IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA, *ex rel.*, THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	FILED DEC 26 2019 OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION
Plaintiff,	)	
vs.	)	**Case No. 18-12-5685**
CHIGURUPATI RAMANA, M.D., LICENSE NO. MD 31923,	)	
Defendant.	)	

VERIFIED COMPLAINT

The State of Oklahoma, *ex rel.*, the Oklahoma State Board of Medical Licensure and Supervision ("Board"), alleges and states as follows for its Complaint against Chigurupati Ramana, M.D. ("Defendant"):

I. JURISDICTION

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. § 480, *et seq.*

2. Defendant, Chigurupati Ramana, M.D., holds Oklahoma medical license number 31923. The acts and omissions complained of herein were made while Defendant was acting as a physician pursuant to the medical license conferred upon him by the State of Oklahoma, and such acts and omissions occurred within the physical territory of the State of Oklahoma.

II. ALLEGATIONS OF UNPROFESSIONAL CONDUCT

3. This case was initiated by a complaint made by a physician alleging that Defendant's poor practice regarding placement of stents was causing actual harm to some of his patients, and potentially exposing others to unnecessary risks by performing procedures that were not medically indicated. The complainant stated that he recently treated a female patient, later identified as patient J.C.C., a former patient of Defendant. Defendant placed a stent in J.C.C. that was undersized, and within a week following the procedure the stent had migrated to J.C.C.'s heart. Complainant subsequently performed heart surgery on J.C.C. to remove the foreign body. This surgery was successful.

4. Complainant found J.C.C.'s condition to be so unusual that he happened to mention it to two of his colleagues. Those colleagues confirmed that they had both had former patients of Defendant with similar problems in the past. Board investigator Lawrence "Larry" Carter interviewed both of those colleagues individually.

5. Dr. J.M.C. stated that he and Dr. D.N.C. have worked on approximately seven (7) of Defendant's patients between them. Dr. J.M.C. stated that each of the 7 patients had a bad outcome associated with procedures performed by Defendant, including at least one death. Of the 7 cases Dr. J.M.C. is familiar with, they all involved migration of stents from the iliac vein to the left or right ventricle, requiring open heart surgery to remove the foreign body. Dr. J.M.C. stated that he is also aware of situations in which Defendant performed procedures that ultimately led to blockages of vessels, and ultimately resulted in amputations that would have otherwise been unnecessary.

6. Dr. J.M.C. claims that Defendant sees quite a few Medicare patients, and Dr. J.M.C. has heard that Defendant orders an angiogram for each Medicare patient, regardless of whether or not the need for an angiogram is indicated. Defendant then "fixes something", even if there is no need for any intervention. Dr. J.M.C. then gave an example: Defendant sees several end-stage renal disease patients, who he performs invasive procedures on, knowing in advance that the patient will not heal properly. Dr. J.M.C. stated that Defendant must know that there is a strong probability that such procedures will likely cause more damage than they correct.

7. Dr. D.N.C. identified two patients who died, and two others who suffered amputations because of procedures done by Defendant. Dr. D.N.C. provided the following information relating to each patient:

8. Patient J.M.C.: Defendant saw J.M.C. for leg pain, but was able to walk into Defendant's office on his own.

- By the time Dr. D.N.C. saw him after Defendant performed a procedure, J.M.C. had "dead leg", and the limb had to be removed.
- Patient R.D.C.: R.D.C. needed a thrombectomy, but the clot could not be removed. Dr. D.N.C. believes that Defendant did not place this patient on Plavix after surgery, which Dr. D.N.C. believes Defendant's failure to properly medicate R.D.C. was most likely the cause of R.D.C.'s death.
- Patient R.C.C.: R.C.C. was on dialysis at the time Defendant performed a procedure on him. After the procedure, R.C.C. developed a pseudo aneurysm. Bleeding developed and R.C.C. ultimately died.
- Patient C.A.C.: C.A.C. presented to the emergency room with an occluded aorta according to CTA images. C.A.C. had dead muscle in the groin, which ultimately led to an amputation.

9. Eight (8) patient records were subpoenaed and received. Each of those was sent for expert review. The expert rendered a summation of his medical record review as well as an opinion regarding each patient.

10. His summary states that Defendant's treatment and practice of medicine was so disturbing that it warrants immediate regulatory attention. He stated that while venous stents should be applied only if necessary with visible stenosis, venous collaterals or cases of thrombus, this was not readily apparent in 3 of the cases he reviewed. He stated that Defendant is routinely stenting when unnecessary and the fact that the stents are embolizing in the short term is proof that the veins were normal. Further, he found that stents should be oversized and post angioplastied which did not occur appropriately.

11. The expert found that other cases demonstrated a clear pattern of repeating unnecessary medical procedures. He stated, "If a patient presents with peripheral arterial disease (PAD), no self-respecting physician is going to pursue venography the problem is so clearly arterial". He found that Defendant would even intervene on patients when the ankle-brachial index (ABI) was normal. He found that Defendant had a clear bias towards financial gain.

More specifically the expert found, as to each record:

Patient J.C.C.:

12. The expert stated that this is one of four (4) cases of the eight reviewed wherein a venous stent embolized to the heart. This was the youngest of the eight (8) patients reviewed at 35 years old. The expert concluded that given her young age and the known short lifespan of stents, conservative management is paramount and stents in 35 year old should only be considered when conservative measures have failed. This patient's venogram was completely negative and no documentation supporting stenosis was provided the expert noted. Pressures could have been obtained via intravascular ultrasound as well, but were not and if stenosis had been encountered, it would have been reasonable to angioplasty and follow for response before stenting. However, he pointed out, there was no urgency to stent in this case. The expert noted that a fourteen (14) mm stent was placed and it immediately embolized to the heart. The fact that it moved so quickly, just like in other cases reviewed, proves that no stenosis was present and it was loose in that vein. The expert determined the resulting stent embolization, sternotomy, pulmonary embolism (PE) and pneumonia would have all been avoided if proper judgment was executed. He further opined that this case is probably one of the most egregious errors in medical judgement in his opinion.

Patient B.L.C.:

13. The expert determined the main harm in this case was the apparent undersizing of the left iliac vein stent which embolized to the heart and may have fragmented. The patient suffered a major PE. The expert stated there were apparently two parts to the stent, one in the right ventricle and one in the left lobe pulmonary artery. The expert determined this stent, as in the patient D.B.C. case below, was underdilated. A diagnosis of May-

Thurner Syndrome was made. A fourteen (14) mm stent was placed and again only dilated to twelve (12) mm. The expert determined this was likely the cause of embolization. He clarified that if one stents a normal vessel, there is no way for the stent to "lock" in place and it can become mobile, especially if it is undersized as in the instant case. The records show that B.L.C.'s ABI tests were normal. The expert found that Defendant described considering bilateral upper extremity arteriograms which were not completed. Instead Defendant did bilateral lower extremity arteriorgrams which showed "significant occlusive disease." The expert determined that this resulted in several more exams and interventions, yet no records or imaging supported such tests and interventions.

Patient D.B.C.:

14. The clinical notes state the patient had PAD. However, the ankle-brachial indices were mostly normal. The presenting complaint to Defendant was unclear as it stated "left leg swelling, numbness" but also later described "PAD with claudication" but did not elaborate. The expert determined the diagnosis of PAD seemed to be fishing for a reason to do an arteriogram. An arteriogram was performed, and it was stated that severe distal disease was seen in the left lower extremity but no arteriogram images were provided. With regards to the veins, Defendant diagnosed May-Thurner Syndrome which by definition, is a narrowing of the left iliac vein by the right iliac artery. The limited images provided demonstrated NO stenosis and NO collaterals to support that diagnosis. Despite a normal venogram, Defendant placed a fourteen (14) mm stent and only dilated to twelve (12) mm. The expert explained that most Interventional Radiologists (IR) will "post angioplasty" to the same dimension as the stent. If not, there is risk of stent migration/embolization. The expert found no indication to place a stent by the venogram. The expert determined the fact that the stent migrated to the heart means the vein was indeed normal size.

Patient J. M. C.:

15. The expert determined that this case is complex and there are some clear indications for intervention. The patient had severe PAD which was well documented. The right foot had an ABI of 0.20, consistent with PAD. The right foot upon initial visits was cold and blue. The PAD in the right lower extremity was treated with 4 different IR procedures. The expert determined a few procedures were reasonable to do for IR, but at some point Defendant should have consulted a vascular surgeon for an operative opinion. The outcome was undesirable with an above the knee amputation on the right side. The expert concluded, however, this patient did have significant arterial disease and the amputation may have been unpreventable. The expert concluded Defendants desire to perform venography in the midst of dealing with what was clearly an arterial issue is suspect. In a patient with severe PAD, a venogram would generally not be medically indicated. The expert found no demonstrable venous stenosis was visible on imaging yet Defendant stented the right iliac vein regardless. In his notes Defendant states "moderate" compression, but this was not evident. The expert determined stenting this vein without further providing evidence may be below the standard of care.

Patient N.C.C.:

16. The expert found there were excessive arteriograms and venograms beyond the standard of care in this case. This patient had nine (9) procedures on her arteries and veins over only 8 months. There was a stent placed in the right external iliac vein which was undersized and migrated to the heart. The expert determined in the instance of this specific stent there may have been indication of need, however, the stent placement was below standard of care.

Patient R.D.C.:

17. This patient had 4 procedures to his leg in almost a month with a fifth procedure recommended. Expert review determined it is unclear whether there was actual need for the stents as the documentation is lacking. Later imaging review of the multiple procedures shows severe peripheral arterial disease. The expert found there was a clear indication to proceed with an intervention, however, Defendant never improved the patient's vasculature/flow despite focusing on a singular issue, the left superficial femoral artery (SFA).

Patient R.C.C.

18. The expert found two main issues in this case. First is the perceived severity of disease or lack thereof relative to the angiogram. He found the angiogram to be relatively normal with just a small lesion in the posterior tibialis. There was no urgency in treating the patient and conservative treatment might have worked on this patient. Second, he found, was the timing of the intervention. According to the records, the patient had gone four (4) days without hemodialysis. The expert stated hemodialysis was the first thing that needed to occur, however, Defendant proceeded with the atherectomy instead. The potassium was later discovered to be 7.5. The expert concluded the patient would have been better off being sent for dialysis rather than atherecotmy. The expert concluded the ultimate outcome of hospitalization and later cardiac arrest and death may or may not be technically directly attributable to Defendants intervention. It is feasible that the contrast load and stress of the procedure did not help the situation.

Patient C.A.C.:

19. The expert found this patient's aorta ultimately occluded. There is no clear documentation in the record as to why. The inadequate charting makes it impossible to tell whether the aorta was treated with a bare metal stent or stent graft (covered stent), what the actual degree of stenosis was or should she have been aggressively anticoagulated after her procedure. The expert found that limited imaging review supports Defendant's diagnosis of bilateral common iliac arterial stenosis, however, no images were seen of an aortic stent. The Aortic occlusion may or may not have happened with IR intervention.

20. The expert noted that of the eight (8) charts reviewed, at least four (4) had stents embolize. He also noted that he has been placing stents for ten (10) years and he has never had a stent embolize.

III. VIOLATIONS

21. Based on the foregoing, the Defendant is guilty of unprofessional conduct as follows:

a. Failure to maintain an office record for each patient which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient in violation of Title 59 § 509(18):

b. Failure to provide a proper and safe medical facility setting and qualified assistive personnel for a recognized medical act, including but not limited to an initial in-person patient examination, office surgery, diagnostic service or any other medical procedure or treatment. Adequate medical records to support diagnosis, procedure, treatment or prescribed medications must be produced and maintained in violation of Title 59 § 509(20):

c. Gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4(15):

d. Being physically or mentally unable to practice medicine and surgery with reasonable skill and safety in violation of OAC 435:10-7-4(17):

e. Practice or other behavior that demonstrates an incapacity or incompetence to practice medicine and surgery in violation of OAC 435:10-7-4(18):

f. Obtaining any fee by fraud, deceit, or misrepresentation, including fees from Medicare, Medicaid, or insurance in violation of OAC 435:10-7-4(28):

g. Failure to provide a proper setting and assistive personnel for medical act, including but not limited to examination, surgery, or other treatment. Adequate medical records to support treatment or prescribed medications must be produced and maintained in violation of OAC 435:10-7-4(41):

CONCLUSION

Given the foregoing, the undersigned requests the Board conduct a hearing and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to the Defendant's professional license, including an assessment of costs and attorney's fees incurred in this action as provided by law.

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VERIFICATION

I, Lawrence Carter, under penalty of perjury, under the laws of the State of Oklahoma, state as follows:

1. I have read the above Complaint regarding the Defendant, Chigurupati Ramana, M.D.; and

2. The factual statements contained therein are true and correct to the best of my knowledge and belief.

Lawrence Carter, Investigator
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION

Date: 26 Dec 2019

Oklahoma County, OK