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,	)	
Plaintiff,	)	
vs.	)	**Case No. 20-12-5948**
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 complaint was filed by an attorney representing patient named E. C., who underwent numerous procedures performed by Defendant from May 2018 through October 2019. Patient's attorney alleged that Defendant damaged vessels in patient E.C.'s legs to the extent that the right leg was amputated in October 2019.

4. Patient E.C.'s medical records were subpoenaed on December 28, 2020. The subpoena was sent directly to Defendant.

5. On February 24, 2021 an electronic copy of E.C.'s records were received from Defendant's counsel and a printed copy was received from Cioxx, the company that manages the electronic records for St. Anthony's Hospital, on March 4, 2021. On May 24, 2021 Defendant supplied a CD with the imaging related to the procedures Defendant performed on E.C.

6. On June 7, 2021, the sister of a patient of Defendant, called to ask questions about limitations on Defendant's license. The caller explained that her brother, patient E.L., had recently been referred to Defendant, who subsequently performed multiple stenting procedures over a period of several days. This occurred after Defendant entered a VSJ prohibiting him placing venous stents. The caller was not sure if the stents placed by Dr. Ramana were venous or arterial, but on June 6, 2021, patient E.L. was taken to the hospital for a suspected blood clot in his leg, and it was unclear if the leg would ultimately need to be amputated.

7. It was decided that the records for E.L and patients with current court cases pending against Defendant be obtained and reviewed. In addition to E.C. and E.L., four (4) more patient records were checked. Two of those did not concern arterial stenting as E.C. and E.L. appeared to. However, the records for patients S.L. and T.P. did have allegations involving problems with arterial stenting. In spite of the subpoenas for these records calling for every page of medical records as well as any diagnostic radiological images belonging to these patients, very few images were provided. Whether that is because Defendant did not have sufficient radiological images created, did not record them in the records, did not cooperate with Board staff, did not maintain the records, or some combination thereof is unclear.

8. The records show that Defendant demonstrates inadequate documentation throughout the records reviewed. Defendant demonstrated poor judgment and technical ability. Stents were overutilized and utilized in instances when it was inappropriate or premature. There were continued and repeated instances of stent thrombosis and very little if any discussion in the record regarding how or why it happened and what to do about it. Defendant continually treated patients in an outpatient lab rather than admitting them to the hospital. When the treatment failed, he didn't seek counsel from others and didn't seem to consider surgical options or alternative treatments. There were instances where the record lacked historical or physical exam findings that supported the care plan.

9. The records for patients E.C., E.L., S.L. and T.P. were sent for expert review. The expert found that Defendant's patient care fell well below the standard of care on numerous occasions. He went on to say "this provider displays consistent inadequacy in documentation, judgement, technical ability and choosing when, where and how to intervene as well as a stunning lack of ability to manage his patients carefully, thoughtfully or effectively".

III. VIOLATIONS

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

a. Dishonorable or immoral conduct which is likely to deceive, defraud, or harm the public in violation of Title 59 § 509(8):

b. The inability to practice medicine with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition in violation of Title 59 § 509(15):

c. 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):

d. 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):

e. Conduct likely to deceive, defraud, or harm the public in violation of OAC 435:10-7-4(11):

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

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

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

i. OAC 475:10-7-4(40): The inability to practice medicine and surgery with reasonable skill and safety to patients by reason of age, illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition in violation of OAC 435:10-7-4(40):

j. 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.

Joseph L. Ashbaker, OBA No. 19395
Assistant Attorney General
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION
313 NE 21ST Street
Oklahoma City, Oklahoma 73105
405/522.2974
405/522.4536 – Facsimile

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: 13 Oct 2021

Oklahoma County