of care on Patient A. He did so by attempting to discredit her. Respondent testified Patient A had a history of mental illness. He further testified that she had a history of suicidal tendencies. According to Respondent, these factors necessitated that Patient A be placed under constant supervision (T. at 253-254). However, reviewing pages 31, 32 and 38 of Patient A's chart shows that throughout her stay there was no constant supervision. At the time of her admission, Patient A denied ever attempting suicide (Ex. 4, pg. 39).

On the date of her arrest, during her initial screening, Patient A indicated she was considering suicide (Ex. 4, pg. 45). However, at no point thereafter did the jail psychiatrist, Leon Krakower, M.D., indicate that she had suicidal ideations. In fact, at a visit on February 5, 2002, Dr. Krakower saw no reason to for subsequent visits to him (Ex. 4, pg. 7). On January 28, 2002 a health care provider notes, "IM (inmate) seen for evaluation. IM reports feeling "stressed" about life circumstances, Not depressed but tension evident. *No suicidal ideation* (emphasis supplied). No psychiatric history; no history of suicidal gestures" (Ex. 4, pg. 7). Respondent never spoke with the jail psychiatrist regarding Patient A's mental status (T. at 310).

During his testimony, Respondent stated he had a good recollection of a conversation with Marlene Partridge, a health care professional at DCJ. That conversation occurred on February 7, 2002, over two years prior to the hearing (T. at 241). This testimony is contradicted by what Respondent initially told OPMC Medical Coordinator, Jack Richard, M.D. At the time of his

interview, with Dr. Richard, Respondent said he had no recollection of the February 7 conversation (Ex. 8, pg. 3). Based upon all the factors described above, the Committee gave Respondent's testimony little weight.

### **CREDIBILITY OF RESPONDENT'S EXPERT**

Dr. Somsak Bhitiyakul testified for Respondent as an expert witness. Dr. Bhitiyakul was argumentative and would not respond to questions posed by Petitioner's counsel (T. at 191, 193-194, 205, 208, 212). Respondent's expert showed a clear bias in favor of Respondent. One such example can be seen when he agreed with Respondent's counsel despite an error in the questioning: Respondent's counsel erroneously stated that the patient had a weight "gain" from 100 to 172 pounds and asked Respondent's expert, "Did you note that when you reviewed the chart?" Respondent's expert stated he did. However, the record clearly shows only a change in weight. One of the issues in the proceeding was whether Patient A had undergone a weight gain or a weight loss (T. at 181-183).

In addition, Respondent's expert demonstrated a serious lack of medical knowledge. Among other examples, Dr. Bhitiyakul testified that a sedentary lifestyle does not affect the risk of cardiovascular disease (T. at 190). Additionally, Respondent's expert took the position that cessation of smoking eliminated the cardiovascular risk regardless of how many years and how much one smoked per day (T. at 187-188).

Respondent's expert vacillated in his opinion that it does not matter what type of arthritis the patient was suffering from (T. at 202, 229-230). Respondent's expert again vacillated on the need for a stress test (T. at 208-209). In addition, this witness changed his position regarding whether or not cardiac disease is the first thing to rule out in a patient such as Patient A (T. at 214-215, 232).

Respondent's expert agreed that a reasonably prudent physician should take a history of chest pain that includes the duration, location, quality and whether exercise exacerbates the chest pain.

However, he then tried to defend Respondent by stating "He can look into the chart, he can see when the chest pain is. It is written by the nurse notes" (T. at 218-219). The record does not support his statement.

In summary, Dr. Bhitiyakul's testimony was evasive, argumentative, biased and, at times, demonstrated a deficient medical knowledge base. The Committee gave his testimony very little weight.

### **CREDIBILITY OF PETITIONER'S EXPERT**

Petitioner presented Richard Toll, M.D. in support of the charges against Respondent. Dr. Toll's diverse experience includes four years as a Clinical Assistant Professor of Medicine with Albany Medical College, Medical Director with Ellis Center Skilled Nursing Facility and President of the Mohawk Valley Medical Associates. Dr. Toll has also been in private practice since 1979. Dr. Toll's testimony was thoughtful, clear, concise and without any bias. His answers during cross examination were not argumentative nor was he evasive. Dr. Toll was highly credible and his testimony was given great weight.

### **CONCLUSIONS REGARDING FACTUAL ALLEGATIONS**

Respondent is charged with:

- A.1 Obtaining a sub-standard patient history;
- A.2 Obtaining a sub-standard physical examination;
- A.3 Failure to order appropriate laboratory and diagnostic tests;
- A.4 Failure to adequately evaluate the cardiac and pulmonary status of Patient A;
- A.5 Inappropriately prescribing Vioxx
- A.6 Failure to order baseline kidney studies;
- A.7 Failure to maintain an adequate patient record.

The Committee sustains each of these allegations. The reasoning behind these findings appears in the discussion of the Specifications which follows.

## **CONCLUSIONS REGARDING SPECIFICATIONS**

### **FIRST SPECIFICATION** **(NEGLIGENCE ON MORE THAN ONE OCCASION)**

The Committee has found Respondent committed multiple acts of gross negligence. Negligence on more than one occasion is a lesser included offense under gross negligence. As will be set forth in detail below, the Committee finds Respondent acted in a grossly negligent manner on during each of the four times he saw Patient A. Hence, he acted in a negligent manner on four occasions. The Committee stresses that each of the acts in support of gross negligence would constitute a separate act of negligence on a separate occasion. Therefore, if the Committee's findings of gross negligence do not survive, negligence on more than one occasion would still be sustained by the findings herein.

Therefore, the **First Specification is SUSTAINED**.

### **SECOND SPECIFICATION** **(INCOMPETENCE ON MORE THAN ONE OCCASION)**

The Committee has found Respondent committed gross incompetence on multiple occasions. Incompetence on more than one occasion is a lesser included offense under gross incompetence. As will be set forth in detail below, the Committee finds Respondent acted in a grossly incompetent manner during each of the four times he saw Patient A. Therefore, he acted in an incompetent manner on four occasions. The Committee stresses that each of the acts in support of gross incompetence would constitute a separate act of incompetence on a separate occasion. Therefore,

if the Committee's findings of gross incompetence do not survive, incompetence on more than one occasion would still be sustained by the findings herein.

Therefore, the **Second Specification is SUSTAINED**.

**THIRD SPECIFICATION**  
**(GROSS NEGLIGENCE)**

The Committee now turns their attention to the allegations involving gross negligence. The Committee utilized this definition: Negligence is the failure to demonstrate that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this State. Gross negligence is defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The term egregious means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

There is a distinction between a finding that an act demonstrates negligence and a finding that a particular physician is a negligent practitioner. In a proceeding before the State Board for Professional Medical Conduct, the Committee is asked to decide if certain alleged conduct demonstrates a failure to exhibit appropriate levels of care and diligence. It is only in the final, or penalty stage of the proceeding, that the Committee is called upon to make an overall judgment about the character of the Respondent's practice abilities. It is noteworthy that an otherwise prudent physician can commit an act of negligence due to a temporary aberration.

In the matter at hand, it is alleged that Respondent acted in a negligent manner by failing to perform histories and physical examinations consistent with accepted standards (Allegations A.1 and A.2). The Committee finds the histories and physical examinations recorded in the file of Patient A were, indeed, significantly substandard. However, the Committee takes notice of the

system under which patients came to see Respondent: Before an inmate could see Respondent, that inmate was required to convince a nurse that he or she was ill and required the attention of a physician. It was then the responsibility of the nurse to conduct an examination of the patient and obtain a relevant history. This responsibility was not carried out by the nurses who examined Patient A.

The Committee is aware that in hospital based institutions, the physician must review and sign for examinations and histories performed by interns, residents and other health care professionals. However, DCJ was a far cry from a hospital based institution. Respondent was placed in a rather untenable position by the system under which he worked. Therefore, the Committee is willing to excuse his failure to complete substandard histories and physical examinations. The factual allegation that Respondent failed to provide adequate histories and physical examinations is true. Therefore, the allegation is sustained. However, the Committee decides that the failure to provide adequate histories and physical examinations shall not form the basis for any finding of misconduct.

In the third factual allegation, Respondent is charged with the failure to order appropriate laboratory and diagnostic studies. The Committee finds Respondent's failure here to constitute gross negligence. During his testimony on February 26, Respondent stated that Vioxx is not prostaglandin dependent (T. 127). However, further evidence pointed out that all NSAIDs suppress prostaglandin. Suppression of prostaglandin is the mechanism by which they decrease inflammation.

One of the known side effects of NSAIDs is that in certain people there is a danger of renal function compromise. Some patients have kidneys which depend on prostaglandin for circulation. Therefore, minimum accepted standards of care require that where NSAIDS are prescribed, there must be testing for anemia and the possible compromise of renal function. Respondent did not order such tests. This failure is particularly egregious in light of these factors: The expert for Respondent agreed that Vioxx suppresses prostaglandin (T 245 line 6 ); Dr. Kagali himself reversed

his statement of Feb. 26, 2004 (T. 127 ). On March 26, 2004 Respondent admitted that Vioxx is prostaglandin dependent. Therefore, he was or should have been aware that the use of NSAIDs could produce renal compromise. Since renal compromise is potentially life threatening, his failure to assure that it was not taking place was an extreme deviation from standards.

Patient A complained of chest wall pain and tightness, burning in the throat area, a lump in the left clavicle area, tingling and pain in her left arm, neck pain, numbness in her hands and stiffness in her chest. She also complained of pain in her left shoulder. These are classic symptoms of cardiovascular disease and, more particularly a heart attack. However, Respondent did not order or repeat, cardiac enzymes tests, and electrocardiograms (EKGs). It would appear from his notes that Respondent thought Patient A was suffering from arthritis. Yet he ordered no tests to determine the type of arthritis and degree of inflammation. (T. at 54-55).

The failures listed constitute gross departures from basic medical standards. Respondent did not demonstrate a degree of diligence expected of a prudent physician in this State. These failures occurred over four separate visits. It follows that during each visit, Respondent was negligent. Therefore, Respondent committed negligence on more than one occasion. Moreover, his acts were very serious deviations from accepted standards of medicine. This constitutes gross negligence. Therefore, the Third Specification is **SUSTAINED**.

#### **FOURTH SPECIFICATION** **(GROSS INCOMPETENCE)**

The Committee utilized the following definition of incompetence: The failure to demonstrate the requisite skill and knowledge expected of a prudent physician in this State. Gross incompetence was defined as, a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct. The term egregious means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

There is a distinction between a finding that an act demonstrates incompetence and a finding that a particular physician is a negligent practitioner. In a proceeding before the State Board for Professional Medical Conduct, the Committee is asked to decide if certain alleged conduct demonstrates a failure to exhibit appropriate skill and knowledge. It is only in the final, or penalty stage of the proceeding that the Committee is called upon to make an overall judgment about the character of the Respondent's practice abilities. It is noteworthy that an otherwise knowledgeable and skilled physician can commit an act of incompetence due to a temporary aberration.

During his testimony, Respondent exhibited a disturbing lack of knowledge concerning the pharmacodynamics of Vioxx. During his testimony on Feb. 26, 2004, Respondent stated that Vioxx is not prostaglandin dependent (T. 127). This is fundamentally erroneous. As explained above, all NSAIDs suppress prostaglandin. This is the mechanism by which they decrease inflammation. Furthermore, as explained above, certain patients depend on prostaglandin for circulation. The use of prostaglandin presents a danger of renal function compromise. It follows that the use of NSAIDs require that a physician have the skill and knowledge necessary to order tests for anemia and renal functions. The failure to perform such tests is potentially life threatening. It demonstrates a very serious departure from accepted standards of skill and knowledge and hence, gross incompetence.

Furthermore, Respondent exhibited serious deviations from accepted standards of skill and knowledge based upon his treatment of the various pains presented by Patient A. This patient had repeatedly complained of sternal chest pain, radiation to the left arm and jaw tightness. A physician exhibiting accepted standards of skill and knowledge, would place cardiac etiology at the top of his differential diagnosis. However Respondent acted as if cardiac concern was at the bottom of his list of differential diagnoses. Given that cardio-vascular disease is generally life threatening, his departure from accepted standards is both gross and dangerous. It is noteworthy that the nurses at the jail showed better judgment by taking two EKGs.

Respondent treated the upper body pain as if it were reflux esophagitis (GERD). However, if GERD was a concern, the physician exhibiting accepted levels of knowledge and skill would stop

prescribing Naprosyn or Vioxx since GERD is a known side effect of NSAIDs. The physician exhibiting accepted levels of knowledge and skill would also have prescribed an antacid or an H2 blocker if he believed the patient to be suffering from GERD. Thus, not only was Respondent's diagnosis in error, he did not even treat this patient within accepted standards for the condition he mistakenly concluded she was exhibiting.

Respondent dismissed the recurrent sternal chest pain, jaw tightness and left arm discomfort reported by Patient A as costochondritis, and the patient was not transferred to a healthcare facility as she wanted. The physician exhibiting accepted levels of knowledge and skill would have realized that any arthritic chest pain, such as costochondritis should have been alleviated with the heavy doses of Vioxx or Naprosyn. Instead, the condition of Patient A deteriorated over the ten day period and she eventually expired from a heart problem that was not even considered by Respondent. The failure to follow-up on classic signs and symptoms of cardiac disease is an egregious deviation from accepted standards of knowledge and skill. This egregious deviation constitutes gross incompetence. Since Respondent saw this patient over four visits and never considered a cardiac condition, he committed at least four separate acts of gross incompetence.

Therefore, the **Fourth Specification** is **SUSTAINED**

**FIFTH SPECIFICATION**  
**(FAILURE TO KEEP ADEQUATE PATIENT RECORDS)**

As stated earlier, the patient record in this case was seriously sub-standard. However, the Committee finds that the quality of the records was dictated by the system under which Respondent worked. Hence, the Committee does not hold Respondent liable for the inadequate patient records. Therefore, the **FIFTH SPECIFICATION** is **NOT SUSTAINED**.

## DETERMINATION AS TO PENALTY

The Committee has found Respondent guilty of gross negligence on at least four separate occasions and gross incompetence on at least four separate occasions. The lesser included offenses of negligence on more than one occasion and incompetence on more than one occasion were also sustained. While these specifications represent very serious deficiencies, the Committee notes circumstances of mitigation.

The Committee takes notice that all prisoners, be they felons, misdemeanants or those awaiting trial, share one common goal: They want as much time out of their cells as possible. This factor makes it difficult for a physician to trust the descriptions of maladies and symptoms reported by prisoners. Common sense leads one to expect that prisoners would be more likely to feign illness or exaggerate symptoms to gain the measure of freedom obtained by attending sick call. Furthermore, a trip to the doctor, while still in the prison, affords prisoners an opportunity to distract themselves from the boredom of incarceration.

The Committee makes it clear that they believe there is only one standard of medicine in this State. All people in this State, including prisoners, are entitled to the same level of care established by accepted standards of medicine (see *Gonzalez v. NYSDOH*, 232 A.D.2d 886, (3rd Dept. 1996), at 888, and *Gant v. Novello*, 302 A.D.2d 690, (3rd Dept. 2003) at 693). However, to provide a level of care commensurate with accepted standards, the physician must be able to trust the patient to accurately report symptoms. Respondent was not able to trust the population he served.

The Committee finds it troubling that during his testimony Dr. Kagali maintained that everything he did was consistent with accepted standards of medicine. The Committee disagrees. The Committee affirms that there was a lack of acceptable clinical knowledge. Respondent exhibited very poor medical judgment in evaluating serious symptoms. He provided Patient A with substandard treatment. He also demonstrated poor understanding of the actions of the medications, their dosage and side effects.

Nevertheless, upon review of all the factors presented, instead of revocation, the Committee believes Respondent should have an opportunity to obtain re-training in the fashion of a residency. In order for Respondent to successfully complete a residency program, he will have to demonstrate appropriate clinical skills and judgment under intensive scrutiny. If he does so, and undergoes probation with intense scrutiny, the public will be protected and a potentially productive physician will not be lost. Should Respondent fail to prove his abilities during a period of intense re-training and supervision, he will not be allowed to practice medicine in this State. Either way, the public is protected.

The Order which follows should be interpreted to suspend Respondent's license for a fixed period of time: The suspension shall be in effect only until Respondent completes a course of retraining in the form of a residency program (see *Daniels v. Novello*, 306 A.D.2nd 644, citing *Hason v. DOH*, 295 AD2nd 818). The precise period of time will be dependant upon the course of study chosen by Respondent and approved by the Director of OPMC.

#### **ORDER**

Based upon the findings of fact and conclusions above,

It is hereby Ordered that:

1. The license of Respondent to practice medicine in this state is suspended;

And it is further Ordered that;

2. The said suspension shall be stayed only to the extent necessary for Respondent to participate in a residency program in whatever field he chooses;

And it is further Ordered that:

3. Said residency program shall be subject to the prior written approval of the Director of the Office For Professional Medical Conduct (Director). Said approval shall include any factors deemed relevant by the Director in his/her assessment of the Residency program selected by Respondent. These factors may include, but are not limited to, the length of the

program, the institution sponsoring the program, and the course of study offered by the program;

And it is further Ordered that:

4. Respondent shall successfully complete the entire course of study prescribed by the sponsor of the residency program;

And it is further Ordered that:

5. 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) of the Public Health Law. Proof of coverage shall be submitted to the Director prior to Respondent beginning the said Residency program after the effective date of this Order;

And it is further Ordered that:

6. Upon successful completion of the said Residency program, the aforementioned suspension shall be lifted subject to the following additional terms and conditions of probation;

#### **TERMS AND CONDITIONS OF PROBATION**

1. For a period of two years, to commence immediately following the successful completion of the approved residency program, Respondent shall practice medicine only when supervised by a physician, board certified in an appropriate specialty, proposed by Respondent and subject to the written approval of the Director.
2. The practice supervisor shall be on-site at all locations, unless determined otherwise by the Director. The practice supervisor shall be proposed by Respondent and subject to the

written approval of the Director. The practice supervisor shall not be a family member or personal friend, or be in a professional relationship which could pose a conflict with supervision responsibilities.

3. Respondent shall ensure that the practice supervisor is familiar with the Order and terms of probation, and willing to report to OPMC.
4. Respondent shall cause the practice supervisor to supervise Respondent's medical practice in accordance with a supervision plan to be approved by the Director.
5. Respondent shall authorize the practice supervisor to have access to his patient records and to submit quarterly written reports, to the Director, regarding Respondent's compliance with the approved supervision plan. These narrative reports shall address all aspects of Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, general demeanor, time and attendance, the supervisor's assessment of patient records selected for review, a detailed case description of any case found not to meet the established standards of care and other such on-duty conduct as the supervisor deems appropriate to report.
6. Respondent shall cause the practice supervisor to report to OPMC within 24 hours any suspected impairment, inappropriate behavior, questionable medical practice or possible misconduct.
7. Respondent shall be solely liable for all expenses associated with these terms, including fees, if any, for the Residency program and the fees and expenses, if any, of the practice supervisor.

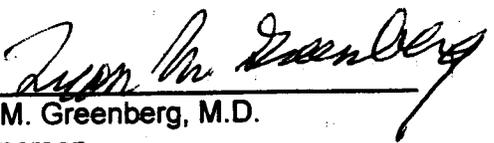
8. Respondent shall conduct himself at all times in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his profession.
  
9. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers 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.
  
10. 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.
  
11. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].
  
12. The period of probation 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 shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

13. 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.
14. 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 regarding controlled substances.
15. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs 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 any such other proceeding against Respondent as may be authorized pursuant to the law.
16. This ORDER shall be effective upon service on the Respondent pursuant to Public Health Law section 230(10)(h).

DATED: Troy, New York  
August 18, 2004

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Lyon M. Greenberg, M.D.  
Chairperson

Arsenio G. Agopovich, M.D.  
Gail S. Homick

# APPENDIX I

IN THE MATTER  
OF  
VIDYADHARA A. KAGALI, M.D.

STATEMENT  
OF  
CHARGES

Vidyadhara A. Kagali, M.D., the Respondent, was authorized to practice medicine in New York State on or about November 18, 1974, by the issuance of license number 122498 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

- A. From on or about January 10, 2002 through February 16, 2002 Patient A, a 35-year-old female (the patient's name is listed in the appendix), received medical treatment at the Dutchess County Jail, Poughkeepsie, New York. Patient A presented with a history of being overweight, depressed, post hysterectomy, cigarette smoking and arthritis. Patient A's medications at the time of admission included Vioxx and Premarin. Respondent was the Medical Director at the facility. Respondent's medical care of Patient A failed to meet accepted standards of medical care in the following respects:
1. Respondent failed to obtain and/or record an adequate history for Patient A.
  2. Respondent failed to perform and/or record an adequate physical for Patient A.
  3. Respondent failed to order appropriate laboratory and/or diagnostic studies for Patient A.

4. Respondent failed to adequately evaluate Patient A's cardiac and/or pulmonary status.
5. Respondent inappropriately prescribed Vioxx to Patient A at 50 mg twice daily for thirty days.
6. Respondent failed to order baseline kidney function tests prior to or at the time of prescribing Vioxx 50 mg twice per day for thirty days.
7. Respondent failed to maintain a record which accurately reflected the evaluation and treatment of Patient A.

### **SPECIFICATION OF CHARGES**

#### **FIRST SPECIFICATION**

#### **NEGLIGENCE ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined in NY Education Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A6.

#### **SECOND SPECIFICATION**

#### **INCOMPETENCE ON MORE THAN ONE OCCASION**

Respondent is charged with committing professional misconduct as defined in NY Education Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A6.

**THIRD SPECIFICATION**

**GROSS NEGLIGENCE**

Respondent is charged with committing professional misconduct as defined in NY Education Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

3. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A6.

**FOURTH SPECIFICATION**

**GROSS INCOMPETENCE**

Respondent is charged with committing professional misconduct as defined in NY Education Law § 6530(6) by practicing the profession of medicine with gross incompetence on a particular occasion as alleged in the facts of the following:

4. The facts in paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, and/or A and A6.

**FIFTH SPECIFICATION**

**FAILURE TO MAINTAIN RECORDS**

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

5. The facts in paragraphs A and A7.

DATED: *January 22, 2004*  
Albany, New York

*Peter D. Van Buren*  
PETER D. VAN BUREN  
Deputy Counsel  
Bureau of Professional  
Medical Conduct

# APPENDIX II

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

X

In the Matter  
of  
VIDYADHARA KAGALI, M.D.

SECOND <sup>B</sup>  
AMENDED 2/26/04  
ANSWER

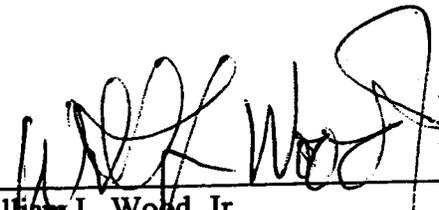
CO-02-12-6688-A

X

VIDYAHARA A. KAGALI, M.D., through his attorneys, WOOD & SCHER, herewith submits his second amended answer to the Statement of Charges:

1. Dr. Kagali denies the factual allegations set forth in paragraphs A.1 through A.7.
2. Dr. Kagali denies that he is guilty of any of the specifications set forth in the Statement of Charges.
3. Dr. Kagali demands a hearing on all of the factual allegations and specifications set forth in the Statement of Charges.

Dated: Scarsdale, NY  
February 23, 2004

  
William L. Wood, Jr.

WOOD & SCHER  
Attorneys for Respondent  
Vidyadhara Kagali, M.D.

The Harwood Building  
14 Harwood Court  
Scarsdale, NY 10583  
1-914-723-3500

EXHIBIT

B 2/26/04  
JH EV.

To: **Anthony M. Benigno, Esq.**  
**NYS Department of Health**  
**Office of Professional Medical Conduct**  
**433 River Street**  
**Troy, NY 10001**

**Hon. Jonathan Brandes**  
**Administrative Law Judge**  
**NYS Bureau of Adjudication**  
**433 River Street**  
**Troy, NY 12180**