



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

December 12, 1997

Kris M. Dawley, Esq.
Edwin L. Skeens, Esq.
Schottenstein, Zox & Dunn
41 South High Street, Suite 2600
Columbus, Ohio 43215

RE: Semur P. Rajan, M.D.

Dear Mr. Dawley and Mr. Skeens:

Please find enclosed a certified copy of the Order and Entry in the above matter approved and confirmed by the State Medical Board of Ohio meeting in regular session on November 12, 1997. This Order and Entry documents the Medical Board's reconsideration of Dr. Rajan's case in accordance with the instructions of the Tenth District Court of Appeals and the Franklin County Court of Common Pleas.

Section 119.12, Ohio Revised Code, may, but does not necessarily, authorize an appeal from this Order. Such an appeal may be taken to the Court of Common Pleas in Franklin County only. Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical board of Ohio and the appropriate court within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 of the Ohio Revised Code.

Very truly yours,

Anand G. Garg, M.D.
Anand G. Garg, M.D.
Secretary

AGG:ll
enclosures

CERTIFIED MAIL #Z 395 590 760
RETURN RECEIPT REQUESTED

cc: Semur P. Rajan, M.D.
CERTIFIED MAIL #Z 395 590 761
RETURN RECEIPT REQUESTED

Mailed 12/12/97

CERTIFICATION

I hereby certify that the attached copy of the Order and Entry of the State Medical Board of Ohio; attached copy of the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; September 13, 1995 Entry of Order in the Matter of Semur P. Rajan, M.D.; and attached excerpt of minutes of the State Medical Board of Ohio, meeting in regular session on November 12, 1997, including a motion approving and confirming the Findings of Fact, amending the Conclusions of Law, and adopting an Order on remand, constitute a true and complete copy of the Order and Entry of the State Medical Board in the Matter of Semur P. Rajan, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and on its behalf.

SEAL

Anand G. Garg, M.D.
Anand G. Garg, M.D.
Secretary

12/12/97
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

SEMUR P. RAJAN, M.D.

*

ORDER AND ENTRY

On or about September 6, 1995, the State Medical Board of Ohio issued its Findings and Order in the Matter of Semur P. Rajan, M.D., suspending Dr. Rajan's license to practice medicine and surgery in the State of Ohio for ninety days and imposing a subsequent probation for at least two years, or until the doctor's next fifty laparoscopic surgical procedures have been monitored, whichever period was longer. A copy of those Findings and Order are attached hereto and incorporated herein.

Pursuant to Section 119.12, Ohio Revised Code, Dr. Rajan appealed the Medical Board's decision to the Franklin County Court of Common Pleas on September 22, 1995. In a Decision issued on June 7, 1996, and documented by Entry filed on June 26, 1996, the Franklin County Court of Common Pleas affirmed the Medical Board's action.

Dr. Rajan appealed to the Tenth District Court of Appeals on July 18, 1996. By Opinion and Entry filed on February 13, 1997, the Appeals Court affirmed the Medical Board's Order insofar as it was based on the conclusion that Dr. Rajan had failed to conform to minimal standards of care, but reversed the Board's conclusion that the doctor had violated 4731.22(B)(5), Ohio Revised Code, by publishing a "false, fraudulent, deceptive or misleading statement" in his post-operative note. The matter was remanded to the Court of Common Pleas with instructions to remand to the Medical Board for further proceedings consistent with the Appeals Court's Opinion.

On July 2, 1997, the Ohio Supreme Court declined to accept jurisdiction of the Medical Board's appeal and Dr. Rajan's cross-appeal. In accordance with the appellate court's instructions, the matter was thus remanded to the Medical Board by the Franklin County Court of Common Pleas on October 7, 1997.

Upon consideration of the original hearing transcripts and exhibits in the Matter of Semur P. Rajan, M.D.; the September 6, 1995 Findings and Order of the State Medical Board of Ohio in the Matter of Semur P. Rajan, M.D.; Dr. Rajan's objections to the Attorney Hearing Examiner's Report and Recommendation; and decisions and entries of the Franklin County Court of Common Pleas and the Tenth District Court of Appeals; and in accordance with the instructions of those Courts; and upon approval and confirmation by vote of the Board on November 12, 1997, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for that date.

It is hereby ORDERED:

1. That the certificate of Semur P. Rajan, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for ninety (90) days.
2. Dr. Rajan's certificate shall be subject upon reinstatement to the following PROBATIONARY terms, conditions, and limitations for a period of at least two (2) years, or until the minimum of fifty (50) cases referred to in subparagraph 3e, below, have been monitored, whichever period is longer:
 - a. Dr. Rajan shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.
 - b. Dr. Rajan shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution stating whether or not there has been compliance with all of the provisions of probation.
 - c. Dr. Rajan shall appear in person for interviews before the full Board or its designated representative at six (6) month intervals, or as otherwise requested by the Board.
 - d. In the event that Dr. Rajan should leave Ohio for three (3) consecutive months, or reside or practice outside the State, Dr. Rajan must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside of Ohio will not apply to the reduction of this probationary period, unless otherwise determined by motion of the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

- e. Within thirty (30) days of the effective date of this Order, Dr. Rajan shall submit for the Board's prior approval the name of a monitoring physician, who does laparoscopic cholecystectomies, who shall carry out a 100% concurrent review of Dr. Rajan's next fifty (50) laparoscopic surgery patient charts and videotapes, and shall submit a written report of such review to the Board on a biannual basis. Such chart review may be done on a random basis. It shall be Dr. Rajan's responsibility to ensure that the monitoring physician's biannual reports are submitted to the Board on a timely basis. In the event that the approved monitoring physician becomes unable or unwilling to so serve, Dr. Rajan shall immediately so notify the Board in writing and shall make arrangements for another monitoring physician as soon as practicable.
3. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Rajan's certificate will be fully restored.

This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio. In the interim, Dr. Rajan shall not undertake the care of any patient not already under his care.

SEAL


Anand G. Garg, M.D.
Secretary

12/12/97
Date



STATE MEDICAL BOARD OF OHIO

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EXCERPT FROM THE DRAFT MINUTES OF NOVEMBER 12, 1997

REPORTS AND RECOMMENDATIONS

Ms. Noble announced that the Board would now consider the findings and orders appearing on the Board's agenda.

Ms. Noble asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: William B. Beuchat, D.O.; Stephen J. Buday, M.D.; Ronald A. Landefeld, M.D.; Hillard M. Lazarus, M.D., et al., University Physicians, Inc.; Myron B. Renner, D.O.; Samson P. Reyes, Jr., M.D.; Howard E. Rissover, M.D.; and Semur P. Rajan, M.D.; and the report and recommendation upon remand in the matter of Brent E. Woodfield, M.D.

A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Bhati	- aye
	Dr. Gretter	- aye
	Dr. Egner	- aye
	Mr. Sinnott	- aye
	Dr. Buchan	- aye
	Dr. Agresta	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Ms. Noble	- aye

Mr. Sinnott indicated that he did not read the materials in the matter of Ronald A. Landefeld, M.D.

Ms. Noble asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Bhati	- aye
	Dr. Gretter	- aye
	Dr. Egner	- aye
	Mr. Sinnott	- aye
	Dr. Buchan	- aye

Dr. Agresta - aye
Dr. Garg - aye
Dr. Steinbergh - aye
Ms. Noble - aye

In accordance with the provision in Section 4731.22(C)(1), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Ms. Noble stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....
REPORT AND RECOMMENDATION IN THE MATTER OF SEMUR P. RAJAN, M.D.

Ms. Noble directed the Board's attention to the matter of Semur P. Rajan, M.D. She advised that this matter is before the Board on remand from the Court of Appeals and Court of Common Pleas. The Court affirmed the Board's suspension Order insofar as it was based on the conclusion that the doctor had failed to conform to minimal standards of care, but reversed the Board's conclusion that the doctor had violated 4731.22(B)(5), O.R.C., by publishing a "false, fraudulent, deceptive or misleading statement" in his post-operative note. In its Opinion, the Court stated that the Board should have known that Dr. Rajan intended to deceive or misrepresent the facts.

The Board is being asked to issue a new Order in Dr. Rajan's case based on all of its previous findings and conclusions, with the exception of the 4731.22(B)(5), O.R.C. violation that was overturned by the Court. Copies of the original transcript and exhibits were provided for review by Board members prior to the meeting, along with the Hearing Examiner's Report and Recommendation, Dr. Rajan's objections, and pertinent Court decisions. Mr. Albert was Supervising Member. Dr. Gretter was Secretary.

Dr. Gretter stated that he was not Secretary at the time this matter was initially considered by the Board. He recalls taking part in the discussion of this case.

Ms. Noble asked for clarification.

Mr. Albert stated that Dr. O'Day was the Board Secretary when this matter was last considered by the Board.

Dr. Steinbergh stated that she reviewed this case again, and she would not change the Order. The findings were appropriate. Regardless of the exception of the fraud violation, she would not change the Order.

Mr. Sinnott agreed with Dr. Steinbergh, stating that when he reviewed the previous minutes of the Board's discussion of this case, it was not the (B)(5) violation driving the decision. The elements of the case were upheld. An appropriate Order would be one that reads as the other, only deleting reference to the (B)(5) violation.

MR. SINNOTT MOVED TO APPROVE AND CONFIRM THE ORIGINALLY APPROVED FINDINGS OF FACT, CONCLUSIONS AND ORDER, WITH DELETION OF ALL REFERENCE TO VIOLATIONS OF 4731.22(B)(5). DR. STEINBERGH SECONDED THE MOTION.

Dr. Garg stated that he remembers there having been very detailed discussion. The Board's decision was based on everything but the (B)(5) allegation.

Dr. Bhati disagreed, stating that there were two issues involved in this case. The first was a question of substandard care, with which he vehemently disagreed. Dr. Bhati stated that he personally reviewed the full tapes, and on more than two occasions went through the cardiovascular status of the patient five minutes before the patient's abdomen was opened. The vascular surgeon was called. There were eight hours' of work on that patient. The Board is not going to re-hash that situation. That is not the purpose of his reminding the Board. His purpose is reminding the Board that there were two factors leading to the Proposed Order at the time. One was the substandard care and the other was fraudulent description of the operative reports. If one factor is taken out, and you're basing the entire Proposed Order only on the so-called substandard care, the Proposed Order cannot be the same. It would have to be less than what it is right now, because the Board based the previous order on the two factors, and now there is only one.

A number of Board members indicated disagreement with Dr. Bhati's statement.

Dr. Egner stated that the Board has these situations all of the time. The disciplinary guidelines call for different levels for different things. Sometimes the Board goes along with them, sometimes it goes below, and sometimes it's stricter. Her feeling is that the evidence shows that the Board should stay with the same recommendation it had previously.

Dr. Buchan agreed with Dr. Egner, stating that if the Board had bifurcated this Order and suggested that 90 days was appropriate for the standard of care issue, and 30 days, for example, was appropriate for the ethics issue, running concurrently there would still be a 90-day suspension. In fact, he would agree with the Order as written, minus the (B)(5) language.

Dr. Gretter spoke in support of the motion, stating that the Board did hear expert witnesses with regard to minimal standards in this case.

Dr. Garg stated that at the time of the original discussion, the Board did use Dr. Bhati's expertise regarding endoscopic procedures in his teacher's status. The initial proposal was for a one-year suspension. After listening to Dr. Bhati's statements, although he personally didn't agree to any suspension, the motion was made for a three-month suspension. That was more because of the results of the surgery. That's what he meant when he said that he remembered the Order being more based on the surgical procedure than on the notes.

A vote was taken on Mr. Sinnott's motion:

VOTE:	Mr. Albert	- abstain
	Dr. Bhati	- nay
	Dr. Gretter	- aye
	Dr. Egner	- aye
	Mr. Sinnott	- aye
	Dr. Buchan	- aye
	Dr. Agresta	- aye
	Dr. Garg	- nay
	Dr. Steinbergh	- aye

The motion carried.

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Semur P. Rajan, M.D., :
Appellant-Appellant, :
v. : No. 96APE07-914
The State Medical Board of Ohio, : (REGULAR CALENDAR)
Appellee-Appellee. :

O P I N I O N

Rendered on February 13, 1997

Schottenstein, Zox & Dunn, Kris M. Dawley and Edwin L. Skeens, for appellant.

Betty D. Montgomery, Attorney General, and Lili C. Kaczmarek and James M. McGovern, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

TYACK, P.J.

On August 11, 1994, the State Medical Board of Ohio ("board") mailed a letter to Semur P. Rajan, M.D., notifying him that the board intended to determine whether or not to take action against his certificate to practice medicine and surgery. The bases for the board's proposed action included allegations of inappropriate surgical care of a patient (hereinafter referred to as "Patient 1") and the giving of inaccurate information in Patient 1's records. Dr. Rajan requested a hearing and on February 22, February 23 and May 4, 1995, a hearing was held before a board hearing examiner.

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On August 11, 1995, the hearing examiner filed a report and recommendation which contained a detailed summary of the evidence presented, findings of facts, conclusions of law and a proposed order. The hearing examiner concluded that Dr. Rajan violated R.C. 4731.22(B)(5) and (B)(6). In his proposed order, the hearing examiner recommended, among other things, that Dr. Rajan's certificate to practice medicine and surgery in Ohio be suspended for not less than one year.

Dr. Rajan filed objections to the report and recommendation with the board. On September 6, 1995, the board met and considered Dr. Rajan's case. The board, among other changes, amended the hearing examiner's proposed order, changing the recommended one-year suspension to a ninety-day suspension.

On September 22, 1995, Dr. Rajan appealed the board's order to the Franklin County Court of Common Pleas. On June 7, 1996, the trial court rendered its decision, finding the board's order was supported by reliable, probative and substantial evidence and was in accordance with law. A judgment entry was journalized on June 26, 1996.

Dr. Rajan (hereinafter "appellant") has now appealed to this court, assigning four errors for our consideration:

"1. The Trial Court erred in affirming the Order of the State Medical Board (the 'Board') because the Board failed to comply with the voting procedure of R.C. §4731.22(B).

"2. The Trial Court erred in affirming the Order of the Board because Dr. Rajan's post-operative note did not constitute 'publishing a false, ... deceptive or misleading statement' as that clause is used in R.C. §4731.22(B)(5).

"3. The Trial Court erred in affirming the Order of the Board because Dr. Rajan's post-operative note did not constitute '[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances' as that clause is used in R.C. §4731.22(B)(6).

"4. The Trial Court erred in affirming the Order of the Board because Dr. Rajan's conduct during surgery was not '[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances' as that clause is used in R.C. §4731.22(B)(6)."

In his first assignment of error, appellant contends the board did not comply with the voting procedure set forth in R.C. 4731.22(B). The minutes from the September 6, 1995 board meeting indicate the following occurred. Board member Dr. Bhati moved to amend the proposed order. Dr. Bhati's amendment included changing the one-year suspension and imposing merely a reprimand. A vote was taken on this motion to amend. Five board members voted in favor of, four voted against and one member abstained from voting on the motion. The minutes indicate that pursuant to this vote, the motion carried.

Dr. Buchan then moved to approve the hearing examiner's findings of fact, conclusions of law and proposed order, as amended. Again, the vote was five in favor, four against and one abstaining. The minutes then indicate the following:

"Lacking the statutorily requisite six affirmative votes, the motion failed."

The board then tabled the matter.

The matter was then removed from the table, and board member Dr. Agresta moved, among other things, to amend the proposed order by substituting

a ninety-day suspension for the proposed one-year suspension. A vote was taken on this motion and seven members voted in favor of, one member voted against and one member abstained from voting on the motion. The motion carried. Board member Mr. Sinnot then moved to approve the hearing examiner's proposed findings of fact, conclusions of law, and order, as amended. The vote was seven in favor, one against and one abstaining. The motion carried and, therefore, appellant's certificate was suspended for ninety days.

Appellant contends that R.C. 4731.22(B) requires only that six members of the twelve-member board participate in voting on a proposed order to take action on a certificate. Appellant argues that the board erroneously interpreted R.C. 4731.22(B) as requiring six *affirmative* votes in order to take action on a certificate. Therefore, appellant contends Dr. Buchan's motion to approve the proposed order, which as amended included merely a reprimand, actually had passed since ten members voted on such motion.

R.C. 4731.22(B) states, in pertinent part:

"The board, pursuant to an adjudicatory hearing under Chapter 119. of the Revised Code and by a vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend a certificate, refuse to register or refuse to reinstate an applicant, or reprimand or place on probation the holder of a certificate for one or more of the following reasons[.]"

The board interpreted the above language to require six affirmative votes in order to limit, revoke or suspend a license, or to reprimand the holder of a certificate. Because only five members voted in favor of a reprimand, the

board found the motion failed. Subsequently, the motion to impose a ninety-day suspension passed after seven members voted in favor of it.

We begin our analysis by noting that the board, as set forth in R.C. 4731.01, consists of twelve members and that, under R.C. 4731.06, six members of the board constitute a quorum. At the September 6, 1995 hearing, ten members were present and participated in voting on the motion to impose a reprimand.

In support of his argument, appellant points to R.C. 4731.22(H) which states:

*** Reinstatement of a certificate surrendered to the board requires *an affirmative vote* of not fewer than six members of the board." (Emphasis added.)

Appellant argues that because the legislature used the word "affirmative" in R.C. 4731.22(H) and not in R.C. 4731.22(B), it intended that six votes, not six affirmative votes, are needed to take action under R.C. 4731.22(B). However, it is a cardinal rule that a court must first look to the language of the statute itself to determine legislative intent. *Shover v. Cordis Corp.* (1991), 61 Ohio St.3d 213, 218. If the language of the statute is plain and unambiguous and conveys a clear and definite meaning, there is no need to apply rules of statutory interpretation. *Cline v. Ohio Bur. of Motor Vehicles* (1991), 61 Ohio St.3d 93, 96, citing *Meeks v. Papadopoulos* (1980), 62 Ohio St.2d 187, 190, citing *Sears v. Weimer* (1944), 143 Ohio St. 312, paragraph five of the syllabus. Where a statute is found to be subject to various interpretations, however, a court may invoke rules of statutory construction in order to arrive at legislative intent. *Cline*. (Citations omitted.)

The statute at issue here, R.C. 4731.22(B), is not so clear and definite that it could not be subject to various interpretations. Therefore, we will apply rules of statutory construction in order to arrive at legislative intent. In determining legislative intent, it is the duty of the court to give effect to the words used, not to delete or insert words. *Cline* at 97. (Citations omitted.) Words and phrases must be read in context and construed according to the rules of grammar and common usage. *Independent Ins. Agents of Ohio, Inc. v. Fabe* (1992), 63 Ohio St.3d 310, 314, quoting R.C. 1.42. Utilizing these rules of statutory construction along with other principles of law, we find that the board correctly applied R.C. 4731.22(B).

The key phrase in R.C. 4731.22(B) is: "[t]he board, *** by a vote of not fewer than six members ***." The use of the word "a" above, modifying the singular word "vote," indicates that the legislature intended that one unit consisting of six of the same votes is needed in order to take action on a certificate. Appellant's interpretation may have been correct had the legislature, in contrast, used the words "the votes" instead of "a vote."

Further, when the remaining first paragraph of R.C. 4731.22(B) is read, it indicates that such a vote is necessary in order to take action against a certificate as opposed to *not* take action. It is reasonable to conclude that the legislature intended that six affirmative votes were necessary to limit, revoke or suspend a certificate, or to reprimand or place on probation the holder of a certificate.

In addition, it makes sense logically to interpret R.C. 4731.22(B) this way. R.C. 4731.06 states that six members constitute a quorum. If appellant's construction was indeed correct, the legislature would not have had to say "by a vote of not fewer than six members" because R.C. 4731.06 requires at least six members to take any action.

Finally, the Supreme Court has held that courts must accord due deference to boards' interpretations of statutes governing such boards, since the legislature deemed them the proper forums to determine certain disputes. *Leon v. Ohio Bd. of Psychology* (1992), 63 Ohio St.3d 683, 687; *Lorain City Bd. of Edn. v. State Emp. Relations Bd.* (1988), 40 Ohio St.3d 257. See, also, *Athens Cty. Bd. of Commrs. v. Schregardus* (1992), 83 Ohio App.3d 861, 868 (interpretation of a statute by an agency charged with its administration and enforcement is entitled to due deference, however, such interpretation must be consistent with the plain language of the statute). Because the board's interpretation of R.C. 4731.22(B) is consistent with the plain language of the statute, we must accord such interpretation due deference.

For all the reasons stated above, we hold that the trial court did not err in affirming the board's order as being in accordance with law.¹ The

¹ While the issue of the number of votes necessary under R.C. 4731.22(B) was not at issue, we also point to the Supreme Court case of *Brost v. Ohio State Medical Bd.* (1991), 62 Ohio St.3d 218. In that case, the board voted to revoke a certificate, with six voting in favor, two voting against and one abstaining. At page 220 of *Brost*, the Supreme Court stated "[b]y the requisite vote of six members, the board adopted, without qualification, the hearing examiner's report." (Emphasis added.) This statement supports the board's interpretation here of R.C. 4731.22(B).

board correctly interpreted R.C. 4731.22(B) as requiring six affirmative votes in order to take certain action on a holder's certificate. Accordingly, appellant's first assignment of error is overruled.

Appellant's remaining assignments of error largely address factual issues and, therefore, a brief background of the facts is warranted. Appellant is a general surgeon who at the time of the incident giving rise to this action had practiced for twenty-four years. Patient 1 suffered from symptomatic gallbladder disease with biliary colic. His condition is commonly referred to as "gallstones." In 1990, the year of the surgery, the treatment for such was cholecystectomy--removal of the gallbladder. This was done either laparoscopically or in an open procedure. Patient 1 consented to a laparoscopic procedure. The surgery was performed on December 11, 1990.

Prior to the surgery, appellant had performed five hundred to six hundred open cholecystectomies and twenty cholecystectomies laparoscopically. During the surgery, appellant retracted the gallbladder straight up rather than up and laterally. The latter method, according to the state's expert, Edwin C. Ellison, M.D., is the proper method. Because appellant did not use the proper method, he did not see the cystic duct, which must be clipped and divided during a cholecystectomy. Therefore, appellant was looking in the wrong place and cut the common bile duct. While an injury to the bile duct is a recognized complication of laparoscopic cholecystectomy, appellant failed to recognize the injury.

The next step in a cholecystectomy is to clip and divide the cystic artery. However, appellant was in the wrong place and instead entered the portal vein and the right hepatic artery. Eventually, appellant divided the cystic artery and used a laser to separate the gallbladder from the liver. About two minutes later, excessive bleeding began, and appellant attempted to control this with the laser. Approximately thirteen minutes later, very serious bleeding began, and appellant attempted to apply a clip to stop the bleeding. Approximately nine minutes later, Patient 1 was still bleeding, and appellant began to convert to an open procedure.

On December 17, 1990, Patient 1 died from shock and multi-system organ failure. Appellant admitted at the hearing that his mistakes during the surgery resulted in Patient 1's death.

Appellant's remaining assignments of error, for the most part, set forth factual issues. The standard of review in appeals from board orders is well-established. In *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 621, the Supreme Court stated that while it is incumbent upon a reviewing trial court to examine the evidence in determining whether or not the board's order is supported by reliable, probative and substantial evidence and is in accordance with law, this is not the function of the appellate court. The appellate court determines only if the trial court abused its discretion, such being not merely an error of judgment, but a perversity of will, passion, prejudice or moral delinquency. *Id.*

In his second assignment of error, appellant contends the board erred in affirming the board's order because his post-operative note did not violate R.C. 4731.22(B)(5). R.C. 4731.22(B)(5) lists as a reason for taking action against a certificate "*** publishing a false, fraudulent, deceptive, or misleading statement." The hearing examiner found that appellant's post-operative note stated that there were "extensive varicosities on the surface of the liver due to probably portal hypertension secondary to ethanol intake." The hearing examiner further found that the evidence supported a finding that there actually were no varicosities or portal hypertension. (Report and Recommendation, p. 30.) The hearing examiner concluded that appellant's post-operative diagnosis contained in the note was, at the very least, false, deceptive and misleading.

Appellant argues that in order for a statement to constitute a violation under R.C. 4731.22(B)(5), there must be evidence of intent to deceive or the probability that others will be deceived. Appellant also contends that there was no evidence of a misrepresentation of fact or a reasonable probability that others would be deceived. R.C. 4731.22(B)(5) defines a false, fraudulent, deceptive, or misleading statement as:

"*** [A] statement that includes a misrepresentation of fact, is likely to mislead or deceive because of a failure to disclose material facts, is intended or is likely to create false or unjustified expectations of favorable results, or includes representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived."

The hearing examiner found that while appellant testified there were varicosities, other evidence such as the autopsy report and Dr. Ellison's testimony indicated otherwise. Contrary to appellant's post-operative note, therefore, the board found there were no varicosities or portal hypertension. Hence, the board found the post-operative note contained, at the very least, a misrepresentation of fact.

The hearing examiner also concluded that it was not necessary to prove an intent to deceive in order to prove a violation of R.C. 4731.22(B)(5). On appeal here, the board cites *Singer v. State Medical Bd. of Ohio* (Sept. 26, 1991), Franklin App. No. 90AP-1204, unreported (1991 Opinions 4694), jurisdictional motion overruled in (1992), 63 Ohio St.3d 1409, in support of the argument that proof of intent is unnecessary. In *Singer*, this court stated that it is unnecessary to establish an intent to defraud or misrepresent in order to find a violation of R.C. 4731.22. *Id.* at 4701. However, in a reported opinion from this court, we found the trial court abused its discretion in affirming a board order that found a physician violated R.C. 4731.22(A) when, although some statements in the physician's application for licensure were technically inaccurate, there was not sufficient evidence that such statements were made with an intent to mislead the medical board. *In re Wolfe* (1992), 82 Ohio App.3d 675, 687-688. While *In re Wolfe* involved an alleged violation of R.C. 4731.22(A), we believe the same proof with regard to intent is required under R.C. 4731.22(B)(5) in this case.

The hearing examiner, in his findings of fact, focused on what the evidence indicated regarding whether or not appellant's post-operative note was correct. The hearing examiner made no findings or conclusions with regard to any evidence or lack of evidence as to appellant's intent to deceive or misrepresent. However, in his summary of the evidence, the hearing examiner noted that Dr. Ellison testified that he believed appellant did not intentionally state anything untrue in the post-operative note. (Report and Recommendation, p. 17.) In addition, the hearing examiner noted that appellant testified that at the time he dictated the report, he believed it was accurate, and he had no intent to deceive. (Report and Recommendation, p. 26.)

As indicated earlier, the hearing examiner concluded intent need not be shown. We find this conclusion erroneous and, instead, follow the analysis set forth in *Wolfe, supra*. Hence, the board, in adopting the hearing examiner's conclusions, applied an incorrect legal standard with regard to whether or not appellant violated R.C. 4731.22(B)(5). There is no evidence that appellant intended to deceive or misrepresent the facts. Therefore, it was erroneous to conclude appellant violated R.C. 4731.22(B)(5). Accordingly, the trial court erred in affirming the portion of the board's order finding appellant violated R.C. 4731.22(B)(5). For these reasons, appellant's second assignment of error is sustained.

Appellant's third and fourth assignments of error are interrelated and, therefore, will be addressed together. Appellant contends the trial court erred in affirming the board's order finding that, pursuant to R.C.

4731.22(B)(6), appellant's conduct during surgery and with regard to his post-operative note departed from or failed to conform to minimal standards of care.

R.C. 4731.22(B)(6) lists another reason for taking action on a certificate:

"(a) A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established[.]"

As to the surgery, the hearing examiner found numerous departures from and/or failures to conform to minimal standards of care. As an example, the hearing examiner found appellant retracted Patient 1's gallbladder improperly and as a result, erroneously clipped and divided the common bile duct and not the cystic duct. Because appellant misidentified the common bile duct, he was working in the wrong area for part of the surgery. Appellant should have recognized the injury to the common bile duct and repaired it. The hearing examiner further found that convincing evidence showed that when presented with excessive bleeding, as in Patient 1's case, the laparoscopic procedure should be discontinued and an open procedure should be performed. However, even when the bleeding became worse, appellant continued to attempt to control the bleeding without opening the patient. Further, the hearing examiner found appellant failed to accurately document the surgery and its complications.

For all of the above and other enumerated reasons, the hearing examiner and board concluded that appellant's conduct departed from or failed to conform with minimum standards of care. We find that the trial court did not abuse its discretion in finding reliable, substantial and probative evidence in support of the board's finding.

Appellant argues that the trial court applied an improper standard in assessing his conduct during surgery. Appellant points to one sentence in the trial court's decision in support of his argument. During a thorough discussion of the evidence, the trial court stated:

"*** First of all, even if comparing an open cholecystectomy to a laparoscopic one is like comparing apples to oranges, as Appellant claims, there is, as Dr. Ellison explained, one standard that exists for both: you don't let the patient bleed to death. ***" (Trial Court Decision, p. 4.)

Appellant contends this is an inappropriate standard because it focuses on the results, not the reasonableness of appellant's efforts. However, this was not the standard used by the trial court. Rather, the trial court examined the evidence and found the board's order was supported by reliable, probative and substantial evidence. The trial court was merely giving one example of the evidence which showed appellant fell below the minimum standard of care.

Appellant sets forth various other arguments in support of his contention that he did not fall below the minimum standard of care. For example, appellant points out there was testimony regarding the difficulty of this particular surgery due to several anatomical anomalies. Appellant cites to testimony by his expert, John A. Matyas, M.D., indicating that retracting the gallbladder during this procedure was new in 1990 and that retracting the gallbladder laterally was not standard practice in 1990. Appellant also contends the evidence shows that his failure to recognize the injury to the common bile duct was not a departure from the minimum standards of care because such injury

was a result of anatomical anomalies and such an injury was within acceptable standards. In addition, appellant argues there was not reliable, probative and substantial evidence demonstrating he violated minimum standards of care by failing to open the patient earlier.

Appellant makes other arguments regarding the evidence in this case. We recognize that this was a difficult surgery. The record in this case includes numerous medical documents, a video recording of the actual surgery, and the testimony of appellant and two expert witnesses. Differences of opinion occurred, however, both experts testified as to shortcomings on the part of appellant. The board is largely made up of physicians who have the expertise to decide factual issues. It is not within our province to second-guess the board. Indeed, the purpose of the General Assembly in providing for administrative hearings in particular fields is to facilitate matters by placing the decision as to facts on boards composed of people who have the necessary knowledge and experience pertaining to a particular field. *Pons* at 621-622, quoting *Arlen v. State* (1980), 61 Ohio St.2d 168, 173.

A majority of the board possesses the specialized knowledge needed to determine the acceptable standard of general medical practice and is quite capable of determining when conduct falls below the minimum standard of care. *Pons* at 623. The minutes from the board hearing contain detailed discussions between the board members on what occurred during this surgery and whether or not errors were made. We must give due deference to such expertise and given the record in this case, it is not within our province to reverse the board's order.

In addition, as appellant's conduct regarding his post-operative diagnosis was inextricably related to his conduct during surgery, we again defer to the board's conclusion that such conduct also fell below the minimum standard of care as set forth in R.C. 4731.22(B)(6).

Here, the board found for various reasons appellant's conduct during surgery fell below the minimum standard of care. A patient died as a result of appellant's conduct. Appellant's certificate was suspended for ninety days. On appeal to this court, appellant in large part attempts to argue his case again. The board decided the issues, and the trial court found the board's order was supported by reliable, probative and substantial evidence and was in accordance with law. In our limited review, we cannot find the trial court abused its discretion in finding reliable, substantial and probative evidence to support the board's conclusion that appellant violated R.C. 4731.22(B)(6). Accordingly, appellant's third and fourth assignments of error are overruled.

In summary, appellant's first, third and fourth assignments of error are overruled. Appellant's second assignment of error is sustained. The judgment of the Franklin County Court of Common Pleas is affirmed in part and reversed in part, and this cause is remanded to the trial court with instructions to remand to the board for further proceedings consistent with this opinion.

*Judgment affirmed in part and reversed in part
and cause remanded with instructions.*

LAZARUS, J., concurs.

CLOSE, J., concurs in part and dissents in part.

CLOSE, J., concurring in part and dissenting in part.

I concur with the majority opinion with the exception of their analysis of the first assignment of error. Because I agree with appellant's argument, I would sustain the first assignment of error and remand to the Board for imposition of penalty consistent with the original vote taken.

In short, R.C. 4731.06 states that six members constitute a quorum. The language, "by a vote of not fewer than six members," pursuant to R.C. 4731.22(B), guarantees that the board not only have a quorum but that, if there is an abstention, discipline cannot be decided by a vote taken by less than six members.

I would hold that R.C. 4731.06, requiring six members to constitute a quorum, is supplemented by R.C. 4731.22(B), requiring, by "a vote of not fewer than six members," means merely that, in addition to having the quorum, six members must vote on the action. I believe this is further illustrated by R.C. 4731.22(H), which requires "an affirmative vote of not fewer than six members," in some cases. The legislature could have said six affirmative votes in R.C. 4731.22(B) if that is what they meant.

I would sustain the first assignment of error.



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

September 8, 1995

Semur P. Rajan, M.D.
275 Cline Avenue
Mansfield, Ohio 44907

Dear Doctor Rajan:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on September 6, 1995, including Motions approving and confirming the Findings of Fact, amending the Conclusions of Law of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal may be taken to the Franklin County Court of Common Pleas only.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 of the Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Thomas E. Greiter, M.D.
Secretary

TEG:cm
Enclosures

CERTIFIED MAIL RECEIPT NO. P 741 124 479
RETURN RECEIPT REQUESTED

cc: Edwin L. Skeens, Esq.
Kris M. Dawley, Esq.

CERTIFIED MAIL NO. P 741 124 480
RETURN RECEIPT REQUESTED

Mailed 9-19-95



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-3315 • (614)466-3934

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on September 6, 1995, including Motions approving and confirming the Findings of Fact, amending the Conclusions of Law of the Hearing Examiner, and adopting an amended Order, constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Semur P. Rajan, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

(SEAL)

Thomas E. Gretter, M.D.
Secretary

9/13/95

Date



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614)466-3934

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

SEMUR P. RAJAN, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on the 6th day of September, 1995.

Upon the Report and Recommendation of R. Gregory Porter, Hearing Examiner, Medical Board, in this matter designated pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED:

1. That the certificate of Semur P. Rajan, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for (90) ninety days.
2. Dr. Rajan's certificate shall be subject upon reinstatement to the following **PROBATIONARY** terms, conditions, and limitations for a period of at least two (2) years, or until the minimum of fifty (50) cases referred to in subparagraph 3e, below, have been monitored, whichever period is longer:
 - a. Dr. Rajan shall obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine in Ohio.
 - b. Dr. Rajan shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution stating whether or not there has been compliance with all of the provisions of probation.
 - c. Dr. Rajan shall appear in person for interviews before the full Board or its designated representative at six (6) month intervals, or as otherwise requested by the Board.
 - d. In the event that Dr. Rajan should leave Ohio for three (3) consecutive months, or reside or practice outside the State, Dr. Rajan must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside of Ohio will not apply to the

reduction of this probationary period, unless otherwise determined by motion of the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

- e. Within thirty (30) days of the effective date of this Order, Dr. Rajan shall submit for the Board's prior approval the name of a monitoring physician, who does laparoscopic cholecystectomies, who shall carry out a 100% concurrent review of Dr. Rajan's next fifty (50) laparoscopic surgery patient charts and videotapes, and shall submit a written report of such review to the Board on a biannual basis. Such chart review may be done on a random basis. It shall be Dr. Rajan's responsibility to ensure that the monitoring physician's biannual reports are submitted to the Board on a timely basis. In the event that the approved monitoring physician becomes unable or unwilling to so serve, Dr. Rajan shall immediately so notify the Board in writing and shall make arrangements for another monitoring physician as soon as practicable.

3. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Rajan's certificate will be fully restored.

This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio.

In the interim, Dr. Rajan shall not undertake the care of any patient not already under his care.



Thomas E. Gretter, M.D.
Secretary

(SEAL)

9/13/95

Date

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**REPORT AND RECOMMENDATION
IN THE MATTER OF SEMUR P. RAJAN, M.D.**

The Matter of Semur P. Rajan, M.D., was heard by R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on February 22 and 23, and May 4, 1995.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated August 10, 1994 (State's Exhibit 1), the State Medical Board notified Semur P. Rajan, M.D., that it proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action upon allegations of inappropriate surgical care of Patient 1 (identified in a Patient Key, sealed to protect patient confidentiality) and inaccurate information contained in the patient record. Dr. Rajan's acts, conduct, and/or omissions, individually and/or collectively, were alleged to constitute: "publishing a false, fraudulent, deceptive, or misleading statement," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code"; "(a) departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code, as in effect prior to March 15, 1993"; and/or "(t)he violation of any provision of a code of ethics of a national professional organization," as that clause is used in Section 4731.22(B)(18)(a), Ohio Revised Code, to wit: Principle II of the American Medical Association's Principles of Ethics."

Dr. Rajan was advised of his right to request a hearing in this Matter.

- B. By letter received by the State Medical Board on September 8, 1994, Kris M. Dawley, Esq., requested a hearing on behalf of Dr. Rajan.

II. Appearances

- A. **On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Lili C. Kaczmarek, Assistant Attorney General.**
- B. **On behalf of the Respondent: Kris M. Dawley, Esq., and Edward Skeens, Esq.**

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EVIDENCE EXAMINED

I. Testimony Heard

A. Presented by the State

Edwin Christopher Ellison, M.D.

B. Presented by the Respondent

1. John A. Matyas, M.D..
2. Semur P. Rajan, M.D.
3. James Bruce Jackson, M.D.

II. Exhibits Examined

In addition to State's Exhibits 1 and 2, noted above, the following exhibits were identified and admitted into evidence:

A. Presented by the State

1. **State's Exhibit 3**: September 9, 1994 letter to Kris M. Dawley, Esq., from the Board, advising that a hearing had been set for September 22, 1994, and further advising that the hearing had been postponed pursuant to Section 119.09, Ohio Revised Code.
2. **State's Exhibit 4**: September 19, 1994 letter to Attorney Dawley from the Board scheduling the hearing for November 28, 1994. (3 pp.)
3. **State's Exhibit 5**: The parties' November 23, 1994 Joint Motion for Continuance.
4. **State's Exhibit 6**: November 23, 1994 Entry granting the parties' Joint Motion for Continuance, and rescheduling the hearing for February 22, 1995 through February 24, 1995.
5. **State's Exhibit 7**: State's February 1, 1995 Motion to Schedule One Additional Day for Hearing. (3 pp.)
6. **State's Exhibit 8**: February 2, 1995 Entry granting the State's Motion to Schedule One Additional Day for Hearing, and scheduling the additional day for March 22, 1995.
- * 7. **State's Exhibit 9**: Copy of Dr. Rajan's office records regarding Patient 1. (34 pp.)

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- * 8. State's Exhibit 10: Certified copy of hospital records regarding Patient 1, from Peoples Hospital, Mansfield, Ohio. (224 pp.)
- * 9. State's Exhibit 11: October 31, 1994 letter from Peoples Hospital to the Board certifying the accuracy of the laparoscopic cholecystectomy video; and videotape recording of the laparoscopic cholecystectomy performed by Dr. Rajan on Patient 1.
- * 10. State's Exhibit 12: Certified copies of medical records regarding Patient 1, from Mt. Carmel Medical Center, Columbus, Ohio. (126 pp.)
- * 11. State's Exhibit 13: Patient 1's death certificate.
- 12. State's Exhibit 14: Dr. Ellison's curriculum vitae. (18 pp.)
- 13. State's Exhibit 15: Picture of male anatomy including liver and gall bladder.
- 14. State's Exhibit 16: Picture from Johns Hopkins Human Anatomy series of the liver, the vascular and biliary systems.
- 15. State's Exhibit 17: Diagram of the gall bladder from *Gray's Anatomy*, 37th Edition, p. 1393.
- 16. State's Exhibit 18: Picture of dissection of the cystic and bowel ducts from *Gray's Anatomy*, 37th Edition, p. 1394.
- 17. State's Exhibit 19: Collection of pictures showing steps of the laparoscopic cholecystectomy procedure.
- 18. State's Exhibits 20 through 23: Artist's renditions of Patient 1's anatomy as seen on the patient videotape (State's Exhibit 11) at different stages of surgery.
- 19. State's Exhibit 24: Videotape of Clinical Case Conference Series, entitled, "Diagnosis and Treatment of Gallstones," dated January 27, 1995.

B. Presented by the Respondent

- 1. Respondent's Exhibit 1: Curriculum vitae of Semur P. Rajan, M.D.
- 2. Respondent's Exhibit 2: Curriculum vitae of Bruce Jackson, M.D. (2 pp.)

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3. Respondent's Exhibit 4: Curriculum vitae of John A. Matyas, M.D. (4 pp.)
- * 4. Respondent's Exhibit 5: Post-operative report concerning Patient 1 prepared by Dr. Rajan, with attached pathology report prepared by Rockni Jalili, M.D. (4 pp.)
- * 5. Respondent's Exhibit 6: Autopsy report regarding Patient 1 prepared at Mt. Carmel Medical Center, Columbus, Ohio. (9 pp.)
6. Respondent's Exhibit 7: Article by George Berci, M.D., entitled, "Biliary Ductal Anatomy and Anomalies: The Role of Intraoperative Cholangiography During Laparoscopic Cholecystectomy," from *Surgical Clinics of North America* (Vol. 72, No. 5, Oct. 1992). (7 pp.)
7. Respondent's Exhibit 8: Article by Robert J. Fitzgibbons, Jr., M.D.
8. Respondent's Exhibit 9: Article by Raphael S. Chung, M.D., and Thomas A. Broughan, M.D., entitled "The Phenomenal Growth of Laparoscopic Cholecystectomy: A Review," from *The Cleveland Clinic Journal of Medicine* (Vol. 59, No. 2). (5 pp.)
9. Respondent's Exhibit 10: Editorial by John L. Cameron, M.D., and Thomas R. Gadacz, M.D., entitled "Laparoscopic Cholecystectomy," from *Ass. Surg.* (Jan. 1991). (2 pp.)
10. Respondent's Exhibit 11: Dr. Rajan's response to a State Medical Board questionnaire. (30 pp.)
11. Respondent's Exhibit 12: Table of contents and agenda from a July 20-22, 1990 seminar entitled, "Laser Laparoscopic Cholecystectomy for the General Surgeon and Gynecologist." (6 pp.)
12. Respondent's Exhibit 13: Collection of letters from the community written in support of Dr. Rajan.
13. Respondent's Exhibits 14 through 19: Affidavits of members of Dr. Rajan's medical community.
14. Respondent's Exhibits 21 and 22: Videotapes of laparoscopic cholecystectomies performed by Dr. Matyas.
15. Respondent's Exhibit 23: Withdrawn. (See Procedural Matters #3, below)
16. Respondent's Exhibit 24: Three-dimensional model of the human liver and gallbladder. (Note: This model will be available for

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viewing by Board Members at the offices of the State Medical Board.)

17. Respondent's Exhibit 25: Seminar materials from the July 20-22, 1990 seminar given at the Grant Laser Center entitled, "Laser Laparoscopic Cholecystectomy for the General Surgeon and Gynecologist." (Multiple pages)

* **Note:** Those exhibits listed above with an asterisk (*) have been sealed to protect patient confidentiality.

III. Post-Hearing Admissions to the Record

- A. At the request of the State, the following additional exhibit is hereby admitted to the record:

State's Exhibit 25: Transcript of a deposition of Dr. Rajan taken on August 22, 1991 for the case entitled *[Wife of Patient 1], Administratrix of the Estate of [Patient 1], Deceased, v. Semur P. Rajan, M.D. and Peoples Hospital, Inc.*, in the Common Pleas Court of Richland County, Ohio. (285 pp.) (Note: This exhibit has been sealed to protect patient confidentiality.)

- B. At the request of the Respondent, the following additional exhibits are hereby admitted to the record:

1. Respondent's Exhibit 25a: Excerpt from Respondent's Exhibit 25, consisting of a section entitled "Exposure of the Gallbladder."
2. Respondent's Exhibit 25b: Excerpt from Respondent's Exhibit 25, consisting of a December 11, 1989 letter to Andrew Pultz, M.D., from Jack M. Lomano, M.D. and E. Christopher Ellison, M.D.
3. Respondent's Exhibit 25c: Excerpt from Respondent's Exhibit 25, consisting of pages 1 and 6 of a report entitled "Safety and Efficacy of Laparoscopic Cholecystectomy." (2 pp.)

- C. On the Hearing Examiner's own motion, the following exhibits are hereby admitted to the record:

1. Board Exhibit A: Transcript of deposition of Dr. Matyas on May 10, 1995, constituting Respondent's surrebuttal. (5 pp.)
2. Board Exhibit B: State's closing argument. (8 pp.)
3. Board Exhibit C: Respondent's closing argument. (10 pp.)

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4. Board Exhibit D: June 1, 1995 Entry granting the Respondent's request for an extension of the deadline for filing documents to June 5, 1995.
5. Board Exhibit E: State's June 5, 1995 Motion for the admission of State's Exhibit 25. (2 pp.)

PROCEDURAL MATTERS

1. The hearing record in this Matter was held open until June 2, 1995, in order to give the Respondent the opportunity to depose Dr. Matyas on surrebuttal and to allow the parties time to prepare written closing arguments. This deadline was later extended to June 5, 1995. The hearing record in this Matter closed on June 5, 1995.
2. The State's June 5, 1995 motion for the admission of State's Exhibit 25 is hereby granted.
3. Following a telephone conference with the parties' representatives on August 10, 1995, it was decided that the Respondent would withdraw Respondent's Exhibit 23, which consisted of an anatomical chart.
4. Copies of all the videotape exhibits (State's Exhibits 11 and 24 and Respondent's Exhibits 21 and 22) have been copied and will be distributed to the Board Members.

SUMMARY OF THE EVIDENCE

All transcripts and exhibits, whether or not specifically referred to hereinafter, were thoroughly reviewed and considered by the Hearing Examiner prior to his findings and recommendations in this Matter.

1. The following physicians testified in this matter:
 - a. Edwin Christopher Ellison, M.D., testified as an expert on behalf of the State of Ohio. Dr. Ellison is a general surgeon, and was certified by the American Board of Surgery. He obtained his M.D. in 1976 from the Medical College of Wisconsin at Milwaukee, and did surgical residency at Ohio State from 1976 to 1983, including two years research in gastrointestinal problems and diseases. Dr. Ellison was licensed to practice medicine in Ohio in 1977. He is the Chief of the Division of General Surgery at Ohio State University. He serves as the Zollinger Chair of Surgery, and is responsible for running the surgical residency program at Ohio State. Approximately 85 - 90% of Dr. Ellison's time is

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spent in clinical practice. The remainder is administrative. His curriculum vitae was admitted to the record as State's Exhibit 14. (Tr. 18-21) He served as a reviewer for Peer Review Systems of Ohio for about four years. He has served on the Quality Assurance Committees at OSU Hospital and Grant Hospital. (Tr. 25-26) Dr. Ellison has performed over 2,000 laparoscopic cholecystectomies in his career. (Tr. 153)

In preparing for his testimony in this case, Dr. Ellison reviewed the hospital records of Patient 1 from Peoples Hospital and Mount Carmel Hospital, and the autopsy report from Mount Carmel. He also reviewed the videotape of the operation. Dr. Ellison identified State's Exhibits 9 through 13 as records he reviewed for this case. (Tr. 27)

- b. John A. Matyas, M.D., testified as an expert on behalf of the Respondent. Dr. Matyas is a general surgeon, and was certified by the American Board of Surgery. He obtained his M.D. in 1975 from the Ohio State University. He did a surgical residency at Riverside Methodist Hospital, Columbus, Ohio, from 1975 to 1979. Dr. Matyas teaches residents and Ohio State University medical students at Riverside. His practice is about 99% clinical. Dr. Matyas testified that he is regularly contacted to review the charts of other surgeons. Dr. Matyas testified that he has performed between 700 and 1,000 laparoscopic cholecystectomies since 1990. Dr. Matyas' curriculum vitae was admitted to the record as Respondent's Exhibit 4. (Respondent's Exhibit 4 and Tr. 190-195)

In preparing for his testimony in this case, Dr. Matyas reviewed the videotape of Patient 1's surgery, as well as the medical records for this case and six other laparoscopic cholecystectomies performed by Dr. Rajan. (Tr. 196-197, 207)

- c. Semur P. Rajan, M.D., testified on his own behalf. Dr. Rajan is a general surgeon, and was certified by the American Board of Surgery. He has practiced in Mansfield, Ohio for 24 years. Dr. Rajan obtained his medical education at Stanley Medical College, Madras, India, in 1961. Dr. Rajan did one year of surgical training in India before coming to the United States in 1963. He did his first year of surgical residency at Mansfield General Hospital, and his second, third, and fourth years of residency at Lutheran Medical Center, which is affiliated with Metro General Hospital, Cleveland, Ohio. He completed this residency in 1967. He completed a preceptorship residency under Dr. James Jackson at Mansfield General Hospital in 1968. From 1967 until 1971, Dr. Rajan lived and worked in Canada, returning to Mansfield in 1971. Dr. Rajan testified that he has performed between 9,000 and 10,000 surgeries in his career. He has performed between 500 and 600 open cholecystectomies. Dr. Rajan curriculum vitae was admitted to the record as Respondent's Exhibit 1. (Respondent's Exhibit 1; Tr. 282-294, 397)

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- d. James B. Jackson, M.D., testified on behalf of Dr. Rajan. Dr. Jackson is a general surgeon who practices in Mansfield, Ohio, and was certified by the American Board of Surgery. He obtained his M.D. from the Ohio State University in 1956. He did one year of internship at Akron City Hospital, and a surgical residency at Akron City Hospital from 1959 to 1964. Dr. Jackson's curriculum vitae was admitted to the record as Respondent's Exhibit 2. (Tr. 387-392)
2. Dr. Matyas stated that laparoscopic cholecystectomy was first performed in France in 1987, and was brought to the United States in 1989. Its history in the United States began in Nashville. It quickly became popular, and was being performed in Ohio by the end of 1989. Dr. Matyas stated that the procedure was first performed at Riverside Hospital, Columbus, Ohio, in May 1990. (Tr. 195-196)

Dr. Ellison stated that laparoscopic cholecystectomy was made possible by the development of a video camera that was small enough to be attached to a laparoscope. Dr. Ellison identified some exhibits to assist the Board in understanding how this procedure is performed, specifically State's Exhibit 19, which consists of some pictures of different stages of this procedure, and State's Exhibit 24, which is a videotape made in January, 1995 for the Ohio Medical Education Network, which features a laparoscopic cholecystectomy performed by Dr. Ellison. The recording of the procedure was edited down to about 10 minutes from the actual 40 minute duration of the procedure. The surgery begins at about 34 minutes and 15 seconds (34:15) into the video, and lasts until approximately 46:00. The remainder of the tape, before and after the procedure, consists of discussions concerning this type of surgery. State's Exhibits 16, 17, and 18 are anatomy charts that show the normal anatomic relationship in the area of the gallbladder. (Tr. 30, 37-42)

Dr. Ellison referred to the second picture on State's Exhibit 19 which shows the setup of the operating team: a camera operator, who can be a nurse, medical student, or another physician; a surgical technician or scrub nurse; the surgeon, who usually stands on the patient's left; and the assistant surgeon, who usually stands on the patient's right. (Tr. 32)

The first part of the operation begins with an incision made near the umbilicus. The abdomen is insufflated with carbon dioxide in order to create a bubble in which to operate. A trocar is then inserted through the incision, and the laparoscope with the attached video camera and light source is inserted through the trocar. This can be seen in State's Exhibit 24 at 36:25. After the camera is inserted, the three operating ports are inserted under direct vision. The first trocar is placed in the subxiphoid position, just below the breast bone. The second is the midclavicular trocar, placed under the rib cage to the right of the midline. The third is the anterior axillary line trocar which is placed in the right lower quadrant much further laterally. The positions of the ports can be seen in the first picture in the upper left-hand corner of State's Exhibit 19.

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The process of inserting these trocars can be seen on State's Exhibit 24 at 36:50 to 37:35. (Tr. 30-32) Most of the surgical dissection during the procedure is done through the subxiphoid port. The other two operating ports are used to retract the gallbladder to expose the area of concern. (Tr. 32-33)

The second part of the operation then begins. The operating field does not present itself in the neat and tidy arrangement generally depicted in anatomical charts, and the cystic duct and cystic artery are often covered with fatty material and adhesions. In order to expose the cystic duct, which runs from the gallbladder to the common bile duct, the gallbladder is retracted up and towards the patient's right shoulder by grasping the top of the gallbladder with a grasping forcep and applying traction. The neck of the gallbladder is then grasped with another forcep and retracted laterally (toward the patient's right) in order to stretch out the cystic duct. The cystic duct, which is usually about 2 cm. long, is then identified and the fatty material dissected away to expose a segment of one or two centimeters. (State's Exhibit 17, State's Exhibit 19, picture 3; State's Exhibit 24 at 37:35 to 39:15; Tr. 34-35, 49) The cystic duct is then clipped; two clips are placed on the side that will remain with the patient to prevent bile leakage from the common bile duct, and one clip is placed on the gallbladder side. (State's Exhibit 19, bottom left hand picture; State's Exhibit 24 at 39:15 to 39:25 and 41:10 to 41:30) Scissors are introduced through the main operating trocar, and the cystic duct is sharply divided. Once this has been accomplished, the cystic artery is usually apparent. (State's Exhibit 24 at 41:30 to 41:40; Tr. 35) The cystic artery is then clipped, using two clips on the side of the artery that remains with the patient and a single clip on the gallbladder side. The cystic artery is then sharply divided with scissors. (State's Exhibit 24 at 41:40 to 42:25; Tr. 35)

After the cystic duct and cystic artery have been cut, the gallbladder is separated from the liver bed using electrocautery or laser. Dr. Ellison testified that laser was frequently used in 1990 because there was no other way to introduce heat energy into the abdominal cavity. Since that time, however, electrocautery instruments have been proven to be superior to laser. The heat energy generated by these devices provides coagulation of small blood vessels as well as separation and cutting ability. During the surgery recorded in State's Exhibit 24, Dr. Ellison used an electrocautery device for this purpose. (State's Exhibit 24 at 42:55 to 43:55; Tr. 35-36)

Once the gallbladder is separated from the liver bed, it can be removed through either the subxiphoid or the umbilical port. This is the third part of the surgery. Oftentimes the gallbladder is packed with stones, which make it too large to pull through the small incision. If this is the case, the neck of the gallbladder can be pulled through the abdominal cavity, the gallbladder opened, and the stones removed using a special instrument. After the gallbladder is removed from the abdominal cavity, the operating area is inspected to be sure that there is no bleeding or bile staining, and the incisions are closed by standard surgical technique. The patient is usually admitted to the hospital for

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observation overnight. (State's Exhibit 19, bottom right hand picture; State's Exhibit 24 at 34:10 to 45:15; Tr. 36-37)

3. Dr. Ellison stated that this area of human anatomy is one in which physical anomalies are commonly encountered. The cystic duct is normally 2 cm., but it can be 1 cm. or less, making it difficult to separate it from the common bile duct. Dr. Ellison said this is the most common variation that he sees. Additionally, the cystic artery can branch off from various anomalous sites. Normally, about 75% of the time, the cystic artery comes off the right branch of the hepatic artery. Sometimes, however, it branches off from the common hepatic artery or one of the gastric arteries. Another anomaly seen is when the right hepatic artery branches off the common hepatic artery very low. Dr. Ellison testified that the surgeon must proceed with caution and expect variations, "and if you have any question about it, then convert to an open operation or do a cholangiogram and find out what is going on." (Tr. 48-50)
4. Dr. Ellison testified regarding indications for converting a laparoscopic procedure to an open procedure. The clear indications for opening the patient include:

- Uncertainty on the part of the surgeon in cases where the anatomy is abnormal.
- A recognized injury to the common bile duct. The patient must be opened so that the bile duct can be repaired.
- Bleeding that cannot be controlled easily by placing a clip on a single vessel. Dr. Ellison teaches his students and residents that if bleeding cannot be controlled with either pressure or coagulation, or if you don't have a single vessel that you can easily see, hold up, and clip, the patient must be opened. One of the problems faced by surgeons when performing laparoscopic procedures is that it is difficult to control bleeding. After the patient is opened, however, the surgeon can use large irrigators, sponges, packs, and pressure. The surgeon can identify what's bleeding, dissect everything out, and see the anatomy in three dimensions.

(Tr. 50-51, 83, 94-95, 434)

5. Dr. Ellison testified that Patient 1 suffered from symptomatic gallbladder disease with biliary colic. In layman's terms, Patient 1 had gallstones. The treatment at that time (late 1990) was cholecystectomy—removal of the gallbladder—by either a laparoscopic approach or an open approach. (Tr. 28-29) On or about September 28, 1990, Dr. Rajan recommended that Patient 1 have his gallbladder removed laparoscopically. Patient 1 consented to the procedure, which was performed on December 11, 1990. (State's Exhibit 9, pp. 3, 19-21, 26)

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6. Dr. Ellison stated that Patient 1's surgery appeared to be pretty standard up to about 4:15 on the videotape (State's Exhibit 11). (State's Exhibit 11 is a videorecording of the actual procedure.) At 4:15, the top of the gallbladder was being grasped by the anterior axillary line forcep. Dr. Ellison noted that the gallbladder was retracted straight up rather than up and laterally. As a result, the cystic duct was not stretched out. This makes it difficult to identify the cystic duct in a normal situation; the cystic duct in this case was very short, making it even more difficult. After the neck of the gallbladder was grasped with another grasping forcep, the direction of the retraction of the gallbladder did not significantly change. (State's Exhibit 11; Tr. 60-63)

Dr. Ellison noted that, at 5:49, the structure visible at the bottom of the screen is the duodenum, which was abnormally adherent to the gallbladder due to inflammation of the gallbladder. (State's Exhibit 11, Tr. 62-63)

At 6:20, Dr. Rajan can be seen removing adhesions in a normal fashion. Dr. Ellison noted that there was minimal bleeding of the adhesions, which was evidence of a lack of portal hypertension and/or varices. Dr. Ellison testified that when varices exist, they often exist in these adhesions. In Dr. Ellison's opinion, if Patient 1 had varices or portal hypertension, there would have been a lot more bleeding than can be seen at this time on the video. Dr. Ellison testified that the amount of bleeding seen at approximately 7:30 is typical for this operation. (State's Exhibit 11; Tr. 63-64)

At 7:59, Dr. Ellison testified that he believed Dr. Rajan was attempting to find the cystic duct. However, because the gallbladder was being pulled straight up, and not out to the side, Dr. Rajan was looking in the wrong place. At 9:22, Dr. Ellison stated that the cystic duct was actually superior and medial to where Dr. Rajan was working. Dr. Ellison noted that the fact that the duodenum was constantly visualized was a clue to the surgeon that he was in the wrong place. Dr. Ellison stated that if Dr. Rajan had retracted the gallbladder laterally, Dr. Rajan probably would have seen the actual location of the cystic duct. (State's Exhibit 11; Tr. 64-66)

At 11:04 on State's Exhibit 11, Dr. Ellison noted that the common bile duct was being dissected out, which means that it was being separated from surrounding tissue such as adhesions and fatty tissue. The common bile duct is an essential organ that delivers bile into the duodenum from the liver. Injury to the common bile duct is a recognized complication of laparoscopic cholecystectomy, and it is within acceptable standards to have an injury to that structure. Nevertheless, the surgeon must recognize that the injury occurred, and repair it. At 13:45, Dr. Ellison noted that it was not yet mandatory to open the patient. The amount of blood loss visible at this point is normal. Dr. Ellison indicated that there were no varicosities visible on the duodenum. (State's Exhibit 11; Tr. 67-69)

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At 14:40, clips were applied to the common bile duct. Dr. Ellison testified that there were a lot of clues that this was the wrong structure: 1) it was close to the duodenum; 2) the gallbladder was being retracted straight up; and 3) it is significantly longer than a cystic duct. A cystic duct is typically about 2 cm.; this structure appears to be about 3 or 4 cm. Dr. Ellison referred to State's Exhibit 21, which shows Patient 1's gallbladder being retracted up and the common bile duct clipped. Dr. Ellison drew attention to the fact that the cystic duct was extremely short. Between 14:30 and 15:10, Dr. Rajan clipped the common bile duct with two clips. At 15:30, he used scissors to cut the common bile duct between the two clips. (State's Exhibit 11; Tr. 69-73)

At about 17:00, Dr. Ellison noted that the next step for the surgeon would be to identify the cystic artery, but Dr. Rajan was in the wrong place; the dissection was being done on the left side of the gallbladder. Dr. Ellison noted that the liver appeared to be normal. At approximately 19:12, a clip came off of the bile duct and some bile escaped. Dr. Rajan reclipped. Dr. Ellison testified that this is a common occurrence, and not a problem, unfortunately, in this case, the clip was on the common bile duct. Dr. Ellison noted the artery being revealed at this time is the right hepatic artery. One can follow its course directly into the right lobe of the liver. It is larger than a cystic artery would be. At 21:00, Dr. Ellison believes that Dr. Rajan recognized that this structure was not the cystic artery. Dr. Ellison referred to State's Exhibit 22 as illustrative of the situation at this point. At 21:36, Dr. Ellison stated that he thinks Dr. Rajan was looking for the cystic artery. Normally, the cystic artery branches off the right hepatic artery. In this case, it does not, which is an anomaly. (State's Exhibit 11; Tr. 74-79)

At 25:00, Dr. Ellison testified that the duct that was cut is attached to something more than just the gallbladder. In three dimensions it is running into the TV set. This is an indication that the wrong duct has been cut. (State's Exhibit 11; Tr. 80)

Dr. Ellison observed, at 26:15, that one can see the gallbladder being pulled straight up. At 27:00, Dr. Rajan appeared to be working on a small arterial branch coming from the right hepatic artery and going up into the area of the gallbladder or bile duct. At 28:23, a clip applier was applied to the small branch artery. Dr. Ellison didn't know if Dr. Rajan believed that this was the cystic artery, but thinks that Dr. Rajan knew that it was a small blood vessel that would bleed if it was not clipped. At 29:18, Dr. Rajan used scissors to cut the small blood vessel. (State's Exhibit 11; Tr. 81-82)

At approximately 29:48, Dr. Rajan used scissors to dissect fatty tissue overlying the porta hepatis, which, Dr. Ellison testified, is an area where the bile ducts, hepatic arteries, and portal vein are located. Dr. Ellison testified that such use of scissors was not appropriate. It would have been preferable to use blunt dissection, because, "for example, if he hadn't seen that [small blood vessel] and he cut inadvertently into that blood vessel there, it could have bled significantly ... one of the problems with laparoscopy is it's difficult to control

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bleeding. You can't put your finger in there to stop the bleeding, or you can't put a clamp on it directly, so you have to be very careful, and I—we err on the side of being safe in these cases." Dr. Ellison believes, however, that there are other surgeons who use scissors in this manner. (State's Exhibit 11; Tr. 82-83)

At 31:37, Dr. Ellison noted that Dr. Rajan was working in the appropriate area. At 32:00, the structure visible in the middle of the screen is the cystic artery, which Dr. Ellison stated branched off the common hepatic artery, which was an anomaly. At 33:20 a hook was introduced to clean the artery off to allow it to be clipped and cut. At 34:36, the clip applicator is used to apply clips to the cystic artery. At 35:46, the cystic artery was cut. (State's Exhibit 11; Tr. 84-87)

After the cystic artery was divided, a laser was introduced to separate the gallbladder from the liver. Dr. Ellison testified that laser was used for cutting, and for coagulating small blood vessels. The device cannot coagulate big vessels. At 37:35, excessive bleeding begins. Dr. Ellison testified that he could not tell where the bleeding was coming from, but knew that it was venous bleeding because it was not pumping. It flowed at a relatively low pressure. Dr. Ellison testified that venous bleeding is just as dangerous as arterial bleeding. Sometimes it is more dangerous, because the surgeon cannot see where it's coming from. It pools and obscures things. Dr. Rajan attempted to control this bleeding with laser. Dr. Ellison testified that, at 38:00, Dr. Rajan should have opened the patient to control the bleeding. Dr. Ellison stated that Dr. Rajan could not see the structures under the pool of blood. (State's Exhibit 11; Tr. 88-90)

Dr. Ellison testified that, at 39:00, a suction device was introduced to remove blood so Dr. Rajan could locate the source of the bleeding. Dr. Ellison noted that, at 40:00, the bleeding had slowed down, but there was a lot of clot in the area. Dr. Ellison testified that he definitely would have opened at this time, even though the bleeding had stopped. A clot forming on the top of the vein would stop the bleeding, but if that clot were knocked off, the bleeding would start again. At 42:04, Dr. Ellison noted that a fifth trocar was inserted. Although this was not inappropriate, it was not reflected in the post-operative note. He speculated that the purpose was to attempt to identify or grasp the bleeder. (State's Exhibit 11; Tr. 90-93)

Dr. Ellison noted that there was a lot more blood visible at 44:00 than four minutes previously, which indicated that the patient had not completely stopped bleeding. Dr. Ellison noted that blood flows in the direction of gravity and would not come up in front until the spaces behind the liver are filled. Dr. Ellison stated that this patient should be opened "[b]ecause of the bleeding that's present and the risk to the patient." These risks include shock, low blood pressure, and damage to surrounding structures because the surgeon could not see anything. The anatomy was obscured by the blood. (State's Exhibit 11; Tr. 93-94)

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Dr. Ellison stated that at 46:35 Dr. Rajan pulled some clot out. At that time he was working underneath the gallbladder. As shown in State's Exhibit 23, the gallbladder was then being retracted more laterally. Dr. Ellison noted that the tubular structure running behind all of these structures is the portal vein, which is a very large blood vessel. Dr. Ellison opined that the bleeding was either coming from the portal vein directly or from the small venules around it. The dissection was taking place directly on top of the portal vein, probably the right branch of the portal vein. This was not the correct field in which to be operating. Dr. Ellison testified that this was a very dangerous area, because the portal vein is a large blood vessel, "and cutting into it is lethal." (State's Exhibit 11; Tr. 95-97)

Dr. Ellison noted that, at 48:13, Dr. Rajan's visualization was impaired by the blood and by the smoke from the laser. Dr. Ellison estimated that 500 cc. (one unit) of blood had been lost by this time. (State's Exhibit 11; Tr. 98-99)

At 50:20, Dr. Ellison noted that the laser tip was inserted. The laser was a neodymium YAG laser. At 50:46, "Very, very serious" bleeding begins. Dr. Ellison stated that this was, without question, portal vein bleeding. Dr. Ellison has seen such bleeding before while doing oncological abdominal surgery. The blood can be seen pouring out. (State's Exhibit 11; Tr. 100)

At 51:25, a clip was applied to try to stop the bleeding. Dr. Ellison stated that this was a mistake. Dr. Rajan could not see where the blood was coming from, and a surgeon should never clip any structure that cannot be seen. At this point, Dr. Ellison said he would have stuffed a big wad of Surgicel (a hemostatic agent) through a trocar, "as much as I could have against that area and applied pressure; called the blood bank, told them to get blood in the room; called another surgeon; continued to have an assistant or somebody hold pressure on that area; and then opened the patient if we got to that point." (State's Exhibit 11; Tr. 100-101)

At 53:00, blood was still pouring out. At 53:17, Dr. Rajan used a grasping forcep to grab the anterior surface of the portal vein. Dr. Ellison stated, "That is not bleeding from varices. That--I mean, there are no varices in this case. That's the portal vein." (State's Exhibit 11; Tr. 101-102)

At 54:00, the bleeding had slowed. At 55:22, Dr. Ellison noted that this was too much bleeding. He testified that there was no way to control this bleeding laparoscopically. "There was no way in 1990. There is no way in 1995." At 58:40, the patient was still bleeding. At 59:15, Dr. Rajan converted to open. Dr. Ellison testified that he saw no evidence of portal hypertension. In his review of the records, he saw no condition that would support a diagnosis of portal hypertension. (State's Exhibit 11; Tr. 102-105, 108-109)

7. On December 14, 1990, Patient 1 was transported by Life Flight to Mt. Carmel Hospital, Columbus, Ohio. (State's Exhibit 10, p. 4) On December 17, 1990,

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Patient 1 died. (State's Exhibit 12, p. 4) The Certificate of Death prepared on December 18, 1995 listed as causes of death: shock and multisystem organ failure. (State's Exhibit 13)

8. Dr. Ellison testified that Dr. Rajan's treatment of Patient 1 fell below the minimal standards of care of similar practitioners under the same or similar circumstances. Dr. Ellison believes that a similar practitioner would have opened the patient earlier than Dr. Rajan did. He testified that there were several times during the procedure in which the patient should have been opened. First, when the bile duct injury occurred. Dr. Ellison testified that it was below the standard of care not to recognize that the bile duct had been severed. Second, when the anatomy proved to be confusing. He testified that it is not below minimal standards to be confused by a patient's anatomy, but it is below minimal standards not to recognize it and open. Third, when the bleeding commenced after the laser was brought in, Dr. Rajan should have opened the patient in order to control the bleeding. He further testified that it was below the standard of care to insert blind clips after the bleeding started. (Tr. 125-127)

Dr. Ellison testified that the biggest problem he saw in this case was that the patient essentially bled to death. He should have been opened earlier and the bleeding controlled with standard surgical techniques. "And although laparoscopic surgery was new at the time this procedure was done, it still falls within the realm of the practice of surgery, in which case the patient's safety is the number one thing, and that standard was broken." (Tr. 439)

Dr. Ellison testified that if Dr. Rajan had correctly identified the cystic duct earlier in the surgery, he probably would not have been operating in the wrong location later on. However, Dr. Rajan did not recognize that the common duct had been cut, and this eventually led him to the incorrect area where he was operating later in the surgery. Dr. Ellison testified that it was like a domino effect: one mistake was made, which led to another, and the situation continued getting more complicated as Dr. Rajan went along. (Tr. 97)

Dr. Ellison testified that it was not reasonable for Dr. Rajan to believe that Patient 1's bleeding was caused by injury to the liver surface or gallbladder surface because there was too much bleeding. The blood in such an injury would not come out like a fountain. (Tr. 180) Dr. Ellison testified that he has experienced bleeding from the liver bed during his surgeries. In Patient 1's case, this was not liver bed bleeding. A surgeon on his 21st laparoscopic cholecystectomy in 1990 should have realized that he could not control this bleeding with laser or clips laparoscopically because of the volume of bleeding. He testified that Dr. Rajan had adequate experience to know when the surgery was going normally and when it was not. He should have made the decision to open the patient for the patient's safety. "That is the standard. The is the essential standard." Dr. Ellison testified that Dr. Rajan failed to meet this standard. (Tr. 425-431)

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Dr. Ellison agreed that bleeding coming from the liver bed or gallbladder bed could have been more easily controlled. If the surgeon mistakenly believed that he was in that area, it could lead him to believe that it's not necessary to open the patient immediately. Nevertheless, if the bleeding is persistent, or comes and goes and the surgeon cannot find where it's coming from, the patient should be converted to an open operation. Dr. Ellison testified that, "There is no question that, during the course of this operation, this patient should have been opened far earlier than he was eventually opened." (Tr. 161-163) Dr. Ellison testified that, even if the surgeon misunderstood where the bleeding was coming from, "in this case, you were beyond what was reasonable and acceptable in terms of bleeding." (Tr. 163) Dr. Ellison testified that no matter what the cause, such serious bleeding could not be controlled laparoscopically. (Tr. 165)

9. Dr. Ellison testified that he reviewed the information concerning Dr. Rajan's training for the procedure, and is aware of the articles and tapes that Dr. Rajan reviewed as part of that training. Dr. Ellison had helped assembled those training materials, and was involved in the seminar that Dr. Rajan attended in July of 1990. The seminar took place at the Grant Laser Center. Dr. Ellison testified that the seminar was two days long, and included one day of didactic and skills training, and one day of animal and black box simulation.

He testified that the students were taught of the warning sign of the duodenum appearing in front of the camera, and of difficulties in seeing ductal structures. He testified that they were taught to retract the gallbladder laterally, "to stretch out the cystic duct and make that area more clear...." (Tr. 425-428)

Part of the training involved the use of laser, however, this course alone would not qualify a surgeon to use laser. He testified that the students in the seminar were informed of that fact. (Tr. 177) Laser was used during the course to take gallbladders out of pigs, and participants were allowed to practice using the laser on pieces of chicken. The portion of the training focusing on laser lasted about 45 minutes. Dr. Ellison testified that there was a separate laser course that was itself two days long, and focused completely on the application of laser and its appropriate uses. (Tr. 139-145)

Dr. Ellison testified that the training seminar did not enable physicians to go out and use a laser. He testified that the students in the seminar were informed of that fact. (Tr. 177) Dr. Ellison testified that a laser was not indicated in this case to stop the bleeding, because it cannot penetrate the blood and seal a surface. It is likely to cause more damage. Dr. Ellison testified that it was below the minimal standards of care to use a laser as Dr. Rajan did in this case. (Tr. 178-179)

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Dr. Ellison testified that he was not aware whether Dr. Rajan had worked with another surgeon on his first few cases. Whether or not such knowledge would be important would depend on the qualifications of the person that he would have been working with. If that person was an expert in laparoscopic cholecystectomy, it would be important. If that person was also learning the procedure, then it would not. Nevertheless, Dr. Ellison testified that he believes at the time the surgery was performed, that Dr. Rajan had adequate experience. (Tr. 145-147)

10. In Dr. Rajan's post-operative report, he listed a preoperative diagnosis of "Chronic cholecystitis, cholelithiasis with biliary colic." His post-operative diagnosis was "Same. Extensive varicosities on the surface of the liver due to probably portal hypertension secondary to ethanol intake." (State's Exhibit 10, p. 111) Dr. Ellison disagreed with Dr. Rajan's post-operative diagnosis. Dr. Ellison testified that one would not see such varicosities on the surface of the liver. Instead, they would be seen on surfaces surrounding the liver, such as the round ligament and the omentum. Dr. Ellison stated that varicosities are very dilated veins that don't require magnification to see. They are tortuous and usually quite large. Dr. Ellison noted that Patient 1's liver appeared to be normal, with no cirrhosis. The veins on the colon mesentery were normal, as well as the veins in the round ligament. Dr. Ellison testified that he saw no evidence of varicosities. (State's Exhibit 11; Tr. 58-59) He testified that a similar practitioner would have recognized that there were no varicosities or evidence of portal hypertension. (Tr. 112)

Although Dr. Ellison did not believe that Dr. Rajan's operative note accurately reflected what was seen on State's Exhibit 11, Dr. Ellison stated that he did not believe that Dr. Rajan was intentionally saying anything untrue. (Tr. 128, 174-175)

Dr. Ellison disagreed with a statement included in that report [following the heading "Procedure in Detail"] that said, "The exploration through the camera revealed there is considerable amount of varicosities noted in the port of hepatis as well as near the liver." (State's Exhibit 10, p. 111; Tr. 113) Dr. Ellison testified that there were no varices present on the videotape. (Tr. 113) Further, he disagreed with the statement "There were a considerable amount of varicosities over the port of hepatis and [Dr. Rajan] felt that this could be controlled with cautery." (State's Exhibit 10, p. 111; Tr. 115) Moreover, Dr. Ellison disagreed with the statement "It was found there was considerable amount of varicose veins draining into the port of hepatis from the superior edge of the duodenum on either side of the portal vein. This was all bleeding in different areas." (State's Exhibit 10, p. 112; Tr. 116) He testified that if this statement were true, Dr. Rajan would have gotten bleeding much earlier. Dr. Ellison said the literature states that if you find severe evidence of portal hypertension, you need to consider opening the patient and not doing a laparoscopic cholecystectomy because of potential bleeding. Finally, Dr. Ellison disagreed with the statement "This bleeding was finally controlled and the liver

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had some fatty metamorphosis [sic] but there was no gross liver which I believe the patient has a pre-existing portal hypertension." (State's Exhibit 10, p. 112; Tr. 116-117) Dr. Ellison testified that he saw no evidence of fatty metamorphosis of the liver, which would have given it a yellow appearance. Dr. Ellison did not see evidence on the videotape that Patient 1's liver had been damaged by drinking. (Tr. 117-118)

Dr. Ellison testified that after the patient was transferred to Mt. Carmel Hospital, Dr. Rajan's post-operative records would have been reviewed by the physicians there. These physicians would make decisions based on Dr. Rajan's records. Dr. Ellison testified that he does not believe that those records were accurate, as far as varicosities and portal hypertension are concerned. In Dr. Ellison's opinion, these inaccuracies may have changed the way the patient was managed at Mt. Carmel. (Tr. 118-120)

On cross-examination, Dr. Ellison testified portal hypertension can contribute to significant bleeding during surgery. (Tr. 169) Dr. Ellison acknowledged that there were parts under the surface of the liver that could not be seen on State's Exhibit 11. (Tr. 171-172) Dr. Ellison acknowledged that you cannot tell from the videotape whether or not a vein was brittle or easily torn, and further acknowledged that an easily torn brittle vein would be considered a varicosity. Nevertheless, Dr. Ellison testified that isolated varicosities are unusual; they usually occur in bunches. (Tr. 172)

11. Dr. Matyas described laparoscopic cholecystectomy as "a safe but tricky surgery." (Tr. 198) It is safe because the patient is under a general anesthetic and the amount of blood loss is low. It is tricky because the surgeon can see only in two dimensions, and loses the ability to feel with his or her fingers. A surgeon needs time to get used to this type of surgery. There is a steep learning curve. The surgeon must have hands-on experience with humans. More complications are associated with the procedure early in a surgeon's experience. The most worrisome complications, although not the most common, are accidental ligation of either the common bile duct or the hepatic artery. Dr. Matyas testified that with laparoscopic surgery, the surgeon, "can retract the gallbladder much easier than you could with the open surgery and you can make the bile duct go up in a more rounded fashion to make it look like it's the cystic duct rather than the common duct." (Tr. 198-201)

Dr. Matyas testified that, about a third of the time, the surgeon runs into anatomic anomalies. (Tr. 199) The size of the common bile duct is very variable. The point of attachment of the cystic duct to the common bile duct is variable. The size of the common bile duct can be about the same size as that of the cystic duct. Dr. Matyas testified that by insufflating the abdomen, the surgeon actually has more room to work than he or she would in an open procedure. The additional retraction that this allows can pull the common bile duct up and make it look more like the cystic duct. Dr. Matyas testified that it

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took time to recognize this, which he believes would have been a common problem in December 1990. (Tr. 202-204)

Dr. Matyas testified that injuries to the hepatic artery can occur because 30% of the time it is not in the normal location. (Tr. 205)

12. Dr. Matyas testified that he is familiar with Dr. Rajan's treatment of Patient 1. He reviewed the videotape of the procedure, and saw mistakes. Dr. Matyas testified that the common bile duct was retracted up and made a "U" configuration. This gave it the appearance of being the cystic duct. It was then mistakenly divided. When the gallbladder was pulled up, the common bile duct appeared to be going into the gallbladder. This occurred primarily because of the retraction, and also because the cystic duct was very short. Dr. Matyas testified that, "if the cystic duct is short and you pull up on it, that will pull the common bile duct up where it shouldn't be, or make it look more like the cystic duct." (Tr. 207-208)

Dr. Matyas testified that the second mistake was that the hepatic artery was mistaken for the cystic artery, and divided. Dr. Matyas testified that it was in an anomalous location. (Tr. 209) [Note: The State's expert, Dr. Ellison, testified that the cystic artery, not the hepatic artery, was divided. (Tr. 84-87)]

Dr. Matyas testified that Dr. Rajan was between one half-inch to one inch from where he should have been. Dr. Matyas testified that it did not appear that Dr. Rajan recognized the common bile duct injury during the surgery. Dr. Matyas testified that, because this was Dr. Rajan's twenty-first laparoscopic cholecystectomy case, it was reasonable that Dr. Rajan would not recognize the injury to the common bile duct. Dr. Matyas testified that the first time he watched the tape, he thought Dr. Rajan did it correctly. (Tr. 210-211)

13. Dr. Matyas testified that the duodenum in the visual field would not, in 1990, have alerted a physician that he was in the wrong place, because people's sizes are so different and laparoscopy was still new. (Tr. 212)
14. Dr. Matyas was asked if it was medically acceptable that, in 1990, Dr. Rajan got lost on his twenty-first case, and did not recognize he got lost. Dr. Matyas testified that at that time it was unknown what was medically acceptable and what was not. Surgeons just began doing the procedure, and no one knew the guidelines. He testified that surgeons got lost in 1990, and are getting lost in 1994. Dr. Matyas brought a videotape to the hearing of a laparoscopic cholecystectomy that he performed approximately two weeks prior to the hearing (Respondent's Exhibit 21). A structure that Dr. Matyas thought was the cystic duct later turned out to be the common bile duct. It appeared to Dr. Matyas as though it was going right into the gallbladder. Dr. Matyas realized what was going on after performing cholangiography. The only reason he did the cholangiogram was because the duodenum seemed to be too close.

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He testified that he would never have recognized that subtle of a clue when he first started doing these procedures. Dr. Matyas testified that his patient also had a very short cystic duct. Dr. Matyas noted that the common duct in his case did not appear any different from a cystic duct in terms of its size. (Respondent's Exhibit 21; Tr. 213-221)

Dr. Matyas testified that he believes that Dr. Rajan's attempts to control the bleeding in this case were acceptable, based upon the location where Dr. Rajan thought he was. Dr. Matyas testified that Dr. Rajan thought he was in the liver bed, below where the gallbladder is attached to the liver. In that area, the surgeon can run into anomalous veins that can cause fairly substantial bleeding, or what appears to be fairly substantial bleeding. Such bleeding can very often be controlled laparoscopically, either with clips or with cautery, about 90% of the time. Dr. Matyas referred to a videotape of a laparoscopic cholecystectomy that he performed within a month prior to the hearing (Respondent's Exhibit 22). In this instance, toward the end of the procedure, while he was separating the gallbladder from the liver bed, Dr. Matyas ran into bleeding which appeared to be quite serious. (Respondent's Exhibit 22 at 12:50 & thereafter) He noted that the bleeder clouded his camera lens. Dr. Matyas quickly controlled the bleeding with pressure by twisting the gallbladder. He suctioned the area to clear the field and remove the smoke. Dr. Matyas tried to use a hemostatic plug, but the plug didn't work. He then tried electrocautery, but that didn't seem to help much either. He then used a bigger plug. This time the bleeding was brought under control. The bleeding lasted for about 20 to 25 minutes, but was under control for about 15 to 18 minutes of that time. The anomalous vein which caused the bleeding in Dr. Matyas' case came off the liver and went into the liver bed. He testified that although this looked like a lot of blood, it really was not that much, less than one half-unit. He said that organs in this area are close together and under magnification. (Respondent's Exhibit 22; Tr. 222-232)

Dr. Matyas testified, based upon the anesthetic record, that Patient 1 was stable at the time Dr. Rajan converted to open. Patient 1 had stable blood pressure and a stable pulse. (Tr. 229) Dr. Matyas testified that laser is not used often to control bleeding today, but that it was used as such in 1990. Dr. Matyas testified that he did not use laser, but that the great majority of surgeons did. Dr. Matyas testified that it is now well known that laser does not control bleeding as well as electrocautery. (Tr. 230, 231-232)

15. Dr. Matyas testified that in his opinion, Dr. Rajan's treatment of Patient 1 was acceptable based on where Dr. Rajan thought he was. When asked for his opinion as to whether Dr. Rajan's treatment of Patient 1 constituted a departure from the minimal standards of care, Dr. Matyas testified, "Once again, I just don't think there was a standard there, so I don't think you can say he was under the standard, not in 1990." (Tr. 232-233) He testified that Dr. Rajan's attempts to control the bleeding laparoscopically did not fall below the standards of care. He testified that the patient was stable and Dr. Rajan

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"was in the same kind of aberrant veins I was into in my case, and what he did appeared to be acceptable for where he thought he was." (Tr. 233-234) It did not appear to Dr. Matyas in viewing State's Exhibit 11 that Dr. Rajan realized he was lost. Dr. Rajan appeared to be proceeding meticulously, not stumbling. Dr. Matyas testified that Dr. Rajan's movements looked good. (Tr. 271)

Nevertheless, Dr. Matyas did not see Dr. Rajan control the bleeding to the point where it would be satisfactory to continue the procedure. He testified that before 50:40 on State's Exhibit 11, the bleeding appeared to be controlled. Dr. Matyas testified that, at 50:40, he would open the patient. When asked if it was below the standard of care for Dr. Rajan to continue laparoscopically for six more minutes, Dr. Matyas testified that he would talk to the anesthesiologist to see how things were going, and if he thought there was a reasonable chance that he could still control it, he would try. However, Dr. Matyas testified that it appeared that Dr. Rajan tried the means that are acceptable, therefore, Dr. Matyas would open the patient at that point. He would want to open the patient while he's still stable. (State's Exhibit 11; Tr. 262-263) He testified that the anesthesia report indicated that there was 500 cc. of blood loss prior to opening. He indicated that, in the next 15 to 20 minutes, the patient lost another 1,000 cc. of blood. (State's Exhibit 10, p. 98; Tr. 264-266)

Dr. Matyas testified that physicians are not trained to retract the gallbladder up and laterally, but rather to expose the Angle of Calot in the safest possible manner. He testified that there was no single, correct standard in this regard. In Patient 1's case, the Angle of Calot was not very well exposed, so the retraction was not optimal. Dr. Matyas stated that retracting the gallbladder up and laterally would be a good way to start. (Tr. 237-241) Dr. Matyas testified that the drawing in State's Exhibit 19 appeared to indicate that the gallbladder was being retracted upward and laterally. (Tr. 243-244) In viewing State's Exhibit 11, the videotape of Patient 1's surgery, Dr. Matyas stated that it appeared, at 6:00, that the gallbladder was being retracted laterally. (Tr. 246) At 7:39, Dr. Matyas testified that the gallbladder was being retracted medially. (Tr. 247) Between 8:00 and 9:00, Dr. Matyas testified that the retraction was acceptable if Dr. Rajan was working on the back of the gallbladder. One might be working in this area to remove adhesions. (Tr. 248)

Dr. Matyas testified that he might try a blind clip if he thought he was in the liver bed where he couldn't hurt anything. However, it would not be his first choice. (Tr. 260)

Dr. Matyas testified that Dr. Rajan's post-operative note was written as though Dr. Rajan thought he had ligated the cystic duct and the cystic artery. (State's Exhibit 10; Tr. 234) Dr. Matyas testified that he did not see any evidence of varicosities on the videotape, but that these would be hard to see on the videotape. He did not see any varicosities around the duodenum.

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Dr. Matyas testified that you cannot see portal hypertension; it has to be measured. Dr. Matyas indicated that portal hypertension is usually caused by cirrhosis, and in his opinion, this patient did not appear to have cirrhosis. (Tr. 268-269)

16. Dr. Ellison agreed in general with Dr. Matyas' statement that the standards for open cholecystectomy applied to laparoscopic cholecystectomy in 1990. However, in the open procedure, the surgeon is never confronted with the decision of whether or not to convert to open. You are already there. There is another decision that needs to be made in laparoscopic procedures. In this respect, he disagrees with Dr. Matyas. (Tr. 452-453)

In response to Dr. Matyas' statement that portal hypertension cannot be seen but must be measured, Dr. Ellison testified that he does quite a bit of surgery on patients with portal hypertension. "You can see it." (Tr. 438) There are large, dilated veins visible around the liver, duodenum, and gallbladder. "You can't actually tell the degree of portal hypertension, but you can say yes or no." Dr. Ellison testified that he saw no such evidence in this case. (Tr. 438)

On the issue of whether or not magnification of the laparoscopic camera could make bleeding look worse than it actually is, Dr. Ellison testified that is all the more reason to open. He testified that most surgeons would be petrified of not opening. (Tr. 455)

17. The anesthesia record of Patient 1's surgery can be found in State's Exhibit 10, pp. 98-101a. The symbol for the beginning of the operation, a circle with a dot in the middle, appears at just before 10:00. About one hour later, just before 11:00, a word that starts Lap... is used. At about this same time, at 11:00, the anesthetist recorded a precipitous drop in Patient 1's blood pressure, down to about 88/50. an estimated blood loss of "7500" is recorded in the quarter-hour space just before 11:00. By 12:00, estimated blood loss was 2500 cc. In the Remarks section, it was noted that Neo-Synepherine was administered "for BP 88/50 mmHg. Blood [illegible] - for type & match." (State's Exhibit 10, p. 98) The surgery lasted until a little after 7:00 p.m. Estimated blood loss at the end of the procedure was 11,000 cc. (State's Exhibit 10, p. 101)

Dr. Rajan testified that the laparoscopic cholecystectomy on Patient 1 began at 11:00 o'clock A.M. The induction of anesthesia occurred at 10:00 o'clock and the temporary drop in blood pressure resulted from that. Dr. Rajan testified that he could not start up the laser and set up instruments until the patient was ready for surgery. (Tr. 368-372)

Dr. Ellison's reading of the medical records was that it appeared that the patient was opened at 11:00 o'clock. The arrow indicates laparotomy. If the patient was opened at 11:00 o'clock, the blood pressure was 88/50, and the patient was not stable. The medical records indicate that the patient received Neo-Synepherine at 11:00 o'clock. Neo-Synepherine is a medication to increase

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the blood pressure. It appeared to Dr. Ellison that the anesthesiologist was making an effort to correct hypotension. By 11:00 o'clock, the patient had 500 cc. of blood loss. The normal blood loss in this procedure is about 10 cc. By 11:30, the patient had lost 2,000 to 2,500 cc. of blood loss. "I don't consider that a stable situation." (Tr. 436-437)

Dr. Matyas testified that "At 10:50—which was approximately five minutes before the patient was [opened]—the blood pressure was 120 over 80 and the pulse was 75. The patient was opened, and five minutes later blood pressure was 90 over 60. So in my opinion, when the patient was [opened], which was—the last recorded blood pressure prior to opening the patient, blood pressure was 120 over 80, which is very stable." (Board Exhibit A, reduced page 6) The drop in blood pressure after opening occurs "[b]ecause there's a certain amount of abdominal pressure created by the abdomen being closed, and that's tamponade. Once you open the abdomen, you drop the intra-abdominal pressure; and it allows for more bleeding..." (Board Exhibit A, reduced pages 6-7)

18. Dr. Rajan testified that he has been a general surgeon for 24 years, concentrating on abdominal surgeries, including thyroid, breast, hernias, hemorrhoids, and trauma. He has performed between 9,000 and 10,000 surgeries during his career. He has had privileges at Peoples Hospital and Mansfield General Hospital for 24 years. He has never been denied a request for privileges during his career, nor had any action against privileges except as a result of not completing charts. He has never before been the subject of any disciplinary action. He has served on various committees and administrative positions, including Chairman of the Department of Surgery, twice at Mansfield General and once at Peoples Hospital. He has been a board member at Peoples Hospital for over 10 years. (Tr. 284-293) Dr. Rajan was on the Credentialing Committee at Peoples Hospital in 1990. He testified that this committee credentialed everyone, including himself. (Tr. 350)

Prior to performing laparoscopic cholecystectomies, Dr. Rajan had experience and training in open cholecystectomies. He had performed approximately 500 to 600 open cholecystectomies. In 1990, Dr. Rajan attended a two-day course in laparoscopic cholecystectomies at Grant Hospital in Columbus, Ohio. The course included using a model and a live anesthetized animal. Dr. Rajan identified Respondent's Exhibit 12 as the information for this course, and Respondent's Exhibit 25 as the course materials. At the seminar, Dr. Rajan was given hands-on training using the YAG laser. Dr. Rajan testified that between 30 and 50 surgeons from all over the country attended the seminar. He recalled that Dr. Ellison was one of the instructors. Dr. Rajan testified that another surgeon who had attended the seminar assisted him in his first six to eight cases, and vice-versa. (Tr. 294-297, 383) Dr. Rajan testified that he had no other training in laser prior to December 1990 other than the Grant Hospital seminar. (Tr. 352)

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Dr. Rajan testified that the open procedure involved an 8 to 10 inch long incision and a long hospital stay. The laparoscopic procedure usually allows the patient to go home the next day, and the patient has less pain and can return to work sooner. There is less scarring. Dr. Rajan described laparoscopic cholecystectomy on pages 299-300 of the transcript. (Tr. 298-300) Dr. Rajan testified that when he began to perform the procedure, it took him about 2 or 2-1/2 hours. He testified that as he has gained experience, it takes less time. Currently, his average time is about 45 minutes to an hour. (Tr. 303)

Dr. Rajan testified that some of the more common complications of laparoscopic cholecystectomy include: inability to insufflate the abdomen due to adhesions, hemorrhage, injury to a bile duct, and injury to blood vessels in the area of the gallbladder. Bile duct injuries can occur for different reasons: as a result of anomalies, because the structures in this area are so close together, and because of adhesions and swelling. The cystic duct itself may be short or attached in different locations. The hepatic artery can also be subject to anomalies. Repeated inflammation can lead to increased vascularity, and an increase in the number of anomalous vessels coming off the liver into the gallbladder. (Tr. 305-309)

19. Dr. Rajan admitted that he made mistakes during the Patient 1's surgery. Dr. Rajan admitted that his mistakes led to Patient 1's death. (Tr. 310, 364) He misidentified the common bile duct as the cystic duct, entered the portal vein and entered the hepatic artery. Dr. Rajan testified that the reason for the misidentification of the common bile duct was that the cystic duct was very short. He testified that the cystic duct is normally 2 to 3 cm. long. In this case, it was less than 1/2 cm. long. He testified that there were multiple adhesions in the area where the cystic duct joins the common bile duct. When the gallbladder was retracted, perhaps more tightly than it should have been, the cystic duct appeared to continue along the common bile duct. Dr. Rajan acknowledged that he would have been able to expose the Angle of Calot if he had retracted the gallbladder laterally. Dr. Rajan testified that he was not aware of the injury caused to the common bile duct when he dictated the post-operative report. (Tr. 310-313)

Dr. Rajan testified that he was not aware of these problems when he was deposed for the civil malpractice case in August 1991. A transcript of that deposition was admitted to the record as State's Exhibit 25. Dr. Rajan testified that, at the time the deposition was taken, he believed his testimony to be accurate. Now, he realizes the mistakes that he made. (Tr. 314) Dr. Rajan testified that he reviewed the tape for the deposition without anyone helping to point anything out. (Tr. 363)

Dr. Rajan referred to State's Exhibit 11 at 14:30 to indicate how the retraction on the gallbladder made the common bile duct appear to be the cystic duct. (Tr. 315) Dr. Rajan testified that in 1990 laparoscopic cholecystectomy was a

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new procedure. Everybody was in the same situation, no one had much experience. Dr. Rajan admitted that the fundus of the gallbladder could have been retracted a little more to the [patient's] right, which may have exposed the junction of the cystic duct and the common bile duct a little better. Once the common bile duct was incorrectly identified as the cystic duct, the right hepatic artery, which was in somewhat of an anomalous location, was mistaken as the cystic artery. (Tr. 315-317)

Dr. Rajan acknowledged that he was about 1/2 inch medial to where he should have been. This ultimately resulted in the portal vein injury. Based on where he thought he was, Dr. Rajan thought the bleeding was the result of anomalous vessels under the liver. He testified that such vessels occur twenty to thirty percent of the time. He testified that there are no vital structures underneath the gallbladder. He tried to control the bleeding with a clip, and with the laser. Dr. Rajan testified that the patient's condition was satisfactory. His blood pressure and vitals were stable during this period. Blood loss was less than 500 cc. The patient's hema crit was satisfactory. Dr. Rajan testified that he wanted to try to stop the bleeding without converting to open. When he realized that he couldn't control the bleeding with cautery, he opened. (Tr. 318-322)

Dr. Rajan testified that it takes 20 to 30 minutes to convert the operating theater to the open procedure. Dr. Rajan requested the assistance of another surgeon, informed the anesthesiologist that he was going to open, obtain new instruments, and ordered blood. In order to maintain the patient's condition, the anesthesiologist gave intravenous fluids. Immediately upon opening, Dr. Rajan tried to control the bleeding. Dr. Rajan testified that there was considerable bleeding underneath the liver where the portal vein enters. Numerous branches of the portal vein were the sources of the bleeding, which, as a result of blood backing up from the portal vein, were tortuous, elongated, friable, and thin walled. They cut through when Dr. Rajan attempted to clamp and ligate. Dr. Rajan testified that these tortuous veins were under the liver and the liver bed. When he tried to suture these veins, they bled more. These veins ran into the esophagus and stomach, mainly. (Tr. 322-325).

Dr. Rajan and the other surgeon were finally able to control the bleeding. When the procedure was complete, Dr. Rajan was not aware that he had injured the hepatic artery or the common bile duct. He testified that he only became aware of these errors within the past year. (Tr. 326) Following the procedure, the patient remained in Mansfield for three days. He was on a ventilator, and suffered from multiple system failure, liver failure, kidney failure, and intravascular coagulopathy. At the suggestion of a colleague, Patient 1 was transferred to Mt. Carmel Hospital, in Columbus. The patient died at Mt. Carmel. (Tr. 326-327)

Dr. Rajan testified that the gallbladder was ultimately removed from Patient 1 after Patient 1 was opened. (Tr. 383) In the normal course of a laparoscopic

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cholecystectomy, the common bile duct may not be visualized. (Tr. 383)
Dr. Rajan testified that he did not look for common duct when the gallbladder was removed, because he was unaware that he had injured the common bile duct, and did not want to increase the surgery time. Although Dr. Rajan had to make a second cut through the common bile duct in order to remove the gallbladder, it was small, and Dr. Rajan thought it was an anomalous duct. (Tr. 384-385)

Dr. Rajan's statements concerning injury to the hepatic artery are based on the autopsy report. (Tr. 363-364)

20. Dr. Rajan testified that the mistakes that he made concerning Patient 1 were due to a combination of factors. It was a new procedure in 1990, and none of the surgeons performing had very much experience. Moreover, Patient 1 had numerous anatomical anomalies. Dr. Rajan testified that he now believes that he has the experience to recognize such problems. (Tr. 346)
21. Dr. Rajan testified that he dictated the operative report about three days after the surgery. He did not review the videotape prior to dictating this report. He testified that the report contained typographical errors. First, where the report said, "Extensive varicosities on the surface...", it should have said, "Extensive varicosities under the surface...". Second, the statement, "No gross liver...", should say, "No gross cirrhosis..." Dr. Rajan testified that, at the time he dictated the report, he believed it to be completely accurate. He did not intend to deceive. (Respondent's Exhibit 5; Tr. 327-330) During his testimony on this issue, Dr Rajan referred to a drawing he made at the hearing, admitted to the record as Respondent's Exhibit 27.

Dr. Rajan testified that, by the term "varicosities," he was referring to "varicosities extending up into the esophagus and extended up to under surfaces. ... The varicosities are the ones which drain from the esophagus, stomach, and duodenum into the portal vein." He referred to them as varicose because they were "friable, very curved, elongated, thin walled..." Dr. Rajan testified that there were very many such vessels. (Respondent's Exhibits 5 and 27; Tr. 331-332)

In the Autopsy Report (State's Exhibit 12, pp. 5-13), it was reported, "Varices are not apparent after removal of the stomach. The splenic vein is very prominent." (State's Exhibit 12, p. 8) In the Microscopic Description of that report concerning the esophagus, however, it was stated, "There are prominent distended venous channels in the submucosa." (State's Exhibit 12, p. 11)

Dr. Rajan testified that he wrote, "... due to portal hypertension secondary to ethanol intake" because Patient 1 had bleeding from varices, and one cause of varices is hypertension. Portal hypertension is caused by increased pressure in the portal vein due to an obstruction in the liver caused by tumor, inflammation, cirrhosis, or other agency. Portal hypertension can be

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associated with extensive venous bleeding. Dr. Rajan testified that he did not indicate in the post-operative report that Patient 1 had cirrhosis, contrary to what is stated in the notice letter. Dr. Rajan referred to "ethanol intake" based on a history related to him by Patient 1's family physician that Patient 1 used 3 to 4 beers per day. He testified that he used the word, "probably" because he was not certain. Dr. Rajan testified that the autopsy report, Respondent's Exhibit 6, supports this judgment: Cause of Death No. 5 refers to "Fatty metamorphosis of the liver." Dr. Rajan testified that, in the United States, this malady is usually caused by alcohol intake. Concerning Cause of Death No. 6, "esophageal varices," Dr. Rajan testified that this condition does not occur unless the patient suffers from portal hypertension. (Tr. 332-337)

Dr. Rajan testified that the honesty and accuracy of his medical records has never been questioned before. (Tr. 339)

22. Dr. Rajan testified that the videotape of Patient 1's surgery was his personal property. He testified that he has always provided this tape to those who asked for it. (Tr. 337-338) Dr. Rajan no longer possesses any tapes of any of his other surgeries. (Tr. 339) Dr. Rajan testified that the videotape of Patient 1's surgery became part of the hospital's record as the result of the litigation that resulted. Dr. Rajan did not know if the hospital or the nurse took the videotape for safe keeping. Dr. Rajan testified that he has kept Patient 1's video because of the civil litigation. Dr. Rajan does not recall the nurse taking the tape and keeping it with the hospital records. (Tr. 376-378)
23. Dr. Rajan testified that he has performed over 130 laparoscopic cholecystectomies up to the date of the hearing. He testified that he has had no significant complications in any patient other than Patient 1. He testified that he has never again misidentified anatomy, improperly retracted the gallbladder, injured the common bile duct, hepatic artery, or portal vein. The same is true for his laparoscopic cholecystectomy cases prior to Patient 1.

Dr. Rajan testified that he rarely needs to convert laparoscopic cholecystectomies to open cases, only about 5% to 8% of the time. (Tr. 342-343)

24. Dr. Rajan testified that the publicity surrounding the Medical Board action has been traumatic. He testified that his reputation has been tarnished, and he has lost most of his practice. It has been very difficult. He still practices surgery, and still performs laparoscopic cholecystectomies. Dr. Rajan believes that he is a good surgeon. (Tr. 345-349) Dr. Rajan expressed remorse for Patient 1's family. (Tr. 348)
25. Dr. James Jackson testified on behalf of Dr. Rajan. Dr. Jackson first met Dr. Rajan when Dr. Rajan was a first-year resident at Mansfield General while Dr. Jackson was supervising that program. He had an opportunity to observe Dr. Rajan's performance as a surgeon. Dr. Jackson said that Dr. Rajan was one of his three or four best residents, out of 24 or 25. (Tr. 394-396)

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Dr. Jackson believes that Dr. Rajan is a competent surgeon. He has good technical skills and compares well to other surgeons in the area. Dr. Rajan has a good reputation as a surgeon and a citizen. Dr. Jackson believes that Dr. Rajan's reputation has survived the negative publicity concerning this case. Dr. Jackson testified that he has always found Dr. Rajan to be honest and professional. When asked if the surgery on Patient 1 is representative of Dr. Rajan's skills, Dr. Jackson replied, "I feel this is a single tragic isolated situation and has no bearing on [Dr. Rajan's] skills in general in this type of procedure." (Tr. 398-405)

FINDINGS OF FACT

1. On or about September 28, 1990, Patient 1 first visited Dr. Rajan. He was diagnosed as suffering from symptomatic gallbladder disease with biliary colic. Dr. Rajan recommended laparoscopic cholecystectomy, to which Patient 1 consented. The surgery was performed at People's Hospital, Mansfield, Ohio, on December 11, 1990. The surgery was videorecorded.

The evidence presented in this matter supports a finding in favor of the State's allegation that "[Dr. Rajan's] conduct throughout the operation showed a clear deficiency in understanding of the anatomy as it appears laparoscopically. The exposure of the gallbladder, use of laser, and blind application of clips and failure to timely convert to an open procedure were all inappropriate surgical techniques." Specifically:

- The gallbladder was retracted improperly. Convincing evidence was presented that the gallbladder should be retracted up, toward the patient's right shoulder, with one grasping forcep; another forcep should then be used to grasp the neck of the gallbladder and retract it laterally (toward the right side of the patient) in order to expose the cystic duct. Dr. Rajan failed to retract the neck of Patient 1's gallbladder laterally. This error, coupled with an anatomical variation of a very short cystic duct, made the common bile duct appear to Dr. Rajan to be the cystic duct. As a result, Dr. Rajan clipped and divided the common bile duct, which is an essential organ.

Although the Respondent's expert, Dr. Matyas, testified that there was no single standard concerning retraction of the gallbladder, he acknowledged that the retraction in this case was not optimal. He also testified that retracting the gallbladder up and laterally is a good starting point.

Injury to the common bile duct is a recognized complication of laparoscopic cholecystectomy. Nevertheless, Dr. Rajan should have recognized the injury and repaired it. Repair of this injury required discontinuing the laparoscopic procedure and opening the patient.

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- Following the transection of the common bile duct, Dr. Rajan attempted to find the cystic artery. However, because the common bile duct had previously been misidentified and transected, he was looking in the wrong place. From about 17:00 until about 31:30 on State's Exhibit 11, Dr. Rajan was working in the wrong area.
- At approximately 29:48 on State's Exhibit 11, Dr. Rajan improperly used scissors to dissect fatty tissue overlying the porta hepatis. Such use of scissors was inappropriate because of the risk of inadvertently cutting into a blood vessel or duct; blunt dissection would have been preferable. The area in which Dr. Rajan was working contained important blood vessels. Moreover, anomalous blood vessels and ducts are common in this area of the anatomy.
- At about 32:00 on State's Exhibit 11, Dr. Rajan was working in the appropriate area and correctly identified the cystic artery. The cystic artery was clipped and then divided at about 35:45 on State's Exhibit 11.
- After the cystic artery was divided, a neodymium YAG laser was introduced to separate the gallbladder from the liver bed. At about 37:35 on State's Exhibit 11, excessive bleeding began. Convincing evidence was presented that excessive bleeding is a clear indication to discontinue the laparoscopic procedure and convert to open. Bleeding is difficult to control laparoscopically; opening the patient would have enabled Dr. Rajan to control the bleeding using conventional surgical techniques. Instead, Dr. Rajan attempted to control the bleeding using the laser. By about 46:35 on State's Exhibit 11, Dr. Rajan was working in the wrong area, directly on top of the portal vein. At about 50:46 on State's Exhibit 11, very serious bleeding began because of injury to the portal vein. This was, by itself or in addition to the previous bleeding problem, a clear indication to open the patient. Nevertheless, Dr. Rajan continued to attempt to control the bleeding laparoscopically, including the placing of clips blindly into the area of bleeding, until about 59:15 on State's Exhibit 11, when he discontinued the laparoscopic procedure and opened the patient.

The evidence supports a finding that Dr. Rajan failed to recognize and treat in timely fashion the injuries that he caused. The evidence further supports a finding that Dr. Rajan failed to accurately document the surgery and its complications, as is discussed in more detail in Finding of Fact #2, below.

On December 14, 1990, Patient 1 was transferred to Mt. Carmel Hospital, Columbus, Ohio. Patient 1 died on December 17, 1990 from shock and multisystem organ failure. Dr. Rajan admitted at hearing that his mistakes during Patient 1's surgery resulted in Patient 1's death.

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2. The evidence presented in this matter supports a finding in favor of the State's allegation that "On or about December 14, 1990 [Dr. Rajan] dictated the patient's operative note and endorsed the transcribed note by signature. Under Postoperative Diagnosis, in this note, [Dr. Rajan] published that there were 'extensive varicosities on the surface of the liver due to probably portal hypertension secondary to ethanol intake.'" (Emphasis original) The evidence supports a finding that there were no varicosities or evidence of portal hypertension.

There were no varicosities or evidence of portal hypertension on the videorecording of Patient 1's surgery, or in the autopsy report, except for a report of "prominent distended venous channels in the submucosa" of the esophagus, as reported in the microscopic description in the autopsy report.

Dr. Rajan testified that the Postoperative diagnosis should have read, "extensive varicosities under the surface of the liver..."

Dr. Rajan offered evidence that the varicosities to which he referred were not visible on the videotape. The varicosities became apparent after the patient was opened. They consisted of numerous friable and tortuous veins that drain from the esophagus, stomach, and duodenum into the portal vein. Dr. Rajan stated that these varicosities are usually caused by portal hypertension. Repair of these veins was made difficult by this condition. Nevertheless, Dr. Rajan's testimony was not corroborated by the autopsy report. Moreover, Dr. Ellison's testimony in this regard was convincing and unequivocal: there were no varicosities, and no evidence of portal hypertension. Had such conditions existed, they would have been visible on the videotape; it would not have required a microscopic examination.

Written statements in support of the postoperative diagnosis, made by Dr. Rajan elsewhere in his operative note, were also refuted by the State. This evidence was considered by the Hearing Examiner in an effort to determine the basis for, and accuracy of, Dr. Rajan's postoperative diagnosis. However, because these allegations were not raised in the Board's August 10, 1994 Notice of Opportunity for Hearing, this evidence was not considered by the Hearing Examiner in forming his Conclusions of Law and Proposed Order.

CONCLUSIONS OF LAW

1. As set forth in Finding of Fact #1, above, the acts, conduct, and/or omissions of Semur P. Rajan, M.D., individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

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Dr. Matyas testified that Dr. Rajan's conduct was acceptable because Dr. Rajan thought he was working in the correct field and that the bleeding was the result of an anomalous vein in the liver bed. Such bleeding can often be controlled laparoscopically. Dr. Matyas presented evidence that bleeding which appears to be serious on video can be controlled laparoscopically. Nevertheless, the video of the bleeding situation that Dr. Matyas encountered (Respondent's Exhibit 22) is distinguishable from Dr. Rajan's. Dr. Matyas was able to quickly control his patient's bleeding, which gave Dr. Matyas time to try different laparoscopic techniques to fix the problem. In contrast, Dr. Rajan was not able to control Patient 1's bleeding, and improperly used laser and blind clips while trying to do so. Further, Dr. Matyas testified that he would have opened Patient 1 earlier than Dr. Rajan did.

Laparoscopic cholecystectomy was a new procedure at the time of this violation. It presented new challenges to surgeons and required the development of new skills. During this new procedure, the surgeon can be faced with one important decision that was never an issue during open procedures: the decision whether or not to discontinue the laparoscopic procedure and convert to open. In Patient 1's case, Dr. Rajan exercised poor surgical judgment when confronted with this decision. Dr. Ellison gave convincing testimony that Dr. Rajan should have converted to an open procedure much earlier than he did; his failure to do so fell below the minimal standards of care of similar practitioners under the same or similar circumstances. First, Dr. Rajan should have recognized the injury to the common bile duct and opened the patient to repair it. Second, Dr. Rajan should have converted to the open procedure when he became confused by Patient 1's anatomy. Although it is not below the minimal standards of care for a surgeon to be confused by a patient's anatomy, it is below the minimal standards of care if the surgeon fails to recognize the situation and open the Patient. Finally, Dr. Rajan should have opened Patient 1 much earlier to control the bleeding.

2. As set forth in Finding of Fact #2, above, the acts, conduct, and/or omissions of Dr. Rajan, individually and/or collectively, constitute: "publishing a false, ... deceptive or misleading statement," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code."

It is not necessary for the State to prove an intent to deceive on the part of the Respondent in order to prove violation of Section 4731.22(B)(5), Ohio Revised Code. The evidence is sufficient to support a conclusion that the postoperative diagnosis contained in Dr. Rajan's operative note was, at the very least, false, deceptive, or misleading.

Furthermore, as set forth in Finding of Fact #1, above, the acts, conduct, and/or omissions of Semur P. Rajan, M.D., individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances,

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whether or not actual injury to a patient is established, as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Dr. Rajan's failure to accurately and honestly document Patient 1's surgery and complications fell below the minimal standards of care. This may have had an impact on the care rendered to Patient 1 by subsequent medical personnel.

3. The evidence presented was insufficient to conclude that Dr. Rajan's acts, conduct, and/or omissions constitute "[t]he violation of any provision of a code of ethics of national professional organization," as that clause is used in Section 4731.22(B)(18)(a), Ohio Revised Code. No evidence was presented concerning this allegation.

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The violations found in this case resulted from a serious lapse of surgical judgment on the part of Dr. Rajan. And although only one patient was involved, the consequences for this patient and his family were tragic. In cases involving patient harm that resulted from a departure from the minimal standards of care, this Board has in the past imposed a period of suspension, followed by probation. During his probation, Dr. Rajan's practice should be monitored in order to ensure that the poor surgical judgment evident in this case was, in fact, a single, isolated tragic incident.

PROPOSED ORDER

It is hereby ORDERED:

1. That the certificate of Semur P. Rajan, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for an indefinite period of time, but not less than one (1) year.
2. The State Medical Board shall not consider reinstatement of Dr. Rajan's certificate to practice unless and until all of the following minimum requirements are met:
 - a. Dr. Rajan shall submit to the Board an application for reinstatement, accompanied by appropriate fees. Dr. Rajan shall not make such application for at least one (1) year from the effective date of this Order.
 - b. In the event that Dr. Rajan has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of Dr. Rajan's fitness to resume practice.

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3. Upon reinstatement, Dr. Rajan's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least four (4) years:
- a. Dr. Rajan shall obey all federal, state, and local laws, and all rules governing the practice of osteopathic medicine in Ohio.
 - b. Dr. Rajan shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution stating whether or not there has been compliance with all of the provisions of probation.
 - c. Dr. Rajan shall appear in person for interviews before the full Board or its designated representative at three (3) month intervals, or as otherwise requested by the Board.
 - d. In the event that Dr. Rajan should leave Ohio for three (3) consecutive months, or reside or practice outside the State, Dr. Rajan must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside of Ohio will not apply to the reduction of this probationary period, unless otherwise determined by motion of the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.
 - e. Within thirty (30) days of the effective date of this Order, Dr. Rajan shall submit for the Board's prior approval the name of a monitoring physician, who shall review Dr. Rajan's patient charts and shall submit a written report of such review to the Board on a quarterly basis. Such chart review may be done on a random basis, with the number of charts reviewed to be determined by the Board. It shall be Dr. Rajan's responsibility to ensure that the monitoring physician's quarterly reports are submitted to the Board on a timely basis. In the event that the approved monitoring physician becomes unable or unwilling to so serve, Dr. Rajan shall immediately so notify the Board in writing and shall make arrangements for another monitoring physician as soon as practicable.
4. Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Rajan's certificate will be fully restored.

This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio. In the interim, Dr. Rajan shall not undertake the care of any patient not already under his care.


R. Gregory Porter
Attorney Hearing Examiner



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

EXCERPT FROM THE DRAFT MINUTES OF SEPTEMBER 6, 1995

REPORTS AND RECOMMENDATIONS

Dr. Garg announced that the Board would now consider the findings and orders appearing on the Board's agenda.

Dr. Garg asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Harjit Bharmota, M.D.; Robert R. Hershner, D.O.; Mukunda D. Mukherjee, M.D.; and Semur P. Rajan, M.D. A roll call was taken:

ROLL CALL:

Mr. Albert	- aye
Dr. Bhati	- aye
Dr. Stienecker	- aye
Dr. Gretter	- aye
Dr. Agresta	- aye
Dr. Buchan	- aye
Mr. Sinnott	- aye
Dr. Heidt	- aye
Dr. Steinbergh	- aye
Dr. Garg	- aye

Dr. Garg asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:

Mr. Albert	- aye
Dr. Bhati	- aye
Dr. Stienecker	- aye
Dr. Gretter	- aye
Dr. Agresta	- aye
Dr. Buchan	- aye
Mr. Sinnott	- aye
Dr. Heidt	- aye
Dr. Steinbergh	- aye

Dr. Garg - aye

In accordance with the provision in Section 4731.22(C)(1), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of this matter. Dr. Gretter did not serve as Secretary in the above-named cases.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....
REPORT AND RECOMMENDATION IN THE MATTER OF SEMUR P. RAJAN, M.D.

Dr. Garg stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and order in the above matter. No objections were voiced by Board members present.

Dr. Garg advised that a request to address the Board has been timely filed on behalf of Dr. Rajan.

Dr. Garg advised Mr. Dawley that there is not a court reporter present, but instead the Board's minutes serve as the Board's official record of the meeting. Mr. Dawley stated that he did not have any objection to the absence of a court reporter.

Dr. Garg reminded Mr. Dawley that the Board members have read the entire hearing record, including the exhibits and any objections filed. He added that the Board will not retry the case at this time, and that pursuant to Section 4731.23(C), Revised Code, oral arguments made at this time are to address the proposed findings of fact and conclusions of the hearing examiner. Dr. Garg stated that Mr. Dawley would be allotted approximately five minutes for his address.

Mr. Dawley stated that, as the Board can tell from the record, this case involves a procedure, called a Laparoscopic cholecystectomy, performed in 1990. This procedure was relatively new at that time. Mr. Dawley indicated that he believes it was introduced into central Ohio in early 1990 or late 1989. These particular charges involved only this procedure, and only one case, in Dr. Rajan's 25-year career as a surgeon. Dr. Rajan has probably performed 8,000 to 10,000 other procedures, as well as another 130 to 150 Laparoscopic cholecystectomies. All records that the State Medical Board wanted were provided. The only charge involved this one case.

Mr. Dawley stated that he is not here to argue the medical issues. There were two of the finest, and probably the best, leading experts in central Ohio on Laparoscopic cholecystectomy. They were Christopher Ellison, M.D., from O.S.U., and John A. Matyas, M.D. They are friends and colleagues. Both

agreed that their opinions deserve respect. They can't reach any agreement on the conclusions in this case. They disagree on whether or not this is a deviation, and the reasons are well stated in the objections and in the record. What they do agree on is that this was earlier in Dr. Rajan's career, and that was unfortunate, because it was a difficult case. There were adhesions and anomalies, and there were a variety of other issues, including a retraction issue done by a physician's assistant, all of which led to this very tragic result.

Mr. Dawley stated that no one is questioning whether Dr. Rajan had sufficient training or was qualified to do this procedure. Dr. Ellison said that he did. Dr. Ellison identified the deficiency in this case as the fact that when the judgment call was made to open, he made the wrong judgment. Dr. Rajan should have opened the patient earlier. Dr. Rajan at the time felt he could control the bleeding and also felt that the patient was stable. In hindsight, he was wrong. Dr. Rajan has admitted the fact that he made the wrong decision.

Mr. Dawley stated that he wants to talk about the charge regarding the recordkeeping. There was no evidence that there was any violation of a false, misleading, deceptive documentation in this case. In fact, Dr. Ellison came out and said that there was no intent to do anything misleading regarding this. Mr. Dawley referred to the Hearing Examiner's report, noting that it indicates that intent is not necessary. That's true if you look at the standard required under the Code. There are two elements of that standard for what is a false, misleading statement. The first does require intent. The second one says that it can be a statement with reasonable probability that would cause an ordinarily prudent person to be deceived. There is no testimony in this record anywhere that there was a statement with reasonable probability that would cause an ordinarily prudent person to be deceived. In fact, the State called no witnesses that said they were deceived in the subsequent care from Mt. Carmel. No one testified to that fact because it didn't occur. That was testified to by Dr. Ellison and Dr. Matyas. Mr. Dawley stated that a further indication of Dr. Rajan's honesty is that there was a charge of a violation of ethics. There was no evidence put on of that. There was no charge that Dr. Rajan was dishonest in the care and treatment of his patient. That charge was dismissed by the Hearing Examiner. Mr. Dawley admitted that it's obvious that Dr. Rajan's report was not accurate. He didn't realize at the time that he'd cut the common bile duct. He didn't realize the exact cause of the bleeding. Even Dr. Matyas and Dr. Ellison testified that they had to look at the videotape two or three times to determine what happened. Dr. Rajan never had a chance to look at the videotape of what occurred. Dr. Rajan had to dictate his report. Dr. Ellison and Dr. Matyas agreed that it would be much more difficult for a surgeon to do this in real time than looking back.

Dr. Garg asked Mr. Dawley to conclude his statements.

Mr. Dawley indicated that Dr. Rajan had questions about the diagnosis, and he put the word "probably" in his notes, and both Dr. Ellison and Dr. Matyas recognized Dr. Rajan's uncertainty. For these reasons, Dr. Rajan objects to the conclusions regarding documentation.

Mr. Dawley stated that there are no questions regarding Dr. Rajan's competency in performing other procedures, nor any questions regarding his competency in performing any laparoscopic cholecystectomies since 1990. He has done 130 cases. His records have been reviewed, and they have been provided. Mr. Dawley asked that the Board consider this. They view this as a malpractice case, and that has been resolved. Dr. Rajan made a mistake, admitted his mistake. It occurred in 1990. There was testimony that Dr. Rajan is a competent surgeon.

Dr. Garg asked whether the Assistant Attorney General wished to respond.

Ms. Kaczmarek stated that she would like to preview her comments with the fact that she disagrees with Mr. Dawley's characterization of to what Dr. Ellison and Dr. Matyas agreed and disagreed. Dr. Rajan is not before the Board because he made a few routine mistakes during a relatively new surgical procedure. Dr. Rajan is here based on violations of the Medical Practices Act, resulting from a serious lapse in medical judgment, and surgical judgment, that resulted in the death of a patient. The patient's wife is here today. This has obviously affected her life, as well as her son's life.

Ms. Kaczmarek stated that, in addition to his poor medical judgment, Dr. Rajan dictated an operative note that was false and misleading, as it attributed the problems with the surgery to inaccurate conditions of the patient rather than documenting the patient's true condition and what really happened during the surgery. As the Board has just witnessed, the Board does not tolerate false or misleading statements in any kind of record. In this case it occurred in a patient record.

Ms. Kaczmarek advised that Dr. Rajan would like the Board to accept his position that the mistakes he made during his surgery were common mistakes that did not fall below the minimal standards of care. What he fails to recognize is, regardless of the newness of the procedure, the patient's safety is the number one primary concern and number one standard of care. That is the standard of care in any surgical procedure.

The State's expert witness, Dr. Ellison, is from Ohio State University Medical Center. Dr. Ellison is the Chief of the Division of General Surgery there. In 1990 he was actively involved in training surgeons. Dr. Rajan took a course in this procedure. Dr. Ellison testified that, while certain mistakes can occur during this procedure, Dr. Rajan's biggest problem was his failure to recognize his mistakes and his failure to open the patient when his mistakes put this patient's life at risk. Dr. Ellison had no problem with opining that the biggest problem was that this patient bled to death and the patient should have been converted to an open procedure in order to prevent that. The number one standard in surgery, patient safety, was broken.

Ms. Kaczmarek continued that Dr. Ellison and Dr. Matyas both discussed indications for opening a patient. It is the State's position that the cumulative mistakes made in this case, which ultimately caused the death of this patient, were mistakes surgeons should not make. Dr. Rajan is an experienced surgeon. The Board heard testimony today that he has had 25 years of experience and has done approximately 130 laparoscopic

cholecystectomies since this procedure. However, Dr. Rajan failed to admit that these mistakes took place, even though he's done these additional surgeries, until he was forced to answer to the Board. Ms. Kaczmarek stated that she finds this especially troubling in light of the fact that Dr. Ellison testified that it took him only one viewing of the tape to recognize that a terrible tragedy took place in this operation. Of equal concern is the fact that the evidence in this case, in her opinion, clearly demonstrates that Dr. Rajan documented false and misleading information in the postoperative record. Dr. Ellison specifically stated that it was his opinion that this information could mislead a subsequent treating physician reviewing these records. There was no reliable evidence to rebut that statement by Dr. Ellison.

Ms. Kaczmarek stated that the State has provided substantial evidence to support the Hearing Examiner's recommendation in this case. Dr. Rajan had over 20 years of experience when he performed the surgery. He therefore should have been aware of the signs to recognize that patient safety was being compromised. Dr. Rajan failed to recognize these signs and failed to recognize his limitations in this case. The State asserts that disciplinary action is warranted, not only for the minimal standards violation, but also for the false documentation of the operation; and it suggests to the Board that it may wish to consider under probationary terms that not only records be reviewed by a monitoring physician, but that those records include videotapes of surgeries.

DR. AGRESTA MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF SEMUR P. RAJAN, M.D. DR. STEINBERGH SECONDED THE MOTION.

Dr. Garg asked whether there were any questions concerning the proposed findings of fact, conclusions and order in the above matter.

Dr. Steinbergh noted that under reinstatement conditions, Dr. Rajan is referred to as an osteopathic physician. That should be corrected.

Dr. Bhati stated that it was very tragic to see a 47-year-old, young man die of an elective procedure. This is very tragic. Unfortunately, these things do happen once you go onto the operating table. One out of 250,000 anesthesia procedures ends in some kind of serious, fatal accident. No procedure is without complications. He doesn't know what went on before the patient was put on the table.

Dr. Bhati stated that he personally is an endoscopist who has taught these surgical procedures for about 15 years. He claims a little bit of expertise in this matter. Dr. Bhati stated that he spent extensive time going through records and looking at the film over and over again. He would like to make some comments for the record before offering his amendment.

Dr. Bhati noted that Dr. Rajan has performed over 10,000 procedures and had done 500 gall bladders by the open method prior to this procedure. This was his 21st laparoscopic cholecystectomy case. Since then he

has done 130 cases. Dr. Bhati stated that his problem with those 130 cases is that he doesn't believe the Board had a chance to look at those cases for complications. Dr. Rajan is before the Board for one particular case.

Dr. Bhati stated that, in reviewing the film, the first thing encountered is the extensive adhesions around the gall bladder, which made it very difficult to do the dissection. Dr. Bhati stated that, having done only 20 cases before, Dr. Rajan did a pretty good dissection of that; but, the dissection at the bottom of the gall bladder was not adequately done because of dense adhesions. It wasn't the fault of the physician's assistant that he couldn't retract the gall bladder upside and laterally as it should normally have been done. It couldn't have been done.

Dr. Bhati continued that, having done that retraction part of it, the cystic artery, which normally comes from the right hepatic artery, came from the common hepatic artery instead. This is a very difficult dissection. One would have to go further underneath to do that dissection. Admittedly, Dr. Rajan made a pretty big mistake of having a common bile duct being clamped instead of a cystic duct. Those complications are known complications with no questions asked. Dr. Bhati stated that when he looked at the film again he found that there was extensive bleeding there. That bleeding was arterial and venous bleeding. You could see the pumping and extensive oozing going on. With only 20 cases previous, for Dr. Rajan to continue to clamp the blood supply was not a very smart thing to do. Nevertheless, five minutes before the patient was opened up, his blood pressure was 120/70 and pulse was 75. Dr. Bhati stated that he would consider that a stable condition. Furthermore, when the patient was opened up, there was only 500 cc blood loss documented at the conclusion of the endoscopic surgery. Once the belly was opened up, the total blood loss was 11,000 cc, or 11 litres. That is a massive hemorrhage. That blood probably came from varices, portal vein hypertension, which Dr. Rajan could not see, and which was destroyed during eight hours of surgery on this young man. The bleeding coming out of the portal vein is not the simplest thing in the world to deal with. He noted from the record that at 11:00 Dr. Rajan started opening the belly, and didn't finish until after 7:00, by the two Board certified surgeons.

Dr. Bhati stated that, unfortunately and tragically, this patient died of a massive hemorrhage and massive transfusions. He noted that there were about 19 units of blood transfused to maintain his blood pressure. This gentleman had a fatal accident because of the massive hemorrhage and a massive transfusion, which led into DIC and multi-system failure. This is not unique to gall bladder surgery, but it is unique to any surgery in which you have a massive hemorrhage and which could and does lead into these consequential problems as described.

Dr. Garg indicated that he felt it was important to note that not only does Dr. Bhati perform this surgery and teach courses in it here in Ohio, he also teaches and performs this procedure internationally.

DR. BHATI MOVED THAT THE CONCLUSIONS IN THE MATTER OF SEMUR P. RAJAN, M.D., BE AMENDED AS FOLLOWS:

1. BY ADDING THE FOLLOWING TO THE END OF THE SECOND PARAGRAPH OF CONCLUSION #2:

“ . . . and is illustrative of his ignorance of the surgical reality.”
2. BY DELETING THE LAST SENTENCE OF CONCLUSION #2, WHICH CURRENTLY READS AS FOLLOWS: “This may have had an impact on the care rendered to Patient 1 by subsequent medical personnel.”
3. BY SUBSTITUTING THE FOLLOWING FOR THE FINAL UNNUMBERED CONCLUSIONARY PARAGRAPH IN THE MATTER SEMUR P. RAJAN, M.D.:

The violations found in this case resulted from a serious lapse of surgical judgment on the part of Dr. Rajan. And although only one patient was involved, the consequences for this patient and his family were tragic. In cases involving patient harm that resulted from a departure from the minimal standards of care, this Board has in the past imposed a period of suspension, followed by probation. As a condition for reinstatement, the suspended licensee has been required to undergo specific training to address demonstrated substandard practices and promote future compliance with acceptable and prevailing standards of care. In Dr. Rajan's case, suspension for this purpose appears unnecessary, as there has been no demonstration that Dr. Rajan's failings with respect to his treatment of Patient 1 are representative of a pattern of poor care that would make additional training beneficial. There has been no evidence that, in the intervening five years, Dr. Rajan has had further surgical problems of this nature. Nevertheless, during his probation, Dr. Rajan's practice should be monitored in order to ensure that the poor surgical judgment evident in this case was, in fact, a single isolated tragic incident.

DR. BHATI FURTHER MOVED THAT THE PROPOSED ORDER IN THE MATTER OF SEMUR P. RAJAN, M.D., BE AMENDED AS FOLLOWS:

1. BY SUBSTITUTING THE FOLLOWING FOR PARAGRAPH #1:
 1. That Semur P. Rajan, M.D., be and is hereby REPRIMANDED.
2. BY DELETING PARAGRAPH #2 IN ITS ENTIRETY.
3. BY DELETING THE WORDS “Upon reinstatement,” AT THE BEGINNING OF PARAGRAPH #3.

4. BY SUBSTITUTING THE FOLLOWING FOR THE INTRODUCTORY LANGUAGE IN PARAGRAPH #3:

Dr. Rajan's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two (2) years, or until the minimum of fifty (50) cases referred to in subparagraph 3e, below, have been monitored, whichever period is longer.

5. BY MODIFYING SUBPARAGRAPH #3c TO REQUIRE PROBATIONARY APPEARANCES AT SIX (6) MONTH INTERVALS, RATHER THAN AT THREE (3) MONTH INTERVALS.

6. BY SUBSTITUTING THE FOLLOWING FOR THE FIRST TWO SENTENCES OF SUBPARAGRAPH 3e:

- e. Within thirty (30) days of the effective date of this Order, Dr. Rajan shall submit for the Board's prior approval the name of a monitoring physician, who shall carry out a 100% concurrent review of Dr. Rajan's next fifty (50) laparoscopic surgery patient charts, and shall submit a written report of such review to the Board on a quarterly basis.

7. BY SUBSTITUTING THE FOLLOWING FOR THE FINAL PARAGRAPH OF THE PROPOSED ORDER:

This Order shall become effective immediately upon mailing of notification of approval by the State Medical Board of Ohio.

DR. STIENECKER SECONDED THE MOTION.

Dr. Heidt stated that this was indeed a regrettable situation. He added that he has done many endoscopic procedures in all of the major joints in the body. He was one of the first to perform such procedures in 1977. He had many problems in those days in finding his way around with the scope. There was no one to tell surgeons how to do this. Dr. Heidt indicated that the learning curve on any of these scope procedures is quite high. Dr. Heidt added that there aren't the same problems going into a knee as there are going into a belly since there are no major vessels in the knee. Dr. Heidt stated that during the first 20 such procedures he performed, he would go in first with the scope, decide what to do, and then open the knee to see what he really had. After a while, a surgeon no longer needs to open up to check the situation. Dr. Heidt stated that in such procedures, the surgeon is in there by himself; it is difficult to have help. He said that it is felt that in arthroscopic procedures, the surgeon must do almost 100 procedures before he is familiar with what he is doing in handling the instruments involved. It's like handling a video game.

EXCERPT FROM THE DRAFT MINUTES OF SEPTEMBER 6, 1995
IN THE MATTER OF SEMUR P. RAJAN, M.D.

Dr. Heidt expressed sympathy for Dr. Rajan's situation. Dr. Rajan got lost in the patient. It was obvious from the video that he was lost. Dr. Heidt stated that he can sympathize with Dr. Rajan's confusion because he has been there. Dr. Heidt stated that whenever new procedures are used, outcomes such as this can occur. Now Dr. Rajan is accomplished in performing the procedure. Dr. Heidt spoke in support of the amendment.

Dr. Agresta asked for an amendment to paragraph 3 of the proposed amendment. He asked that the words, "and video tapes," follow the word, "charts."

Dr. Bhati and Dr. Stienecker agreed to include that change as part of the amendment.

Dr. Gretter stated that he doesn't have the advantage of being an expert in Laparoscopic cholecystectomies or endoscopies, but he did have the opportunity to review the transcript in this case, to view the video tapes, review the expert testimony, and to listen to the expert testimony of two members of the Board who have considerable experience in endoscopic procedures. Dr. Gretter stated that everyone is in agreement that a mistake was made and the patient died as a result of that mistake. In going back and looking at the procedure itself, as it developed there were times when the surgeon got into trouble. Dr. Rajan had the option to open the patient up much sooner than he did. Everyone agrees with that. The question is what to do about this case. He realized that this occurred early on in the performance of this procedure in central Ohio, but when something happens the surgeon should rely on what he knows best. Open surgery is what Dr. Rajan knew best. He had the ability to rectify the problem, but he failed to recognize the problem and failed to rectify it. Dr. Gretter spoke against the amendment.

Dr. Bhati begged to differ with Dr. Gretter's comments about opening the abdomen. Two things make him disagree. The total blood loss at the conclusion of the Laparoscopic cholecystectomy was 500 cc, in comparison to 11 litres lost after eight hours of open surgery. The hemodynamics recorded on the patient chart five minutes before opening the belly showed a blood pressure of 120/70 and a pulse of 75. He does not believe the patient was hemodynamically unstable. He believes that the problem occurred during the eight hours of open surgery where the portal vein damage and varices had a hard time to stop the bleeding and keep putting the sutures on that part of it. There's no way in the world in an autopsy they will be able to find portal vein varices when someone has worked there for eight hours. The only place you'll be able to identify this complication or this problem would be esophageal varices which were easily identified on an examination of that esophagus.

Dr. Garg asked Dr. Bhati whether, when he said that he could identify the bleeding as venous and arterial, you're looking under 15 magnification. A drop of blood looks like a pool of blood there.

Dr. Bhati agreed.

Dr. Garg stated that the Board should keep that in mind. He added that he thinks Dr. Agresta, who is a microscopic surgeon himself, will agree with that.

Dr. Gretter stated that he is not in a position to argue surgical technique, and he doesn't pretend to be. But he can review the statements of the experts, all of which state that Dr. Rajan should have opened the patient sooner.

Dr. Steinbergh agreed with Dr. Gretter, and spoke against the amendment. She has concern about all of those things. She added that she is not a surgeon, but one of the most basic things a physician learns is to know when he or she doesn't know. There was an error in judgment in that Dr. Rajan wasn't being intellectually honest about what had occurred. He failed to recognize the difficulty with the patient's anatomy, and he should have opened sooner. Had the open procedure been done at a more appropriate time, there was a better chance for success.

Mr. Sinnott stated that he appreciates that there will be bad results. This patient didn't die because of an act of God, but because of an act of Dr. Rajan. Mr. Sinnott stated that he is at a loss to understand how the proposed amended conclusions are suggested by the hearing record. Mr. Sinnott proposed that the Board make a finding that Dr. Rajan engaged in "poor surgical judgment," which is indicated by the hearing record. There is actionable conduct here. Mr. Sinnott stated that he doesn't believe that the Board wants to adopt a rule whereby the first patient death is disregarded. If there was a pattern of patient injury or death, plainly the appropriate sanction would be revocation. That is not being recommended in this case, apparently because there is evidence of only one such case where care fell below standards. The Hearing Examiner's recommendation strikes him as a very measured response to a documented deviation. The Board cannot forget what happened to the patient. The sanction should include time out of practice. The proposed amendment does away with the one significant sanction available to the Board, and he cannot support that.

Dr. Buchan stated that he found Dr. Matyas to be a very credible expert. He reviewed the experts' testimony and relied on it. The patient was opened in a stable situation. This is a judgment issue as to whether or not the patient should have been opened earlier. It is not a standards of care issue. Dr. Buchan spoke in support of Dr. Bhati's amendment, adding that he feels a reprimand is a reasonable sanction in this case.

Dr. Stienecker stated that he never performed this surgery, except as a first assistant in open procedures only. In viewing the videotape, he felt his touchstone was at what point would he, working as an assistant, cross clamp that porta hepatis to shut off that amount of bleeding. If he would have had to do that, as a first assistant, that would have been the time that, as a surgeon, he would have opened that patient. Dr. Stienecker stated that he feels that he probably would have acted as his goal about the point that Dr. Ellison suggested was the time that the bleeding was excessive and the patient should have been opened. But that was within minutes of the time that this process actually started. Having done some surgery, there is a

point sometimes where there is an inertia of panic. When things are out of control, it takes a little bit to get you going. Dr. Stienecker stated that he believes most surgeons would agree that there have been times that they've been in that position.

Dr. Stienecker stated that he will back the amendment because he can closely relate to some of the circumstances that occurred.

Dr. Garg stated that he would like to make a few observations, especially because certain comments have been made that he doesn't believe he can let pass. Being a surgeon he must say it.

Dr. Garg noted that Dr. Heidt talked about confusion, that the surgeon was confused. Dr. Garg disagreed with that. The surgeon appears confused, but it was a mistake and not confusion. Dr. Rajan did not think he was clipping the common bile duct. If he did, or if he thought he was not in the right place where he was, and that a small area of 1 cm or 2 cm, then it was confusion. It was not confusion. Is this an act of Dr. Rajan or an act of God? Dr. Garg stated that he doesn't know. If it is so, Dr. Ellison, or any expert witnesses, or any of the Board members is not in those divine shoes where we can pass judgments and say that "we do everything right, nobody else does that same as I do." Dr. Garg stated that he doesn't take the word of anybody as gospel.

Dr. Garg continued that, as Dr. Buchan put rightly, this is the first case in which he found two experts on both sides who are of equivalent qualifications and expertise and experience. They both have totally different opinions. Dr. Garg respects them both, except one of two things that were said which he will mention. They would do the case differently. So would every surgeon. Surgery is an art, it is not a perfect thing. You try, and the learning curve does not stop at 20 cases, 50 cases, 100 cases. A surgeon can practice for 30 years and he's still learning. The learning curve may be a little flat, and a surgeon may improve. Surgeons try to improve their technique every time, but learning doesn't stop. To say that after 25 cases a surgeon is okay and shouldn't do anything wrong, that learning curve business is wrong.

Dr. Garg stated that he already mentioned about bleeding. Dr. Ellison was adamant that it was all venous bleeding. Dr. Garg doesn't agree, and he noted that Dr. Bhati doesn't agree. The blood is blue and black there, and red. There were spurters, which were arterial, and there was venous bleeding. He cannot buy Dr. Ellison's comment that it was all venous bleeding and Dr. Rajan should have known that it was all coming from the portal vein. Dr. Garg stated that he doesn't do gall bladder surgery, but he has seen venous bleeding. One runs into bleeding every time in the brain. He also did gall bladder surgery when he was a resident.

Dr. Garg stated that there is a question of judgment. There are surgeons who have cold feet, and there are surgeons who don't have cold feet. Every time something bleeds some surgeons will say, "let me close it up," or in this case, "let me make it an open case." Every endoscopic and laparoscopic cholecystectomy will become open under the hand of such surgeons. You go as far as you go, and you go as far as you think

is safe. Dr. Garg stated that he agreed with Dr. Matyas' testimony and Dr. Bhati's comments that up to 50 minutes there was no problem. The bleeding became the problem after the spurting at 50 minutes. The case was converted to an open case at 57.5 or 59 minutes. Dr. Garg does not believe that the 7 to 9 minutes made a difference. The blood loss was 500 cc. It can look like a pool. It can look like a sea there under the 15 magnification, and it always does, but there was not a reason to open. Concerning the testimony that retraction was not lateral, Dr. Bhati has already explained that this unfortunate patient happened to have every anomaly that you can think of: there were adhesions due to peritonitis, and an anomalous situation. If you understand that the bile duct has been clipped, you will open, and if you don't, it's gross negligence. If a doctor thinks he clipped the hepatic artery, as in this case, to say it should have been opened then, yes. But it was not recognized. It was thought by the surgeon that he had clipped the cystic duct and the cystic artery.

Dr. Garg stated that there was also mention of deceptive recordkeeping. He doesn't buy the argument that there was. Dr. Ellison indicated that when somebody says "probably," that means to him more or less 100% definite. Dr. Garg stated that he doesn't know where he got that definition of "probably." The physician says there are "varicosities," or the physician says "probable varicosities." The latter means, "I'm not sure, but I think there may be varicosities." That's all it is saying. There can be high probability and there can be low probability. Dr. Garg disagrees that there was deceptive recordkeeping. A physician puts his diagnosis in an abbreviated form after surgery. In this case it was done three days after surgery. The diagnosis listed was probable varices and probable massive necrosis due to the hepatic artery. Anyway, Dr. Ellison indicated, correctly so, that there was no cirrhosis. There were no varices. The Board knows by the pathological report that there were definitely varices. And there was definitely a lot of venous structures under the liver. They didn't develop in three days, until the unfortunate demise of the patient.

Dr. Garg stated that the Board needs to consider a lot of this before it makes its decision. He added that he could go on about a lot of things. He related an anecdote about Dr. Ian Aird, one of the giants in surgery when Dr. Garg was in training. His was the surgical textbook that was like a bible. Dr. Aird used to say that there is not one mistake he has not made in his surgical life. He made every mistake, but he tried not to repeat them. Dr. Garg stated that to expect that there will be no complications or mistakes in surgery, then there should be no surgery and every surgeon in the world should probably be disciplined. Dr. Garg stated that he is sure that all surgeons have made mistakes somewhere in the process.

Mr. Sinnott asked whether Dr. Garg was speaking against the amendment and suggesting dismissal of the charges.

Dr. Garg stated that he is only making observations. He stated that he could have gone for dismissal with a reprimand. But he agrees that if the Board wants to monitor 50 cases, that's fine.

Mr. Sinnott stated that a reprimand and dismissal would be mutually exclusive alternatives.

Dr. Garg stated that he is not offering an amendment, just making observations of the case after listening to discussion.

A vote was taken on Dr. Bhati's motion to amend:

VOTE:	Mr. Albert	- abstain
	Dr. Bhati	- aye
	Dr. Stienecker	- aye
	Dr. Gretter	- nay
	Dr. Agresta	- nay
	Dr. Buchan	- aye
	Mr. Sinnott	- nay
	Dr. Heidt	- aye
	Dr. Steinbergh	- nay
	Dr. Garg	- aye

The motion carried.

DR. BUCHAN MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF SEMUR P. RAJAN, M.D. DR. BHATI SECONDED THE MOTION. A vote was taken:

VOTE:	Mr. Albert	- abstain
	Dr. Bhati	- aye
	Dr. Stienecker	- aye
	Dr. Gretter	- nay
	Dr. Agresta	- nay
	Dr. Buchan	- aye
	Mr. Sinnott	- nay
	Dr. Heidt	- aye
	Dr. Steinbergh	- nay
	Dr. Garg	- aye

Lacking the statutorily requisite six affirmative votes, the motion failed.

MR. SINNOTT MOVED TO TABLE THE MATTER OF SEMUR P. RAJAN, M.D. DR. GRETTOR SECONDED THE MOTION. A vote was taken:

VOTE:	Mr. Albert	- aye
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Dr. Bhati	- aye
Dr. Stienecker	- aye
Dr. Gretter	- aye
Dr. Agresta	- aye
Dr. Buchan	- aye
Mr. Sinnott	- aye
Dr. Heidt	- aye
Dr. Steinbergh	- aye

The motion carried.

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DR. AGRESTA MOVED TO REMOVE THE MATTER OF SEMUR P. RAJAN, M.D., FROM THE TABLE. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

VOTE:	Mr. Albert	- aye
	Dr. Bhati	- aye
	Dr. Stienecker	- aye
	Dr. Gretter	- aye
	Dr. Agresta	- aye
	Dr. Buchan	- aye
	Mr. Sinnott	- aye
	Dr. Heidt	- aye
	Dr. Steinbergh	- aye

The motion carried.

Dr. Agresta noted that the Board voted to approve the amendment, and then voted down the amended Findings of Fact, Conclusions and Order. He asked whether the Board is now starting from scratch.

Mr. Bumgarner stated that it is. He noted that there is a motion to approve and confirm the Hearing Examiner's original Proposed Findings of Fact, Conclusions and Order before the Board.

Dr. Agresta stated that, as all the Board members know from his previous record, he tries to be fair and vote on the evidence in the case. He also tries to vote in keeping with the disciplinary guidelines. Although he is not involved in surgical cases such as this, he can state that any surgeon will run into judgment calls when doing surgery. Sometimes the surgeon may make the wrong judgment. These judgments, at times, may result in poor outcomes. No one likes to be involved in those kinds of cases. The surgeon doesn't. Nor does the surgeon make such judgments with malintent.

Dr. Agresta stated that he agonized over this case following the Board's earlier discussion. It is classical in relationship to how physicians have to make decisions during surgery because it brings all the elements up in relationship to judgment at the time of surgery, and what is a poor surgical outcome, how you should get involved, who should be disciplined and who shouldn't in relationship to cases with outcomes that are not what you'd like to have. Poor outcomes don't necessarily mean the person received poor care. However, in this case, he feels there is agreement that there was faulty judgment. Dr. Agresta stated that on the most part he agrees with Dr. Bhati's previously proposed amendment; however, he had, in his own mind, a tough time not ordering a period of suspension. As a surgeon, ideally, he would say that Dr. Rajan deserves a reprimand. But when a patient death is involved, it is hard not to do something beyond a reprimand.

DR. AGRESTA MOVED THAT THE CONCLUSIONS IN THE MATTER OF SEMUR P. RAJAN, M.D., BE AMENDED AS FOLLOWS:

1. BY ADDING THE FOLLOWING TO THE END OF THE SECOND PARAGRAPH OF CONCLUSION #2:

“... and is illustrative of his ignorance of the surgical reality.”

2. BY DELETING THE LAST SENTENCE OF CONCLUSION #2, WHICH CURRENTLY READS AS FOLLOWS: “This may have had an impact on the care rendered to Patient 1 by subsequent medical personnel.”
3. BY SUBSTITUTING THE FOLLOWING FOR THE FINAL UNNUMBERED CONCLUSIONARY PARAGRAPH IN THE MATTER SEMUR P. RAJAN, M.D.:

The violations found in this case resulted from a serious lapse of surgical judgment on the part of Dr. Rajan. And although only one patient was involved, the consequences for this patient and his family were tragic. In cases involving patient harm that resulted from a departure from the minimal standards of care, this Board has in the past imposed a period of suspension, followed by probation. In some instances, as a condition for reinstatement, the suspended licensee has been required to undergo specific training to address demonstrated substandard practices and promote future compliance with acceptable and prevailing standards of care. In Dr. Rajan's case, extended suspension for this purpose appears unnecessary, as there has been no demonstration that Dr. Rajan's failings with respect to his treatment of Patient 1 are representative of a pattern of poor care that would make additional training beneficial. Suspension would, instead, serve the purpose of recognizing Dr. Rajan's significant failing in surgical judgment in this case, which contributed to Patient 1's loss of life. There has been no evidence that, in the intervening five years, Dr. Rajan has had

further surgical problems of this nature. Nevertheless, during his probation, Dr. Rajan's practice should be monitored in order to ensure that the poor surgical judgment evident in this case was, in fact, a single isolated tragic incident.

DR. AGRESTA FURTHER MOVED THAT THE PROPOSED ORDER IN THE MATTER OF SEMUR P. RAJAN, M.D., BE AMENDED AS FOLLOWS:

1. BY SUBSTITUTING THE FOLLOWING FOR PARAGRAPH #1:

1. That the certificate of Semur P. Rajan, M.D., to practice medicine and surgery in the State of Ohio, shall be SUSPENDED for ninety (90) days.

2. BY DELETING PARAGRAPH #2 IN ITS ENTIRETY.

3. BY SUBSTITUTING THE FOLLOWING FOR THE INTRODUCTORY LANGUAGE IN PARAGRAPH #3:

Dr. Rajan's certificate shall be subject upon reinstatement to the following PROBATIONARY terms, conditions, and limitations for a period of at least two (2) years, or until the minimum of fifty (50) cases referred to in subparagraph 3e, below, have been monitored, whichever period is longer:

4. BY MODIFYING SUBPARAGRAPH #3c TO REQUIRE PROBATIONARY APPEARANCES AT SIX (6) MONTH INTERVALS, RATHER THAN AT THREE (3) MONTH INTERVALS.

5. BY SUBSTITUTING THE FOLLOWING FOR THE FIRST TWO SENTENCES OF SUBPARAGRAPH 3e:

- e. Within thirty (30) days of the effective date of this Order, Dr. Rajan shall submit for the Board's prior approval the name of a monitoring physician, who does laparoscopic cholecystectomies, who shall carry out a 100% concurrent review of Dr. Rajan's next fifty (50) laparoscopic surgery patient charts and video tapes, and shall submit a written report of such review to the Board on a quarterly basis.

DR. STEINBERGH SECONDED THE MOTION.

Mr. Sinnott stated that he still believe the Hearing Examiner's Proposal is more appropriate, but he recognizes that this may be the best the Board can do. The amendment is helpful, and he will vote for it.

Dr. Bhati stated that he is rather disappointed that after the very extensive surgical discussion on this matter the Board is basing a suspension on the basis of emotions rather than the facts of what went on. He personally cannot support the suspension because he has not seen a surgical technology which has been deviated from enough to make Dr. Rajan responsible and deserving of three-months' suspension. He doesn't think that is fair. If Dr. Rajan had not opened the belly at the appropriate time, which Dr. Bhati believes he did, the suspension would be appropriate. Had he stayed in endoscopy and the patient would have bled and gotten into the DIC problem and a multi-system failure, Dr. Bhati would totally support an even longer suspension.

Dr. Bhati stated that some Board members are surgeons, and when they are in the operating room they know how many times they run into a difficult situation and get another colleague to assist. Here is a gentleman who opened the patient when the patient was not in shock. The total blood loss was less than 500 cc. He called another board-certified surgeon, and worked with him for eight hours after opening the belly. They lost 11 litres of blood. This is portal vein bleeding there. Dr. Bhati stated that he would rather have an aorta bleeding on him, and put a suture in to stop the bleeding, then have a portal vein bleeding on him. It is a very, very unfortunate situation. Dr. Bhati stated that he is very sorry that the patient died and he feels very bad about the family. He wishes it had never happened. But if a surgeon is in an operating room, he knows that technical problems do occur. Dr. Bhati spoke against the suspension.

Dr. Garg asked Dr. Bhati whether he thought there was a delay in going to the open procedure.

Dr. Bhati stated that he did not feel there was a delay at all. At the last recording, the patient's blood pressure was 120/70 and his pulse was 75 at the time he opened.

Dr. Heidt stated that the patient bled tremendously, but the cause of death might have been the severe massive necrosis of the liver from the ligation of the common hepatic artery. Whether he bled or not, he was going to die.

Dr. Bhati stated that as soon as a patient gets 19-20 blood transfusions, people get into DIC and multiple-system failure. This is a common situation.

Dr. Gretter stated that he would like to reiterate the fact that at the hearing the Board not only had two experts, both of whom agreed that there had been an error in judgment, it also had the surgeons themselves who agreed that there had been a significant error in judgment. There are individuals on the Board who have performed the procedure who agree that there was an error in judgment. That's the thing the Board must go on. He doesn't think the Board can argue surgical technique. When talking about what caused death, there was a great argument about a President from northern Ohio, who was shot and died some 125 days after he was shot. The argument was that he didn't die of the bullet wound, and the assailant didn't murder him, but he died of the infection later on. Dr. Gretter stated that the Board needs to look at where

all of this came from. The patient had massive necrosis from the hepatic area, and bleeding, but where did that come from? Somebody started that.

Dr. Garg asked Dr. Gretter whether he felt the error in judgment was the delay in opening the patient.

Dr. Gretter stated that it was.

Dr. Garg stated that that is not what he read. The first expert said from the beginning that he would have opened the patient even when he thought the bile duct was uprooted or clipped, which was not the knowledge that was done. The second expert said that he would have opened after 50 minutes. Dr. Garg stated that he doesn't know what Dr. Gretter is calling the error in judgment.

Dr. Gretter stated that the record is fairly clear in his mind. He read that both of the experts, including the surgeon himself, agreed that there was an error made. All agreed that there was an error.

Dr. Bhati disagreed, stating that Dr. Matyas even brought his own film as a record to show that he had a similar situation and he could manage to stop the bleeding, and he disagreed totally on it. Dr. Bhati stated that he agrees with Dr. Matyas simply for the fact that the patient was stable. There was only 500 cc of blood loss on that situation. The total blood loss came after the belly was open from 11:00 a.m. to 7:00 p.m. The bleeding was coming from the portal vein varices. That's where the bleeding was coming from. It's very simple. The patient died of DIC, of massive hemorrhage. Yes, it started from the start of the surgery, which led to the massive blood transfusions and DIC and multiple-system failure. You see the same thing in obstetrics/gynecology. In any major surgical procedure where you have massive blood transfusion, you run the risk of DIC, you run the risk of multi-system failure.

Dr. Buchan stated that, as so many times happens, the Board has a case boiling down to expert versus expert. The Board now has another expert that's testifying. Dr. Buchan continues to believe that Dr. Matyas is a very credible expert in this case, as difficult as it is, and as such, although he thinks there are problems, he will continue to move for a period of lesser suspension or reprimand.

Dr. Garg stated that he didn't get the error in judgment call from the record that Dr. Gretter got.

Mr. Sinnott stated that it is evident that there are some members of the Board who feel that the standard of surgical care reflected by the record in this case is one the Board ought to sanction. If the Board members conclude that there was a deviation from the prevailing standard in this case, he doesn't see how the Board can argue against a period of suspension. If a physician deviates from a standard of care in such a way that he contributes to a patient's death, he ought to spend some time out of practice. 90 days is a very modest sanction for having that Practice Act violation.

Dr. Bhati agreed, but pointed out that the problem is that there wasn't a deviation in this case. It was a judgment call.

Dr. Heidt stated that he believes from the discussion that the Board is agreed on the 90 days. He doesn't feel there's a problem.

Dr. Bhati disagreed.

Dr. Gretter called the question.

A vote was taken on Dr. Agresta's motion to amend:

VOTE:	Mr. Albert	- abstain
	Dr. Bhati	- nay
	Dr. Stienecker	- aye
	Dr. Gretter	- aye
	Dr. Agresta	- aye
	Dr. Buchan	- aye
	Mr. Sinnott	- aye
	Dr. Heidt	- aye
	Dr. Steinbergh	- aye

The motion carried.

MR. SINNOTT MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF SEMUR P. RAJAN, M.D. DR. STEINBERGH SECONDED THE MOTION. A vote was taken:

VOTE:	Mr. Albert	- abstain
	Dr. Bhati	- nay
	Dr. Stienecker	- aye
	Dr. Gretter	- aye
	Dr. Agresta	- aye
	Dr. Buchan	- aye
	Mr. Sinnott	- aye
	Dr. Heidt	- aye
	Dr. Steinbergh	- aye

The motion carried.



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

August 10, 1994

Semur P. Rajan, M.D.
275 Cline Avenue
Mansfield, OH 44907

Dear Doctor Rajan:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio intends to determine whether or not to limit, revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand or place you on probation for one or more of the following reasons:

- (1) On or about September 28, 1990, Patient 1, a 47 year old, identified in the attached patient key (Key confidential--to be withheld from public disclosure) presented to your office with complaints of intermittent right upper quadrant distress. Nausea, vomiting and jaundice were noted not to be present. Clinical impression was that of cholelithiasis with mild symptoms.
- (2) On or about December 11, 1990, you admitted Patient 1 to the hospital for an elective, laparoscopic cholecystectomy. This surgery, performed by you, was video recorded and later time tracked.
- (3) Your conduct throughout the operation showed a clear deficiency in understanding of the anatomy as it appears laparoscopically. The exposure of the gallbladder, use of laser, and blind application of clips and failure to timely convert to an open procedure were all inappropriate surgical techniques. Such deficiencies and uses of inappropriate techniques include but are not limited to the following:
 - (a) Upon introduction of the retractor, you retracted the gallbladder in the wrong direction. You then misidentified the common bile duct as the cystic duct. Thereupon, you clipped and transected the common bile duct. Upon transection, you failed to note that the proximal portion of the common bile duct was extending into the liver, a clear indication that this was the common bile duct. At this point, the laparoscopic procedure should have been terminated and converted to an open procedure. Nevertheless, you continued the laparoscopic procedure.

Mailed 8/11/94

- (b) By 18:10 and thereafter, on the time tracked video, you were clearly lost in the dissection. You were looking in the wrong areas for the cystic artery and by 21:53, on the time tracked video, you were working on the wrong side of the gallbladder in your attempt to identify arterial anatomy.
 - (c) At or around 30:00, on the time tracked video, you began using scissor dissection with electrocautery, despite being unable to see behind the structures being cut, which is not a safe technique.
 - (d) By 38:00, on the time tracked video, you had caused excessive bleeding, a clear indication to convert to an open procedure. Nevertheless, you again failed to convert and continued the laparoscopic procedure.
 - (e) At 48:00 on the time tracked video, you were not operating in the correct field. Between 48:00 and 51:00, you inappropriately utilized the laser in an attempt to stem the flow of blood, which in fact caused more damage resulting in increased bleeding. The increased, excessive bleeding is a clear and continuing indication to convert to an open procedure. Nevertheless, you continued with the laparoscopic procedure .
 - (f) At approximately 51:40 on the time tracked video, you began placing clips blindly into the area of bleeding, which created more bleeding. Again, you should have converted to an open procedure. Nevertheless, you continued with the laparoscopic procedure.
- (4) Further, you failed to recognize the injuries you caused. You failed to treat these injuries appropriately and in a timely manner, and you failed to accurately and honestly document in the hospital record the surgery and its complications.
 - (5) On December 14, 1990, Patient 1 was transferred to another hospital.
 - (6) On December 17, 1990, Patient 1 expired from shock and multisystem organ failure following your attempted laparoscopic cholecystectomy.

Your acts, conduct, and/or omissions as alleged in paragraphs (3) through (6) above, individually and/or collectively, constitute "(a) departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code, as in effect prior to March 15, 1993.

- (7) On or about December 14, 1990 you dictated the patient's operative note and endorsed the transcribed note by signature. Under Postoperative Diagnosis, in this note, you published that there were "extensive varicosities on the surface of the liver due to probably portal hypertension secondary to ethanol intake."

In fact there were no varicosities apparent, no evidence of portal hypertension nor any suggestion of cirrhosis, in the video or in the autopsy report.

Your acts, conduct, and/or omissions as alleged in paragraph (7) above, individually and/or collectively, constitute "publishing a false, fraudulent, deceptive, or misleading statement," as that clause is used in Section 4731.22(B)(5), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (7) above, individually and/or collectively, constitute "(a) departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code, as in effect prior to March 15, 1993.

Further, your acts, conduct, and/or omissions as alleged in paragraph (7) above, individually and/or collectively, constitute "(t)he violation of any provision of a code of ethics of a national professional organization," as that clause is used in Section 4731.22(B)(18)(a), Ohio Revised Code, to wit: Principle II of the American Medical Association's Principles of Ethics.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty (30) days of the time of mailing of this notice.

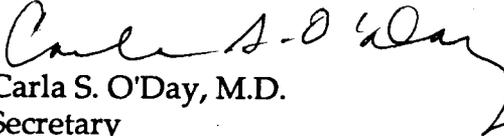
You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

August 10, 1994

In the event that there is no request for such hearing received within thirty (30) days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Copies of the applicable sections are enclosed for your information.

Very truly yours,


Carla S. O'Day, M.D.
Secretary

CSO:jmb

Enclosures:

CERTIFIED MAIL #P 348 885 077
RETURN RECEIPT REQUESTED