

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

March 11, 2013

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jayakumar Thotambilu, M.D.
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NYS Department of Health
Corning Tower Room 2512
Empire State Plaza
Albany, New York 12237

RE: In the Matter of Jayakumar Thotambilu, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 13-69) 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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent 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.

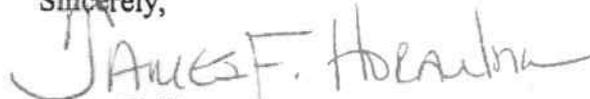
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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 that reads "James F. Horan". The signature is written in a cursive style with a large initial "J" and "H".

James F. Horan
Chief Administrative Law Judge
Bureau of Adjudication

JFH:nm

Enclosure

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

COPY

IN THE MATTER

DETERMINATION

OF

AND

JAYAKUMAR THOTAMBILU, M.D.

ORDER

RPMC-13-69

A Notice of Hearing and Amended Statement of Charges were served upon the Respondent **JAYAKUMAR THOTAMBILU, M.D.** **ANDREW J. MERRITT, M.D.**, Chair, **BERTON SHAYEVITZ, M.D.** and **VIRGINIA R. MARTY**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Administrative Law Judge **KIMBERLY A. O'BRIEN, ESQ.** served as the Hearing Officer.

The Department of Health appeared by **JAMES E. DERING, ESQ.**, General Counsel, by **JOEL ABELOVE, ESQ.**, of Counsel. The Respondent, **JAYAKUMAR THOTAMBILU, M.D.** appeared in person and by Counsel **JAMES D. LANTIER, ESQ.**

Evidence was received and argument heard, and transcripts of these proceedings were made. After consideration of the entire record, the Hearing Committee issues this Determination and Order.

STATEMENT OF THE CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York pursuant to Section 230 et seq. of the Public Health Law of New York. This case was brought by the New York State Department of Health, Office of Professional Medical

Conduct (hereinafter "Petitioner" or "Department") pursuant to Section 230 of the Public Health Law. Jayakumar Thotambilu, M.D. (hereinafter "Respondent") is charged with thirty specifications of misconduct, as set forth in Section 6530 of the Education Law of the State of New York (hereinafter "Education Law"). The specifications include negligence on more than one occasion, gross negligence, incompetence, gross incompetence and failure to maintain a patient record, all relating to his care and treatment of Patients A-G (Ex.1; See Education Law Sections 6530(3), 6530(4), 6530(5), 6530(6) &6530(32)). The Department has the burden of proof in these proceedings and must prove by a preponderance of the evidence that Respondent's care with respect to Patient A, Patient B, Patient C, Patient D, Patient E, Patient F and/or Patient G constitutes professional misconduct. Respondent and Petitioner were provided with a copies of the General Counsel's memorandum ("Memorandum") outlining the definitions of misconduct and given an opportunity to supplement the explanations and case law set forth in the Memorandum, and neither the Respondent nor the Petitioner offered supplementation (ALJ Ex. 1A).

Respondent admits that he treated Patients A- G, denies all the factual allegations and thirty specifications of professional misconduct set forth in the Notice of Hearing and Statement of Charges and requests that all charges and specifications of misconduct set forth in the Notice of Hearing and Statement of Charges be dismissed (Ex. A). The Notice of Hearing and Statement of Charges is attached hereto as Appendix 1 and made part of this Determination and Order (Ex.1).

PROCEDURAL HISTORY

Prehearing Conference	May 16, 2012
Hearing Dates	May 30-31, 2012; August 15, 2012; August 21, 2012; September 5, 2012; and October 3, 2012*

Witnesses for Petitioner	Steven Kobren, M.D., F.A.C.C.; Justin Marchesani, Investigator
Witnesses for Respondent	Jayakumar Thotambilu, M.D.; Thomas Grady M.D.
Parties Briefs	December 5, 2012**
Deliberations	January 9, 2013

* On October 23, 2012, one day before the last scheduled hearing day, Respondent rested his case.

**Respondent's Counsel was granted an unopposed extension of the briefing schedule.

FINDINGS OF FACT

The following Findings of Fact ("FOF") 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 ("Hearing Committee" or "Committee"). Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers or letters 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 argument and considered the testimony and documentary evidence presented, the Hearing Committee hereby makes the following findings of fact:

1. On or about August 29, 2003, Respondent, JAYAKUMAR THOTAMBILU, M.D., was authorized to practice medicine in New York State by the issuance of license number 229781 (Ex. 3).
2. The Physicians' Desk Reference ("PDR") is an authoritative reference book which contains detailed information from drug companies about an individual drug's effective use including: dosage; contraindications; and management of side effects and complications (See Tr. 108 & Ex. C including at pp.

10, 13). The PDR is updated annually and it is not uncommon that significant changes are made about the use of a drug (See Tr. 108 & Ex.C).

3. Natreacor is a drug used, in 2004 through 2009, to treat all forms of decompensated heart failure including the retention of fluid and the development of congestion and/or reduced cardiac output or blood flow. Its use was not contraindicated by impaired renal function and/or the presence of infiltrative cardiomyopathy (Tr. 340, 864-865, 875, 955, 1031, 1033-1034; See Ex. H).
4. Dobutamine is a drug used to improve the heart's systolic function and ejection fraction (Tr. 839 - 840).
5. Coumadin is an anticoagulant drug or "blood thinner" used to prevent formation of blood clots and/or stroke. Its use can manifest unsafe and excessive anticoagulation /"INR levels" and for this reason periodic determinations of INR levels must be made (Ex. C including at pp. 10&11). Signs of unsafe INR levels include among other things, "excessive bruising or persistent oozing from superficial injuries, and bleeding which may be controlled by discontinuing Coumadin therapy and, if necessary, by administration of oral or parenteral Vitamin K1 Vitamin K and/or Factor IX complex and only in exceptional or life-threatening bleeding episodes secondary to Coumadin" (Ex. C including at pp.10-11, 13; Tr. 49, 108-109, 113-114, 961-962, 1012).

PATIENT A

6. On or about July 22, 2003 - August 24, 2003, at SUNY Upstate Medical University, Syracuse, New York ("University Hospital") and Respondent's office,

Respondent provided cardiac care and treatment to Patient A, a 77- year old female (Ex. 4).

7. Respondent appropriately managed, monitored and documented Patient A's Coumadin and INR levels and followed the prevailing standards for the management of Coumadin therapy and elevated INR including: regular INR level testing and recognizing elevated INR levels; discontinuing Coumadin and monitoring INR level; and instructing the patient to go to the emergency room if she had any bleeding (Ex. 4 including at pp. 37, 45, 49, 355; Ex. C including at pp. 10&13; Tr. 49, 108-109, 260, 961-962, 1026-1027; See FOF 2&5).
8. After Patient A presented at A.L. Lee Memorial Hospital with an elevated INR level and signs of bleeding, hospital physicians treating the patient continued to observe the patient's INR level and did not order administration of Vitamin K (Tr. 41, 49, 51,84, 85, 108, 113, 260, 355, 1026 -1027; Ex. 4 including at pp. 12-13, 19, 37, 40; Ex. C including at pp. 10-11, 13; See FOF 2&5).

PATIENT B

9. On or about February 6, 2004, at A.L. Lee Memorial Hospital, Fulton New York, Respondent provided care and treatment to Patient B, a 76-year old male with a history of diabetes, permanent pacemaker, hypertension, hyperlipidemia and COPD, who presented at the hospital with symptoms of shortness of breath and signs of congestive heart failure (Ex. 5).
10. Respondent appropriately assessed and treated Patient B for congestive heart failure. Respondent's use of Natreacor was not contraindicated and fell within

the accepted standards of care (Ex. 5 including at pp. 6-7, 20; Tr. 1031, 1033-1040; See FOF 2, 3&5)

PATIENT C

11. On or about April 11, 2005 - April 19, 2005, at A.L. Lee Memorial Hospital, Fulton, New York, Respondent provided care and treatment to Patient C, an 87-year old female who was admitted from her nursing home (Ex. 6 including at pp. 36-37).
12. Respondent appropriately assessed and treated Patient C by considering cardiac rhythm strips and pulmonary edema; recommending placement of a pacemaker; and noting the site was intact and the pacemaker itself was working properly (Ex. 6 including at pp. 36-37, 113, 160-161, 170-172, 242, 294-352; Tr. 735, 737, 805-806, 822, 825, 827, 1072 – 1074, 1078).

PATIENT D

13. On or about December 1, 2006, at A.L. Lee Memorial Hospital, Fulton, New York, Respondent provided care and treatment to Patient D, an 88-year old male with a history of congestive heart failure, COPD and chronic renal failure (Ex. 7).
14. Respondent appropriately considered Patient D's medical history, assessed his condition, diagnosed heart failure, documented prescribing and use of Lovenox, Dobutamine and Natrecor, and addressed the patient's lytic lesion (Ex. 7 including at pp. 73-74, 82, 99, 156-158; Tr. 340, 838- 848, 875; See FOF 3&4).

PATIENT E

15. On or about December 23, 2004 - January 19, 2005, at A.L. Lee Memorial Hospital, Fulton, New York, Respondent provided care and treatment to Patient E, a 91-year old female with a history of temporal arteritis, pontine CVA, COPD and atrial fibrillation, and syncope (Ex. 8a & 8b).
16. Respondent appropriately assessed, diagnosed and treated Patient E; considered cardiac rhythm strips; obtained orthostatic blood pressure; and ordered and evaluated appropriate diagnostic tests (Ex.8a including at pp. 3, 23-22, 25 & 8b; Tr. 423- 425, 924-930, 937-938).

PATIENT F

17. At various times between January 5, 2009 and April 12, 2009, at A.L. Lee Memorial Hospital, Fulton, New York, Respondent provided care and treatment to Patient F, a 57- year old female with a history of diabetes, hypertension, coronary artery disease, status post stent, and depressed left ventricular function (Ex. 9).
18. On March 16, 2009 and April 3, 2009, Respondent appropriately assessed and treated Patient F for heart failure. Respondent administered Natreacor infusions to the patient according to accepted guidelines (Ex. 9 including at pp. 75, 77, 106, 150-151; Tr. 1112-1113, 1118-1119, 1122-1124).

PATIENT G

19. On or about February 2, 2009, February 3, 2009, and February 8, 2009, at A.L. Lee Memorial Hospital, Fulton, New York, Respondent provided care and treatment to Patient G, a 60-year old female with a history of coronary artery disease, status post bypass surgery, mitral valve repair, status post DD permanent pacemaker, history of laryngeal carcinoma, status post tracheotomy, history of G-tube placement, and history of chronic anemia secondary to occult GI bleeding. Patient G was admitted to the hospital "for shortness of breath and progressive anemia on January 31, 2009", and then admitted again on February 6, 2009 with profound vomiting and an "anion gap of 26" (Ex. 10b; See Ex. 10a).
20. Patient G was under the care of multiple physicians including an oncologist and a gastroenterologist. Respondent appropriately managed the patient's care on February 2, 2009, February 3, 2009 and February 8, 2009 (Ex. 10b including at pp.42, 45, 51; Tr. 1145, 1151-1153, 1161-1163).

DISCUSSION

The Hearing Committee's conclusions were unanimous and based on the entirety of the record including testimony of the Department's and Respondent's witnesses and the documentary evidence. The Department has the burden of proof and must establish by a preponderance of evidence that the Respondent is guilty as charged. The Committee found all the cardiologists including Department's expert witness Steven Kobren, M.D., F.A.C.C, Respondent's expert witness Thomas Grady, M.D., and Respondent himself, to be credible. Although the Committee found that the cardiologists were all qualified by education, training, and experience to render an opinion about the standards of care in this

case, it is important to note that the Committee discounted Dr. Kobren's testimony about Natrecor because of his lack of experience using the drug. While the Committee recognized that the care Respondent provided is being questioned and he has a significant stake in the outcome of these proceedings they found that Respondent consistently provided detailed and thoughtful testimony about his care and treatment of Patients A-G which was confirmed by qualified expert witnesses and supported by each of the patient medical records. The following is a discussion of the Committee's findings and conclusions regarding each patient.

Patient A

The Department charged Respondent with multiple deviations from the standard of care regarding his care and treatment of Patient A including failing to appropriately document, manage, monitor and frequently follow-up on Patient A's Coumadin therapy, and administer "blood products to lower Patient A's INR to therapeutic levels."

After Patient A had cardiac by-pass surgery at University Hospital she was placed on Coumadin by her cardiac surgeon, Dr. Fink. Dr. Fink, who remained involved in the patient's care, referred the patient to Respondent. On or about August 3, 2003, Respondent was provided with the discharge and referral orders from University Hospital and a list of patient medications, and was advised of a "blood draw for PT/INR on Monday, 8/4/03, and then weekly or as directed—results to Dr. Jay Thotambilu's office." Respondent began to manage the patient's Coumadin therapy and based on her INR levels advise her about when to take or "hold"/ "discontinue" use of the drug. The first lab report dated August 4, 2003 showed an INR of 3.9, and Respondent advised the patient to hold the Coumadin for a day. A lab report dated August 11, 2003 showed the patient had an elevated INR ("8+"). Respondent called the patient that same day and advised her to stop taking the Coumadin for one week, and if she

had any bleeding to go to the emergency room. A subsequent lab report, dated August 22, 2003, also showed the patient's INR level was 8+. Again Respondent called the patient that same day and advised her to stop the Coumadin for six days. On or about August 24, 2003, the patient was admitted to A.L. Lee Memorial Hospital with a history of nausea and vomiting and a bruise on the elbow. At the time of the hospital admission, the patient was not taking Coumadin and her INR level was greater than 8.0. The hospital physicians chose to observe the patient's INR and did not administer Vitamin K to reverse the effects of the Coumadin. The patient had a large left parietal hemorrhage and died on August 24, 2003.

The Committee recognized the importance of examining the care provided in this case, where Patient A's death was attributable to the effects of elevated INR levels. Dr. Kobren, Dr. Grady and Respondent ("cardiologists") all agreed that while Coumadin therapy is essential to preventing blood clots and stroke in many cardiac patients, the drug's anti-coagulation effects ("INR" level) must be closely monitored because non-therapeutic anticoagulation levels pose significant risk to a patient of developing massive bleeding. The cardiologists also agreed that the *Physician's Desk Reference* ("PDR") is a well-recognized and widely consulted drug manufacturers' guide which is updated annually. Finally, the cardiologists agreed that in 2003 the PDR did not provide cutoffs in terms of INR levels and treatment, and Respondent's decision to discontinue the Coumadin and observe when the patient's INR level was 8+ was within the accepted standard of care.¹ Based on the foregoing, the Committee determined that Respondent met accepted standards of care regarding his care and treatment of Patient A.

¹ The Committee gave little weight to Dr. Kobren and Dr. Grady's "musings" that in 2003 while not "required" they would have administered Vitamin K to this patient to "reverse" the anticoagulation effect of the Coumadin, as both these witnesses enjoyed the luxury of 20/20 hindsight with the benefit of the entire patient record/ outcome and current understanding of Coumadin management and treatment protocols.

Patient B

The Department charged Respondent with failure to meet the standard of care in his treatment of Patient B alleging that “if” Patient B was experiencing congestive heart failure he was in diastolic heart failure for which the use of the drug Natreacor is contraindicated. The Department also alleged that Respondent failed to “adequately monitor the patient hemo-dynamically or follow up on or mention Patient B’s INR.”

On or about February 6, 2004, at A.L. Lee Memorial Hospital, Respondent provided care and treatment to Patient B, a 76-year old male with a history of diabetes, permanent pacemaker, hypertension, hyperlipidemia and COPD. Patient B’s medical record reflects that another physician, Dr. Shaw, diagnosed him with congestive heart failure. Dr. Ahmed was the patient’s admitting and attending physician and he ordered and continued the patient on Coumadin, and was monitoring the patient’s INR. After Respondent performed a physical exam and considered the patient’s history, medications, orthopnea, lower extremity edema, persistent shortness of breath and need for increasing doses of Lasix, he administered Natreacor to the patient.

The Committee determined that Respondent did not diagnose the patient with congestive heart failure and did not order and was not responsible for managing the patient’s Coumadin therapy. Respondent reasonably relied on Dr. Shaw’s diagnosis of congestive heart failure, and after making his own full patient assessment administered Natreacor to the patient. Based on the foregoing, the Committee found the Respondent met accepted standards of care regarding his care and treatment of Patient B.

Patient C

The Department alleged that Respondent failed to correctly interpret Patient C's cardiac rhythm strips as third degree AV block rather than second degree AV block Mobitz I type; wait until the patient's Digoxin level dropped before making a determination about whether a pacemaker was needed; address in his notes or treat patient's pulmonary edema which was revealed on post-pacemaker x-ray; note after the pacemaker insertion whether he checked the insertion site; and produce pacemaker strips to ensure the pacemaker was working.

Patient C was an elderly nursing home patient being treated by her own cardiologist, Dr. Ahmed, who also admitted her to the hospital. Before the patient's admission to the hospital, Dr. Ahmed had prescribed Coumadin and Digoxin to the patient. After the patient was admitted into the hospital and treated for Digoxin toxicity, Respondent was asked to perform a cardiac consult. Respondent assessed Patient C's heart rhythms, medical condition and history, and determined she was a candidate for a pacemaker. A pacemaker was placed, the pacemaker site and function were checked, and the patient was discharged from the hospital.

The Committee concluded from the very lengthy and detailed testimony provided by all three cardiologists that competent and qualified physicians can reasonably make different and "nuanced" interpretations of the patient's cardiac rhythm strips ("strips"). The Department's expert Dr. Kobren agreed with the other cardiologists that there is no "rule" to support the Department's allegation that Respondent should have waited until the patient's Digoxin level dropped before making a determination whether to place a pacemaker and conceded that it is an "individualized decision." It was clear to the Committee that Respondent's decision to place the pacemaker was appropriate and based upon a full consideration of the patient's age, history, heart rate and blood pressure, episodic

heart block, strips, and self-reports about symptoms and condition (including a recent syncopal episode). Finally, the Committee found that the Department's remaining allegations are simply not supported by the patient's record. The record clearly shows that the condition of the pacemaker insertion site and pacemaker operation were checked, it was noted how therapeutic INR levels were to be maintained, and Respondent addressed the patient's pulmonary edema. Based on the foregoing the Committee determined that Respondent met accepted standards of care regarding his care and treatment of Patient C.

Patient D

The Department charged Respondent with failure to meet the standard of care in his treatment of Patient D in that he failed to treat the patient's kidney disease. According to the Department, the patient "was most likely fluid overloaded from renal insufficiency" and "not from heart failure." The Department also alleged that Respondent improperly used Natrecor, Dobutamine and Lovenox. The Department alleges the use of Natrecor was contraindicated because of the patient's impaired renal function and "possible" infiltrative cardiomyopathy. The use of Dobutamine was allegedly inappropriate because the patient had "normal" left ventricular systolic function and was not in heart failure. Further, the Department alleges that Lovenox "may" have been contraindicated because the patient had renal failure and/or Respondent did not note the reason for using Lovenox. Finally, the Department alleges that Respondent failed to address or evaluate the patient's spinal lytic lesion.

Patient D was admitted to the hospital because he was experiencing dyspnea and was thought to be in congestive heart failure. The patient medical record contained among other things a documented history of congestive heart failure and renal insufficiency, a full nephrology report and a recent CT scan showing a "lytic lesion." The patient's Doppler echocardiogram showed a significantly

depressed ejection fraction even while being treated with therapeutic levels of Dobutamine. The presence of diastolic dysfunction was evidenced by the thickness of the heart muscles and aortic incompetence, and the patient's history of heart failure. The initial order for Lovenox was made by Dr. Porcari, and Respondent later documented that he lowered the dosage of Lovenox and the reason for doing so. Respondent diagnosed this patient with heart failure and treated him with Natrecor, Dobutamine and Lovenox. The patient was sent for an orthopedic surgery consult with Dr. Blecha, who addressed the lytic lesion.

The Committee found Respondent's testimony showed he was mindful of the patient's kidney disease. Respondent noted that while the patient had chronic renal insufficiency, he was treated with very significant doses of diuretics and was putting out a significant amount of urine. Further, the Committee found Respondent's testimony and the record showed he properly documented his use of Lovenox, and carefully assessed the patient's condition and medical history before diagnosing the patient with heart failure and treating him with Dobutamine and Natrecor. Finally, an appropriate referral was made to an orthopedic surgeon to address the lytic lesion. Based on the foregoing, the Committee determined that Respondent met accepted standards of care regarding his care and treatment of Patient D.

Patient E

The Department alleged Respondent failed to meet the standard of care in his treatment of Patient E in that he failed to comment on the patient's cardiac rhythm strips, obtain orthostatic blood pressure, order electrophysiological studies, evaluate the patient for a bypass tract, or order blood tests.

On or about December 23, 2004 - January 19, 2005, at A.L. Lee Memorial Hospital, Respondent provided care and treatment to Patient E, a 91-year old female with a history of

diverticulitis, status post colostomy, history of breast cancer, hysterectomy, temporal arteritis, pontine CVA, COPD and atrial fibrillation. The Respondent had evaluated and treated this patient in the past and was aware of the patient's history.

The Committee found the Department's allegations that Respondent failed to comment on the patient's cardiac rhythm strips, obtain orthostatic blood pressure, order /consider relevant blood tests including "T3" uptake and "TSH," and determine whether the patient had a bypass tract that was allowing excessive conduction are simply careless. The patient record clearly shows that Respondent provided specific and detailed comments, took numerous orthostatic blood pressures, evaluated the patient's rhythm strips and noted the EKG showed no evidence of a bypass tract. Respondent did not order the thyroid blood tests; however, he was aware of the test results and the patient's thyroid condition. The Committee found Respondent reviewed and considered all the above information to inform his treatment of the patient. Finally, the Committee found that the Department's allegation that the Respondent failed to order "necessary" extensive electrophysiological studies was frivolous and in no way supported by the record. Not only did the Department fail to show the "need" for these invasive tests, the record shows that this 91 year-old patient suffered from severe respiratory problems, numerous comorbidities, had already declined a less invasive test, and could not tolerate or benefit from these studies. Based on the foregoing the Committee determined that Respondent met accepted standards of care in his treatment of Patient E.

Patient F

The Department alleged that Respondent inappropriately utilized Natrecor because the patient's March 16, 2009 chest x-ray revealed no congestion and the patient had low BNP on March 16th and April 3, 2009. The Department also alleged that Respondent failed to assess, diagnose and treat the

patient in that he failed consider cardiac rhythm strips, obtain orthostatic blood pressures, and order and evaluate appropriate diagnostic tests.

Patient F was a 57- year old female with a history of diabetes, hypertension, coronary artery disease, status post stent, and depressed left ventricular function. The patient had been admitted to the hospital on multiple occasions for Natreacor infusions and had responded well to the treatments. On both March 16, 2009 and April 3, 2009, Respondent examined and assessed the patient and based upon accepted guidelines administered Natreacor infusions to the patient.

The Committee found that Dr. Kobren's testimony about Respondent's alleged inappropriate use of Natreacor was based upon a limited amount of patient information which included a March 16, 2009 chest x-ray he considered to be "normal" and a low BNP on both March 16, 2009 and April 3, 2009. Respondent's testimony about the patient record revealed that the patient had a complex cardiac history including "flash pulmonary edema" which in the past had required that the patient be intubated. It was obvious to the Committee that Respondent considered much more than the patient's March 16, 2009 chest x-ray and March 16th and April 3rd BNP readings, and in both instances administered Natreacor only after he conducted a thorough assessment of the patient's condition including completion of a Natreacor infusion form that indicated the use of Natreacor was appropriate. Based on the foregoing the Committee determined that Respondent met accepted standards of care regarding his care and treatment of Patient F.

Patient G

The Department charged Respondent with multiple deviations from the standard of care regarding his care and treatment of Patient G including that Respondent failed on February 2, 2009 and February 3, 2009 to perform a rectal examination and attempt to find the cause of the patient's

anemia, and on "February 6, 2009 [sic] to appropriately diagnose and manage the patient, given the fact that she presented with profound vomiting and was noted to be extremely acidotic with anion gap of 26" (Ex. 1 at p. 6).

The Committee found once again that the patient record does not support the Department's allegations. Respondent's testimony and references to the record consistently show that for both the first admission on January 31, 2009 and the second admission February 6, 2009 the patient was admitted to the hospital by a physician other than Respondent, and was being treated by and/or under the care of a number of physicians including an oncologist and a team of gastroenterologists and all well before Respondent saw the patient. Specifically, during the first admission Respondent saw the patient for a cardiac consult on February 2, 2009, days after the patient had been admitted to the hospital and provided with a blood transfusion. Respondent testified that while he found the patient was in a very fragile condition her hematocrit and hemoglobin were stabilized, she was under the care of a gastroenterologist, and there was no indication for Respondent to conduct a rectal examination. When the patient was admitted to the hospital for the second time on February 6, 2009, the patient was given "bicarb" in the emergency room to lower her anion gap of "26." Respondent did not see the patient until the afternoon of February 8, 2009. By the time the Respondent saw the patient on February 8, 2009, the record reflects her anion gap was not "26" it was "18.6" and her acidotic condition was addressed and resolved. Based on the foregoing the Committee determined that Respondent met accepted standards of care regarding his care and treatment of Patient G.

CONCLUSION

The Hearing Committee has carefully considered all of the evidence in the record and unanimously concluded that the Department failed to prove any of the charges. This determination was supported by a preponderance of the evidence including the patients' medical records, prevailing practice standards at the time of treatment, and credible expert testimony. Pursuant to the Findings of Fact and Conclusions set forth above, the Hearing Committee determined that the Respondent met the applicable standards of care in his treatment of Patients A-G, and all the factual allegations and thirty specifications of misconduct raised against the Respondent shall be DISMISSED. Accordingly, the Committee determined that no action shall be taken against the Respondent's license to practice as a physician in New York State.

ORDER

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

1. All the factual allegations and thirty specifications of misconduct as set forth in the Statement of Charges (Ex.1) are **DISMISSED**;
2. This **ORDER** shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

DATED: 3-6, New York
2013

BY: Andrew Merritt MB
ANDREW J. MERRITT, M.D. Chairperson
BERTON SHAYEVITZ, M.D.
VIRGINIA R. MARTY

To: Jayakumar Thotambilu, M.D.
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Bureau of Professional Medical Conduct
Empire State Plaza Corning Tower Room 2512
Albany, New York 12237

APPENDIX 1

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

05/16/2012

IN THE MATTER
OF
JAYAKUMAR THOTAMBILU, M.D.

NOTICE
OF
HEARING

TO: JAYAKUMAR THOTAMBILU
6234 Steinway Drive
Jamesville, New York 13078

JAYAKUMAR THOTAMBILU
522 South 4th Street, Suite 1300
Fulton, New York 13069

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on May 30-31, 2012, from 10:00 a.m. - 4:00 p.m., at the New York State Department of Health, Central Regional Office, 217 South Salina Street, Conference Room 3A, Syracuse, New York, 13202, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of

Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. JAMES F. HORAN, ACTING DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date.

Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
April 17, 2012



Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Joel E. Ablove
Associate Counsel
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2512
Albany, New York 12237-0032
(518) 473-4282

IN THE MATTER
OF
JAYAKUMAR THOTAMBILU, M.D.

STATEMENT
OF
CHARGES

JAYAKUMAR THOTAMBILU, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 29, 2003, by the issuance of license number 229781 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. Respondent provided care and treatment to Patient A, a 77-year-old female, on various occasions from 7/22/03 through 8/24/03, at SUNY Upstate Medical University, 750 East Adams Street, Syracuse, New York 13210, and at Respondent's office. Patient A presented with a chief complaint of chest pain. Respondent performed a cardiac catheterization on Patient A the following day, and Patient A underwent coronary artery bypass grafting on 7/25/03, at SUNY Upstate Medical University. Following her discharge, Respondent continued to follow Patient A until she expired on August 24, 2003. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in the following respects:
1. Respondent failed to appropriately manage Coumadin in Patient A and/or administer blood products to lower Patient A's INR to therapeutic levels.
 2. Respondent failed to appropriately monitor or instruct frequency of follow-up which would be critical in managing Coumadin, and/or failed

to document the same.

B. Respondent provided care and treatment to Patient B, a 76-year-old male, on or about February 6, 2004, at A.L. Lee Memorial Hospital, 510 South Fourth Street, Fulton, New York 13069. Patient B, with a history of diabetes, permanent pacemaker, hypertension, hyperlipidemia and COPD, presented with shortness of breath and symptoms of congestive heart failure. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in the following respects:

1. Respondent used Natreacor with no medical indication.
2. Respondent, after the infusion of Natreacor, failed to adequately monitor Patient B hemodynamically, and failed to follow up on, or mention, Patient B's INR.

C. Respondent provided care and treatment to Patient C, an 87-year-old female, on or about April ~~14~~^{- April 19, 2005, PG 8 5/30/12 NG 85}, 2005 at A.L. Lee Memorial Hospital, 510 South Fourth Street, Fulton, New York 13069. Patient C was admitted from the nursing home and diagnosed with third degree AV block. Respondent installed a pacemaker in Patient C. Respondent's care and treatment of Patient C failed to meet accepted standards of medical care in the following respects:

1. Respondent misinterpreted Patient C's cardiac rhythm strips as third degree AV block, when they more likely represented second degree AV block Mobitz I type.
2. Respondent failed to wait until Patient C's Digoxin level dropped to

less than 0.8 before determining that further action may need to be taken.

3. Respondent failed to address Patient C's pulmonary edema - revealed on post-pacemaker chest x-ray - either in his notes or therapeutically.
4. Respondent failed to note after the pacemaker insertion whether he checked the insertion site and the pacemaker strips to ensure it was functioning properly.
5. Respondent failed to note how Patient C's INR levels were going to be maintained at a therapeutic level.

D. Respondent provided care and treatment to Patient D, an 88-year-old male, on or about December 1, 2006, at A.L. Lee Memorial Hospital, 510 South Fourth Street, Fulton, New York 13069. Patient D, with a history of congestive heart failure, COPD, chronic renal failure, moderate mitral insufficiency, moderate aortic insufficiency, moderate aortic stenosis, sick sinus syndrome, status post permanent pacemaker and atrial fibrillation, was admitted with dyspnea and was thought to be in congestive heart failure. Respondent's care and treatment of Patient D failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to treat Patient D's kidney disease, despite the fact that he was most likely fluid overloaded from renal insufficiency and not from heart failure given his normal left ventricular systolic function and no evidence of significant diastolic dysfunction.
2. Respondent's use of Natreacor was dangerous since one of the contraindications is impaired renal function.
3. Respondent's use of Natreacor was improper since Patient D's

echocardiogram revealed the possibility of an infiltrative cardiomyopathy for which Natrecor is relatively contraindicated.

4. Respondent administered an inotropic agent - dobutamine - despite Patient D having normal left ventricular systolic function.
5. Respondent failed to note the reason he put Patient D on Lovenox.
6. Respondent's use of Lovenox in Patient D, who suffered from renal failure, was extremely dangerous, and should at least have been used with a markedly reduced dose.
7. Respondent failed to address or evaluate the lytic lesion on Patient D's spine, which could indicate a potential cause of renal failure.

E. Respondent provided care and treatment to Patient E, a 91-year-old female, on or about December ^{16th 5/31/12} 23, 2004, and January 18, 2005, at A.L. Lee Memorial Hospital, 510 South Fourth Street, Fulton, New York 13069. Patient E, with a history of diverticulosis, status post colostomy, history of breast cancer, hysterectomy, temporal arteritis, pontine CVA, COPD and atrial fibrillation, was admitted after having a syncopal episode upon sitting on a commode in front of her daughter. Patient E had a history of syncopal episodes. Patient E was again admitted for syncope secondary to possible old brain stem infarct. She was in atrial fibrillation with rapid ventricular response and a low blood pressure. Respondent's care and treatment of Patient E failed to meet accepted standards of medical care in the following respects:

1. Respondent, on or about December ^{16th 5/31/12} 23, 2004, failed to comment on Patient E's cardiac rhythm strips, which demonstrate episodes of rapid ventricular rates.
2. Respondent failed to obtain orthostatic blood pressure to determine if

Patient E was indeed orthostatic.

3. Respondent failed to order an extensive electrophysiological evaluation to determine if indeed she was having supraventricular or ventricular arrhythmia causing hemodynamic compromise, which can lead to syncope.
4. Respondent, on or about January 18, 2005, failed to determine - by electrophysiological evaluation and possibly electrophysiological guided therapy - whether Patient E had a bypass tract in her heart that was allowing excessive conduction.
5. Respondent failed to order any blood tests, including thyroid, to determine if there was an underlying cause.

F. Respondent provided care and treatment to Patient F, a 57-year-old female, at various times between January 5, 2009, and April 12, 2009, at A.L. Lee Memorial Hospital, 510 South Fourth Street, Fulton, New York 13069. Patient F, with a history of diabetes, hypertension, coronary artery disease, status post stent, initially depressed left ventricular systolic function who was subsequently noted to have improved left ventricular function, was admitted on multiple occasions for Natreacor infusions. Respondent's care and treatment of Patient F failed to meet accepted standards of medical care in the following respects:

1. Respondent improperly utilized Natreacor for decompensated heart failure, despite the fact that on March 16, 2009, her chest x-ray revealed no congestion and a low BNP, and on April 3, 2009, her BNP was low as well.

G. Respondent provided care and treatment to Patient G, a 60-year-old female, at various times between January 31, 2009, and March 29, 2009 at A.L. Lee Memorial Hospital, 510 South Fourth Street, Fulton, New York 13069. Patient G, with a history of coronary artery disease, status post bypass surgery, mitral valve repair, status post MAZE procedure, sick sinus syndrome, status post DDD permanent pacemaker, history of laryngeal carcinoma, status post tracheostomy, history of G-tube placement, history of chronic anemia secondary to occult GI bleeding, was admitted for shortness of breath and progressive anemia on January 31, 2009. Respondent's care and treatment of Patient G failed to meet accepted standards of medical care in the following respects:

1. Respondent failed to perform a rectal examination on Patient G on ^{about} ~~2/3/09~~ and 2/3/09 ^{KAO} 5/3/12
2. Respondent failed to attempt to find the cause of Patient G's anemia on ^{about} ~~2/3/09~~ and 2/3/09 ^{KAO} 5/31/12
3. Respondent failed to appropriately diagnose and manage Patient G on or about February 6, 2009, given the fact that she presented with profound vomiting and was noted to be extremely acidotic with anion gap of 26.

SPECIFICATION OF CHARGES

FIRST THROUGH SEVENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(3) by Practicing the Profession 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.
2. The Facts in Paragraphs B and B.1, B and B.2.
3. The Facts in Paragraphs C and C.1, C and C.2, C and C.3.
4. The Facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.6, D and D.7.
5. The Facts in Paragraphs E and E.2, E and E.3, E and E.4, E and E.5.
6. The Facts in Paragraphs F and F.1.
7. The Facts in Paragraphs G and G.1, G and G.2, G and G.3.

EIGHTH THROUGH FOURTEENTH SPECIFICATIONS

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(4) by Practicing the Profession with Gross Negligence on a Particular Occasion, as alleged in the facts of one or more of the following:

8. The Facts in Paragraphs A and A.1, A and A.2.
9. The Facts in Paragraphs B and B.1, B and B.2.
10. The Facts in Paragraphs C and C.3.
11. The Facts in Paragraphs D and D.2, D and D.3, D and D.6.
12. The Facts in Paragraphs E and E.3.
13. The Facts in Paragraphs F and F.1.
14. The Facts in Paragraphs G and G.3.

FIFTEENTH THROUGH TWENTY-FIRST SPECIFICATIONS
PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN
ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(5) by Practicing the Profession with Incompetence on More Than One Occasion, as alleged in the facts of two or more of the following:

15. The Facts in Paragraphs A and A.1, A and A.2.
16. The Facts in Paragraphs B and B.1, and B.2.
17. The Facts in Paragraphs C and C.1, C and C.2, C and C.3.
18. The Facts in Paragraphs D and D.1, D and D.2, D and D.3, D and D.4, D and D.6, D and D.7.
19. The Facts in Paragraphs E and E.2, E and E.3, E and E.4, E and E.5.
20. The Facts in Paragraphs F and F.1.
21. The Facts in Paragraphs G and G.1, G and G.2, G and G.3.

TWENTY-SECOND THROUGH TWENTY-SEVENTH SPECIFICATIONS
PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(6) by Practicing the Profession with Gross Incompetence, as alleged in the facts of one or more of the following:

22. The Facts in Paragraphs A and A.1, A and A.2.
23. The Facts in Paragraphs B and B.1, and B.2.
24. The Facts in Paragraphs D and D.2, D and D.3, D and D.6.
25. The Facts in Paragraphs E and E.3, E and E.4, E and E.5.
26. The Facts in Paragraphs F and F.1.
27. The Facts in Paragraphs G and G.3.

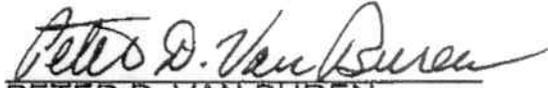
TWENTY-EIGHTH THROUGH THIRTIETH SPECIFICATIONS
FAILING TO MAINTAIN ACCURATE MEDICAL RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Education Law §6530(32) by Failing to Maintain a Record for Each Patient Which Accurately Reflects the Evaluation and Treatment of the Patient, as alleged in the facts of one or more of the following:

28. The Facts in Paragraphs C and C.3, C and C.4, C and C.5.
29. The Facts in Paragraphs D and D.5.
30. The Facts in Paragraphs E and E.1.

DATE:

April 17, 2012
Albany, New York



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