

# State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127



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Executive Director

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May 13, 2009

Venkanna Kanna, M.D.  
3409 Waterpoint Drive  
Columbus, OH 43221

RE: Case No. 08-CRF-102

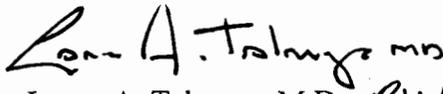
Dear Doctor Kanna:

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 May 13, 2009, including motions approving and confirming the Findings of Fact and Conclusions 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 must be taken to the Franklin County Court of Common Pleas.

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

THE STATE MEDICAL BOARD OF OHIO

  
Lance A. Talmage, M.D. *RW*  
Secretary

LAT:jam  
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3936 3071 0948  
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.  
CERTIFIED MAIL NO. 91 7108 2133 3936 3071 0955  
RETURN RECEIPT REQUESTED

*Mailed 5-26-09*

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 13, 2009, including motions approving and confirming the Findings of Fact and Conclusions 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 Venkanna Kanna, M.D., Case No. 08-CRF-102, 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.

Lance A. Talmage MD  
Lance A. Talmage, M.D. RW  
Secretary

(SEAL)

May 13, 2009  
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

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CASE NO. 08-CRF-102

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VENKANNA KANNA, M.D.

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on May 13, 2009.

Upon the Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner, designated in this Matter 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 that no further action shall be taken in the matter of Venkanna Kanna, M.D.

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

(SEAL)

Lance A. Talmage MD  
Lance A. Talmage, M.D. RW  
Secretary

May 13, 2009  
Date

2009 APR 15 A 10:44

**BEFORE THE STATE MEDICAL BOARD OF OHIO**

**In the Matter of**

\*

**Case No. 08-CRF-102**

**Venkanna Kanna, M.D.,**

\*

**Hearing Examiner Porter**

**Respondent.**

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**REPORT AND RECOMMENDATION**

Basis for Hearing

By letter dated August 14, 2008, the State Medical Board of Ohio [Board] notified Venkanna Kanna, M.D., that it intended to determine whether to impose discipline against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on an allegation that the Veterans Administration Medical Center in Chillicothe, Ohio, had terminated Dr. Kanna's clinical privileges, and that the termination of his privileges violated Section 4731.22(B)(24), Ohio Revised Code. The Board advised Dr. Kanna of his right to request a hearing in this matter, and received his written request on September 5, 2008. (State Exhibits 1-A, 1-B)

Appearances

Richard Cordray, Attorney General, and Barbara J. Pfeiffer, Assistant Attorney General, for the State of Ohio

Eric J. Plinke, Esq., for Dr. Kanna

Hearing Date: January 27, 2009

**SUMMARY OF THE EVIDENCE**

All exhibits and the transcript of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

**Background Information**

1. Venkanna Kanna, M.D., obtained his medical degree in 1971 from Osmania Medical College in Hyderabad, Andhra Pradesh, India. From 1971 through 1979 he practiced medicine in India. Dr. Kanna then immigrated to the United States, and, from 1980

through 1983, he completed an internal medicine residency at St. John's Episcopal Hospital in Brooklyn, New York, and St. Michael's Medical Center in Newark, New Jersey. In 1993, Dr. Kanna was certified by the American Board of Internal Medicine [ABIM], and he recertified in October 2008.<sup>1</sup> Dr. Kanna served as a Major in the United States Army Reserve from 1984 through 1992, including duty in Operation Desert Storm from December 1990 through May 1991. (Hearing Transcript [Tr.] at 60; Respondent's Exhibit [Resp. Ex.] D-1)

2. Dr. Kanna testified that he is in the process of obtaining additional qualifications in geriatric medicine offered by the ABIM. (Tr. at 28-29)
3. Dr. Kanna testified that he is currently employed as a locum tenens physician at two locations in the Columbus area, one a family practice office and the other an urgent care facility, and at one urgent care facility in Dayton. Dr. Kanna testified that, added together, he is working nearly full-time. (Tr. at 25-27)
4. From 1984 through 1989, Dr. Kanna worked as a staff physician at the U.S. Department of Veterans Affairs [VA] Medical Center in Tomah, Wisconsin, and, from 1989 through June 2006, he worked as a staff physician at the VA Medical Center in Chillicothe, Ohio [VAMC]. (Resp. Ex. D-1)

#### **Dr. Kanna's Termination from the VAMC and Appeal to the Disciplinary Appeals Board**

5. On May 26, 2006, Dr. Kanna was notified by the Director of the VAMC [director] that his employment at that institution had been terminated. Dr. Kanna indicated that the termination became effective on June 2, 2006. Dr. Kanna appealed his termination to a VA Health Administration Disciplinary Appeals Board [DAB] which conducted a hearing on October 3, 2006. (St. Ex. 1 at P2; St. Ex. 2 at 4-5; St. Ex. 2A at 7)

Following the hearing, the DAB reviewed the evidence and made findings concerning the VAMC's allegations against Dr. Kanna. Those allegations had arisen from three different incidents that occurred between January 28 and February 1, 2006:

- a. The first concerned Dr. Kanna's conduct during an assignment as Medical Officer of the Day [MOD]. The DAB found that MODs who worked a shift ending at 7:00 p.m. had been required to see and complete evaluations of all patients who arrived prior to 6:30 p.m., even if it became necessary for the MOD to remain later than 7:00 p.m. The DAB found that, despite being aware of that policy, on February 1, 2006, Dr. Kanna had left at 7:00 p.m. without seeing patients who had checked in prior to 6:30, which resulted in significant wait times for patients and additional work for the oncoming MOD. Moreover, the DAB found that, prior to leaving, Dr. Kanna had not responded in a timely manner to pages from nurses in the Admissions area. (St. Ex. 1 at P3-P6)

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<sup>1</sup> Dr. Kanna noted that his ABIM certification had lapsed between 2003 and October 2008. (Hearing Transcript at 60-61)

- b. The second incident also occurred during Dr. Kanna's MOD assignment on February 1, 2006. Dr. Kanna received a call from the lab reporting that an inpatient had "a critical lab value of potassium 7.2[.]" At the DAB hearing, Dr. Kanna had expressed an understanding of "the seriousness and potentially fatal consequences" of delaying treatment for such a condition. (St. Ex. 1 at P6)

At about 6:50 p.m., Dr. Kanna contacted a staff nurse and "instructed her to wait for the oncoming MOD and to tell him of the patient and the critical potassium level." Approximately ten minutes later, Dr. Kanna called the nurse and instructed her to transfer the patient to the ICU and obtain an EKG. However, Dr. Kanna admitted at the DAB hearing that he "did not review the EKG or check on the patient's cardiac rhythm." (St. Ex. 1 at P6-P7) The DAB found:

Dr. Kanna did not appropriately react to the information of the patient's critical potassium. His first reaction was instructing the nurse to just wait and notify the oncoming MOD. He did not ask any questions concerning the patient or his status. He made no attempt to see the patient. By his own testimony, Dr. Kanna states that his decision to reverse his instructions and transfer the patient to the ICU was made due to the concern about the review of his supervisor rather than concern over the patient's condition.

(St. Ex. 1 at P7)

In addition, the DAB noted that there had been conflicting testimony with regard to whether Dr. Kanna had adequately advised the oncoming MOD of the patient's critical potassium level. Dr. Kanna testified at the DAB hearing that he had advised the oncoming MOD that there was a patient being transferred to the ICU with a high potassium level. However, the oncoming MOD testified that Dr. Kanna had told him only that a patient was being transferred to the ICU, and that he had not learned of the patient's critical potassium level until he was contacted by the ICU nurse. The DAB found that "Dr. Kanna did not appropriately notify [the oncoming MOD] of the patient's condition when he assumed the MOD duties." (St. Ex. 1 at P7)

- c. The third incident charged by the VAMC had occurred on January 28, 2006. That charge, which was sustained by the DAB, stated:

On January 28, 2006, patient L.W. was admitted for chest pain under Dr. Kanna's care. The patient's history and physical were completed by another physician. Dr. Kanna made no entry in the patient's chart the following day. The patient was discharged on January 31, 2006. At the time of the discharge, he failed to provide discharge instructions for follow-up with the primary care provider and he failed to recommend further diagnostic testing as suggested by the community provider responsible for transferring the patient to our medical center. When

questioned regarding this matter, Dr. Kanna acknowledged that he should have ordered specific care for the patient.

(St. Ex. 1 at P8) Indicating that they had reviewed the patient's chart, the DAB found:

The patient had known cardiac disease and had many risk factors. He was admitted with an abnormal EKG and elevated CPK and CPK MB. Dr. Kanna testified that the enzyme elevations were likely from cardiac ischemia. \* \* \* Despite this, the patient had no further cardiac work up prescribed. The [DAB] considered this well below an acceptable standard of care.

(St. Ex. 1 at P8)

6. On January 7, 2007, the DAB issued its Decision in the Discharge of Venkanna Kanna, M.D., [Decision] which sustained the termination of Dr. Kanna's employment at the VAMC. (St. Ex. 1 at P11)

### **Dr. Kanna's Defense**

#### *Personnel Dispute*

7. Dr. Kanna testified that the VAMC's action had arisen from a personnel dispute between Dr. Kanna and management at the VAMC. Dr. Kanna noted that, when he first started working at the VAMC, physicians had done "24-hour duty," which required the physicians to remain on call and on the premises for 24-hour periods. However, Dr. Kanna testified, VA physicians were supposed to work only 40 hours per week. Dr. Kanna testified that he and other physicians approached management and that management had entered into an agreement with the Ohio State University [OSU] whereby physicians engaged in fellowships in internal medicine subspecialties such as cardiology or nephrology would be on call for the VAMC during the overnight hours. While that agreement was in place, VAMC physicians worked from 8:00 a.m. until 7:00 p.m. and were on back-up call only after 7:00 p.m. Dr. Kanna testified that that arrangement benefitted the staff physicians and worked well for about 14 years. (Tr. at 34-36, 39, 68-70)

Dr. Kanna testified that, when the director took over management at the VAMC, the director determined that the arrangement with OSU was too expensive and, "on the pretext of saving [a] half a million dollar budget deficit," proposed cancelling that arrangement. Dr. Kanna further testified that he, along with other staff physicians, objected to the director's proposal, which would put the staff physicians back on 24-hour duty. Dr. Kanna testified that the VAMC was already short of staff and he had believed that the proposal would have negative results for physicians and patients alike. (Tr. at 39-40)

Dr. Kanna along with some other physicians embarked on a letter-writing campaign to Ohio congressional representatives.<sup>2</sup> However, Dr. Kanna testified that the letter-writing campaign was unsuccessful. Moreover, Dr. Kanna testified, as a result of his efforts to reverse the director's proposal, "small things blew up big" and the director terminated him. (Tr. at 40, 79-80; Resp. Ex. A)

*Ethnic Discrimination*

8. Dr. Kanna testified that the internal medicine service at the VAMC had consisted of 16 or 17 physicians, 13 of whom were of Indian or other Asian origin. Dr. Kanna further testified that the director's testimony at the DAB hearing indicated that Dr. Kanna's ethnicity had played a role in the director's decision to terminate Dr. Kanna's employment. (Tr. at 30-31, 33-34, 52-56; St. Ex. 1 at P10)

In its Decision, the DAB noted that it had heard testimony from the director. The director testified that, during his tenure, he had been advised by patient advocates and others that Dr. Kanna had been uncooperative in resolving patient complaints. The director further testified that he had spoken with the chief of staff and Dr. Kanna's first-level supervisor concerning Dr. Kanna's behavior and steps taken to correct the behavior. (St. Ex. 1 at P2) The DAB further noted:

[The director testified] regarding the ethnicity of the providers and the Chief of Staff at the Chillicothe VA Medical Center. [The director] stated that he felt the lack of action addressing Dr. Kanna's conduct was due to ethnicity being honored before medical center business. \* \* \* The [DAB] did not consider these comments when making their final decision on the charges, but feel that [the director's] comments were not reflective of the diversity embraced by the VA.

(St. Ex. 1 at P10)

9. Dr. Kanna testified that he has filed a lawsuit in federal court against the Veteran's Administration. Dr. Kanna further testified that the primary ground for his lawsuit is discrimination. (Tr. at 30-31, 52-56)

Dr. Kanna also testified that he had filed a complaint with the U.S. Equal Employment Opportunity Commission [EEOC], and that the EEOC investigated his complaint. However, he stated that the outcome of the investigation favored the VA. (Tr. at 64-65)

**Dr. Kanna's Clinical Privileges at the VAMC**

10. In his responses to interrogatories from the Board, Dr. Kanna stated that his clinical privileges at the VAMC had been terminated when he was removed from his position as a staff physician at the VAMC. (St. Exs. 2, 2-A)

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<sup>2</sup> Copies of the letters and responses were presented by Dr. Kanna at hearing and are dated from December 2005 through May 2006. (Resp. Ex. A)

At the present hearing, Dr. Kanna testified that, at the time he answered the Board's interrogatories, he had been under an impression that the VAMC had revoked his clinical privileges. However, Dr. Kanna testified that, after re-reviewing the Decision, he found that it actually does not address his clinical privileges. (Tr. at 31-32)

11. Dr. Kanna testified on cross-examination that, today, he would not be allowed to admit a patient to the VAMC or to treat a patient there, and that he does not currently have privileges at that facility. Dr. Kanna further testified that a physician cannot have clinical privileges or practice at the VAMC unless he or she is employed there. However, when asked on redirect-examination about the OSU physicians who had practiced at the VAMC, Dr. Kanna indicated that it is possible to have privileges at the VAMC without being employed there. (Tr. at 65-66, 78)

Dr. Kanna testified on recross-examination that the OSU physicians who practiced at the VAMC had already completed their primary residencies and were licensed to practice medicine. Dr. Kanna further testified that they had practiced at the VAMC pursuant to a contract between OSU and the VAMC. (Tr. at 82-84)

#### **Additional Information**

12. At the DAB hearing, the parties stipulated that Dr. Kanna had been employed by the VA for 21 years and that, during that period, up to and including his final evaluation in January 2006, all of his evaluations "were rated as either satisfactory or highly satisfactory." (St. Ex. 1 at P2)

Dr. Kanna testified that, prior to the VAMC's efforts to remove him, he had received only positive performance evaluations from the VAMC. Dr. Kanna further testified that he had also received commendations for his performance at the VAMC. (Tr. at 45-48; Resp. Exs. B, C)

The performance evaluations presented by Dr. Kanna cover a period from 1988 through 2004. The majority of the evaluations rate Dr. Kanna as "High Satisfactory"<sup>3</sup> in categories that include clinical competence, administrative competence, and personal qualities. A few earlier evaluations reflect difficulties with documentation and dealing with patients and their families. However, aside from one negative evaluation dated September 28, 1989, which was updated two months later to reflect a satisfactory rating, the performance evaluations do not suggest that Dr. Kanna is lacking in medical knowledge or clinical competency. (Resp. Ex. C)

13. Dr. Kanna presented a letter of support from a current employer, and patient and physician evaluations that relate to his ABIM re-certification, all of which cast Dr. Kanna in a positive light. (Resp. Exs. E, F)

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<sup>3</sup> "High Satisfactory" is defined in the evaluations as follows: "Usually exceeded reasonable expectations by a substantial margin." (Resp. Ex. C)

### **FINDINGS OF FACT**

1. As reflected in the Decision in the Discharge of Venkanna Kanna, M.D., [Decision] issued on January 2, 2007, by a Disciplinary Appeals Board for the Department of Veterans Affairs: on or about June 2, 2006, Dr. Kanna was removed from his position as a staff physician at the Veterans Administration Medical Center in Chillicothe, Ohio [VAMC].
2. In response to interrogatories from the Board, Dr. Kanna admitted that his removal from employment at the VAMC had also resulted in the termination of his clinical privileges at that facility. At hearing, Dr. Kanna retracted that statement and accurately noted that the Decision did not directly address his clinical privileges at the VAMC. Therefore, he argued, the Decision constituted only an employment action and not an action against his privileges. However, the Hearing Examiner does not find this argument convincing. The record clearly indicates that, in order to obtain clinical privileges at the VAMC, a physician must either be employed by the VAMC or have some sort of contractual arrangement with it. Accordingly, the evidence is sufficient to support a finding that the Decision removing Dr. Kanna from employment at the VAMC terminated his clinical privileges at that institution.

### **CONCLUSION OF LAW**

The Decision, as described in the Findings of Fact, constitutes “[t]he revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs \* \* \*,” as that clause is used in Section 4731.22(B)(24), Ohio Revised Code.

### **RATIONALE FOR THE PROPOSED ORDER**

The evidence establishes that Dr. Kanna’s termination from the VAMC concerned conduct that affected patient care. The evidence further establishes that, with regard to the patient with the high potassium level and the patient who was having chest pains, Dr. Kanna’s conduct seriously jeopardized those patients’ safety. Moreover, the evidence is clear that Dr. Kanna does not lack medical knowledge or clinical ability, and that his conduct was intentional. Furthermore, the evidence establishes that Dr. Kanna placed his dispute with VAMC management ahead of his duty to his patients. His conduct was so egregious that permanent revocation of his medical license would be an appropriate disposition. The Proposed Order stops short of that, however, and instead imposes a lengthy suspension, reinstatement requirements that include completion of medical and professional ethics courses, and probationary monitoring following reinstatement or restoration.

## PROPOSED ORDER

It is hereby ORDERED that:

- A. **PERMANENT REVOCATION, STAYED; SUSPENSION:** The certificate of Venkanna Kanna, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such revocation is STAYED, and Dr. Kanna's certificate shall be SUSPENDED for an indefinite period of time, but not less than two years.
- B. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Kanna's certificate to practice medicine and surgery until all of the following conditions have been met:
1. **Application for Reinstatement or Restoration:** Dr. Kanna shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
  2. **Medical and Professional Ethics Course(s):** At the time he submits his application for reinstatement or restoration, Dr. Kanna shall provide acceptable documentation of successful completion of a course or courses dealing with medical and professional ethics. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.  
  
In addition, at the time Dr. Kanna submits the documentation of successful completion of the course or courses dealing with medical and professional ethics, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.
  3. **SPEX:** Within six months prior to submitting his application for reinstatement or restoration, Dr. Kanna shall take and pass the SPEX examination or any similar written examination that the Board may deem appropriate to assess Dr. Kanna's clinical competency following suspension.
- C. **PROBATION:** Upon reinstatement or restoration, Dr. Kanna's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least two years:
1. **Obey the Law:** Dr. Kanna shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
  2. **Declarations of Compliance:** Dr. Kanna shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has

been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Kanna's certificate is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances:** Dr. Kanna shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Kanna's certificate is restored or reinstated, or as otherwise directed by the Board. Subsequent personal appearances must occur every six months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
4. **Monitoring Physician:** Within thirty days of the date of Dr. Kanna's reinstatement or restoration, or as otherwise determined by the Board, Dr. Kanna shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Kanna and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Kanna and his medical practice, and shall review Dr. Kanna's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Kanna and his medical practice, and on the review of Dr. Kanna's patient charts. Dr. Kanna shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Kanna's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Kanna must immediately so notify the Board in writing. In addition, Dr. Kanna shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Kanna shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

5. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Kanna is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

- D. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Kanna's certificate will be fully restored.
- E. **VIOLATION OF THE TERMS OF THIS ORDER:** If Dr. Kanna violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
- F. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

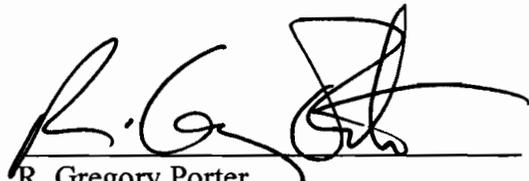
1. **Required Reporting to Employers and Others:** Within 30 days of the effective date of this Order, Dr. Kanna shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services (including but not limited to third-party payors), or is receiving training; and the Chief of Staff at each hospital or health-care center where he has privileges or appointments. Further, Dr. Kanna shall promptly provide a copy of this Order to all employers or entities with which he contracts to provide health care services (including but not limited to third-party payors), or entities to which Dr. Kanna applies for or receives training, and the Chief of Staff at each hospital or health-care center where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Kanna receives from the Board written notification of the successful completion of the probation.

In the event that Dr. Kanna provides any health-care services or health-care direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Kanna receives from the Board written notification of the successful completion of the probation.

2. **Required Reporting to Other State Licensing Authorities:** Within 30 days of the effective date of this Order, Dr. Kanna shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Also, Dr. Kanna shall provide a copy of this Order at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Kanna receives from the Board written notification of the successful completion of the probation.
3. **Required Documentation of the Reporting Required by Paragraph F:** Dr. Kanna shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (1) the

return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

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



R. Gregory Porter  
Hearing Examiner

  
**State Medical Board of Ohio**  
30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.  
Executive Director

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EXCERPT FROM THE DRAFT MINUTES OF MAY 13, 2009

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDER

Dr. Madia announced that the Board would now consider the Reports and Recommendations and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Madia asked whether each member of the Board had received, read and considered the hearing record; the Findings of Fact, Conclusions of Law and Proposed Orders, and any objections filed in the matters of: Emad S. Atalla, M.D.; Menna Berhane, M.D.; Randall Jay Bolar, M.D.; Ralph Arden Hugunin, M.D.; Venkanna Kanna, M.D.; Kathy Lynn Kruger, D.O.; Marietta J. Medel, M.D.; Robert L. Turton, D.O.; and Jeffrey E. White, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Varyani	- aye
	Mr. Jacobson	- aye
	Mr. Hairston	- aye
	Dr. Amato	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Madia	- aye

Dr. Madia 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. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Varyani	- aye
	Mr. Jacobson	- aye
	Mr. Hairston	- aye
	Dr. Amato	- aye
	Dr. Stephens	- aye

Dr. Mahajan - aye  
Dr. Madia - aye

Dr. Madia noted that, in accordance with the provision in Section 4731.22(F)(2), 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. They may, however, participate in the matters of Dr. Berhane and Dr. Medel, as those cases are not disciplinary in nature and concern only the doctors' qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

Dr. Madia advised that no oral motions may be made by either party during these proceedings.

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

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VENKANNA KANNA, M.D.

Dr. Madia advised that he has a conflict of interest in this matter, and would recuse himself from this case. He at this time left the Chair.

Dr. Amato, as Vice-President, assumed the Chair in Dr. Madia's absence. He directed the Board's attention to the matter of Venkanna Kanna, M.D. He advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members. He advised that with those objections, Dr. Kanna filed a Request for Remand. The State, in turn, filed a Memorandum Contra the Motion to Remand. Dr. Amato advised that he was provided with the motion to remand, and the memorandum contra, and he subsequently denied the motion to remand.

It was at this time established that a request to address the Board was timely filed on behalf of Dr. Kanna. Dr. Amato stated that five minutes would be allowed for that address.

Dr. Kanna was accompanied by his attorney, Eric J. Plinke.

Mr. Plinke stated that he would like to address a couple of points that he mentioned in his objections. The primary thrust of the objections is, in reading Mr. Porter's report, he gets to the point where he examines the clinical issues that are referenced in the VA termination of employment document. Based on the Report and Recommendation, it's clear that those issues are very significant to him. Mr. Plinke stated that they really didn't have a hearing about those issues. They had a hearing about whether or not, when Dr. Kanna was fired from the VA, something which he reported to the Board years ago when he renewed his license, whether when he was fired his privileges were terminated. Dr. Kanna acknowledged in

interrogatories that they were terminated. Upon further reflection, Mr. Plinke contends that Dr. Kanna actually was never told what happened to his privileges. Mr. Plinke stated that Mr. Porter addressed that issue in the Report and Recommendation, but after doing that he cites to these clinical issues that clearly, in Mr. Porter's mind, up the ante, so to speak, on the disciplinary scale. Those were not addressed in the hearing.

Mr. Plinke stated that it has happened before where the Board proposes to take discipline on another action, it doesn't give notice that it wants to base discipline on the acts underlying that action. In those cases, when the Board does do that, the Common Pleas Court has reversed those orders. Mr. Plinke stated that if the Board wants to have a hearing about those issues, Dr. Kanna is happy to do that. Before the Board imposes any discipline at all on those issues, he would think that, as a medical review board, the Board might like to have medical records and witness testimony about those clinical issues. However, that was not the case that was noticed or heard here.

Mr. Plinke stated that if the Board does want to consider anything in this document, the most telling line is where the VA panel acknowledges that the person responsible for terminating Dr. Kanna had admitted at the VA hearing that he had done so because he had perceived what he called an "Asian provider bias," and that he needed to correct that bias by firing Dr. Kanna. After making that admission, this VA review panel said that it ignored that evidence. Mr. Plinke stated that that's all the Board needs to know, along with his legal objections to this, about the reliability of this document.

Dr. Kanna stated that he is a physician who has dedicated his life to service, starting in a small town in India, where he accepted vegetables as payment for his service. For 22 years he has given service to his fellow veterans in the VA hospitals. In all those years he had an outstanding professional record, evidenced by many patient letters of appreciation and his evaluations by supervisors. His firing from the VA was not reflective of his overall attitude or performance as a physician. The document the Board has regarding his firing is not true, and that is why it is the subject of his federal lawsuit. No one from the Board ever asked him about these painful issues in either the interrogatories or the Board's hearing. Everything that was asked concerned whether his firing meant that he had lost privileges. His answer was yes, but no one ever told him that. It was just his assumption.

Dr. Kanna stated that he loves being a doctor, he believes that he is a good one, and many patients and colleagues have echoed that sentiment. He requested that the Board allow him to continue to practice his art, as he has done for over 38 years. He has recently been recertified by the Internal Medicine Boards, and he is currently recertifying in geriatrics. In recent surveys, both his colleagues and his patients rated him highly. He's an active member of the American Association of Physicians of Indian Origin, and he was a fellow of the American College of Physicians, though his membership is no longer active. Dr. Kanna stated that he is a good person and a responsible member of the community, and, above all, a conscientious physician. Dr. Kanna stated that the portions of the document that the Hearing Examiner identified that reflect to the contrary are not true and were the result of an admittedly discriminatory and retaliative finding.

Dr. Kanna stated that if the Board finds him to be at fault in any way, he readily agrees to anything that would guide him to become a better doctor, short of limiting his ability to practice medicine. He's willing to do course work or to go on probation to address the Board's concerns.

Dr. Amato advised Dr. Kanna that his time is up, and he asked him to finish his statement.

Dr. Kanna stated that he does not and he did not abandon his duties or his patients. To the contrary, when the care of a veteran was threatened, he found it his personal duty as a physician and veteran to protect them by writing to those politicians. The suggestion that he allowed his dispute with the administration over that issue to interfere with his duties to patients is not true. He's currently appealing the VA's decision to terminate him because the allegations were not true, and because of the ethnic bias.

Dr. Kanna asked that the Board allow him the privilege to continue his practice. If the Board wants to hear about medical issues, he will cooperate with the review and tell the Board what happened.

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

Ms. Pfeiffer stated that, as the Board deliberates, it should keep in mind that this particular case is comparable to a bootstrap case where the Board takes disciplinary actions based upon what another state medical board has done against an Ohio physician. When a physician is practicing with the VA, the Board does not have that more traditional type of disciplinary action coming in from the state, necessarily. However, when the Federal Government, which regulates and supervises VA hospitals, takes action, the Board has the statutory ability to take action. Ms. Pfeiffer stated that the Board should equate it that way. Just like in bootstrap cases, the VA basically fired Dr. Kanna. In order to have privileges at the VA hospital, you have to have some kind of employment relationship with that hospital. Ms. Pfeiffer stated that Dr. Kanna tried to make a lot of hay out of the fact that it never really said that his privileges were terminated, but the fact that he was fired and can't come back to work at that hospital means he has no privileges. Ms. Pfeiffer stated that she thinks that it's clear in this particular case that Dr. Kanna's privileges were terminated. The document that was used in evidence to prove that termination was a decision from the VA. That's what the Board has in evidence, just like in bootstrap cases, when you have the other state's orders, it's consent agreements, and you look at those and you take them into consideration. The Board has the right to discipline solely on the fact that this physician's privileges were terminated by the VA. That's the basis of the Board's decision in this case. The Board can look at the evidence that documented why Dr. Kanna was terminated. That was part of the evidence in this case, because it showed that he was, in fact, terminated and why. The Board can take that into consideration. The Board is not disciplining him or charging him with standard of care violations. It's solely the fact that he was terminated by the VA.

**DR. VARYANI MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF VENKANNA KANNA, M.D. MR. HAIRSTON SECONDED THE MOTION.**

Dr. Amato stated that he would now entertain discussion in the above matter.

Mr. Jacobson stated that when the Board deals with a bootstrap case, it is disciplining for the same reason as the bootstrap. In other words, it's not that someone imposed discipline so "because someone else took an action, we're just going to take one, too." It's not piling on. The Board looks at what the bootstrap was about to find out if what they disciplined on was a violation in Ohio. He stated that the Board doesn't have the right to discipline someone just because they were disciplined in another state for something that is not actionable in Ohio. When the Board looks at a bootstrap case, it looks at the record of the bootstrap, because it helps the Board figure out if there's a problem here.

Mr. Jacobson stated that that's not what happened here. It's not the same thing. They looked at the fact that he got disciplined and decided that that's the reason Ohio should act. All they were looking for was to figure out whether or not Dr. Kanna got fired or whether he gave the right answer to a question. Because they decided that, the Hearing Examiner looked and said, "Oh, well while I'm here, look at all these bad things he did." Mr. Jacobson stated that if those were truly worth disciplining on, then he thinks that Dr. Kanna deserves the right to defend himself. He deserves the right to have a hearing on those issues. This is not a case where he was brought before the Board because of what he did wrong at the VA Center in another jurisdiction and was sanctioned for that. This is a case where the Board was only interested in whether or not he answered a question correctly, and while we were there we decided that, oh, we can get him on this other thing.

Mr. Jacobson stated that this is a due process violation, at best. He understands the argument of, "did you lose your privileges, yes or no," but it seems to him that it's a semantical basis at best for a sanction of this magnitude. At a minimum, if the Board thinks that the underlying issues, the reasons he was fired, are worth pursuing, it should remand the matter back to the Hearing Examiner for consideration on that grounds.

Dr. Mahajan agreed with Mr. Jacobson. He stated that the Board should get more details into the circumstances of why it happened, and whether it's worth the Board's considering it.

Dr. Suppan stated that she also agrees with Mr. Jacobson. She stated that she looked specifically at the incidents and incident number one was that he left and it caused the patients to have to wait too long to see another physician. That incident wouldn't have come to the Medical Board. Concerning incident number 2, a critical value of potassium, Dr. Kanna sent the patient to ICU and asked for ICU to find the next doctor on call to handle that patient, Dr. Suppan stated that that's a quality of care, communication thing. She stated that, once again, that in and of itself would not have come to the Medical Board. Concerning incident 3, the patient was admitted to Dr. Kanna's service, a history and physical was done by another doctor, and he never saw the patient or made a note in the chart. Again, that's a hand-off communication issue. Dr. Suppan stated that these things are faced in hospitals every day. These are the kinds of cases that she reviewed in the family practice department or the surgery department. There was no expert testimony in this case, there was no due process, and the Board doesn't know what the bylaws said in the hospital.

Mr. Jacobson stated that having heard the explanation that these three things are not things that would have come before the Board, then there is nothing on the face of it that would cause the Board to have an investigation in the first place. There is nothing here to suggest that he fell below the minimal standard of care and the way that the Board is involved in discipline actions. He doesn't even think it's fair to send it back to the Hearing Examiner.

Dr. Varyani asked what the Board does when you are off of CMS, and that entity has determined that a physician has committed Medicare or Medicaid fraud and the person is convicted of that. Does the Board have to retry the whole thing again before it sanctions the person?

Mr. Whitehouse stated that, more than retry, it means almost a re-citation if the Board goes back and gets into all these instances. If the Board bases its action on those, that would be a violation of due process. The Board would be taking action based on something that was not alleged. What is alleged here is the "revocation, suspension, restriction, reduction or termination of clinical privileges." This is what the Board needs to constrain its discussion to.

Dr. Varyani stated that that's where he's going. He added that, if a hospital removes someone's privileges, they're supposed to report to every agency why. Does that mean that every agency will have to investigate that?

Dr. Suppan stated that they terminated Dr. Kanna first, and that was an issue between an employer and an employee. She stated that, in her view, these things would have been handled in another way, not with a termination.

Mr. Whitehouse stated that the reference to the specific incidents underlying the VA action are there, not for the Board's investigation but to give a little bit of clarity. It's not up to the Board to then review and see whether it agrees with that.

Mr. Jacobson stated that, absent that, then you have to ask yourself whether or not what is proposed as a sanction here is an appropriate sanction for a semantical difference as to whether or not being fired is the same thing as losing your privileges. Mr. Jacobson stated that the physicians on the Board can tell, better than he can, whether or not this is a big deal.

Dr. Varyani stated that to him it's a big deal. He then asked for an explanation of the Conclusion of Law, which reads:

The Decision, as described in the Findings of Fact, constitutes "[t]he revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs \* \* \*," as that clause is used in Section 4731.22(B)(24), Ohio Revised Code.



Dr. Talmage	- abstain
Dr. Suppan	- aye
Dr. Varyani	- nay
Mr. Jacobson	- aye
Mr. Hairston	- aye
Dr. Stephens	- aye
Dr. Mahajan	- aye
Dr. Madia	- abstain
Dr. Amato	- aye

The motion carried.

**DR. SUPPAN MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF VENKANNA KANNA, M.D. MR. HAIRSTON SECONDED THE MOTION.**

Dr. Amato stated that he would now entertain discussion in the above matter.

There was no further discussion.

A vote was taken on Dr. Suppan's motion:

ROLL CALL:	Mr. Albert	- abstain
	Dr. Talmage	- abstain
	Dr. Suppan	- aye
	Dr. Varyani	- nay
	Mr. Jacobson	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Madia	- abstain
	Dr. Amato	- aye

The motion carried.



# State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.  
Executive Director

(614) 466-3934  
med.ohio.gov

August 14, 2008

Case number: 08-CRF-102

Venkanna Kanna, M.D.  
3409 Waterpoint Drive  
Columbus, Ohio 43221-4951

Dear Doctor Kanna:

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

- (1) On or about June 2, 2006, you were removed from your position as a staff physician at the Veterans Administration Medical Center in Chillicothe, Ohio. At the time of your removal, your clinical privileges also were terminated. You have admitted that the removal from your position and termination of your clinical privileges was affirmed in a Decision In the Discharge of Venkanna Kanna, M.D. [Decision] issued on or about January 2, 2007, by the Disciplinary Appeals Board, Department of Veterans Affairs. A copy of the Decision is attached hereto.

The Decision, as alleged in paragraph (1) above, constitutes “[t]he revocation, suspension, restriction, reduction, or termination of clinical privileges by the United States department of defense or department of veterans affairs or the termination or suspension of a certificate of registration to prescribe drugs by the drug enforcement administration of the United States department of justice,” as that clause is used in Section 4731.22(B)(24), Ohio Revised Code.

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 days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, 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,

*Mailed 8-14-08*

or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty 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, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.  
Secretary

LAT/CDP/fib  
Enclosures

CERTIFIED MAIL #91 7108 2133 3934 3688 1460  
RETURN RECEIPT REQUESTED

cc: Eric J. Plinke  
Dinsmore & Shohl, LLP  
191 West Nationwide Blvd.  
Suite 300  
Columbus, Ohio 43215

CERTIFIED MAIL #91 7108 2133 3934 3688 1453  
RETURN RECEIPT REQUESTED



DEPARTMENT OF VETERANS AFFAIRS  
Veterans Health Administration  
Washington DC 20420

JAN 02 2007

In Reply Refer To:

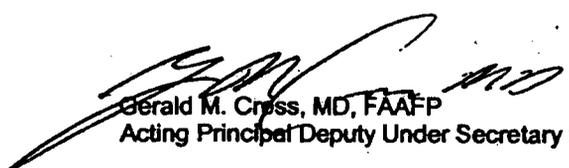
**Decision In the Discharge of Venkanna Kanna, M.D.**

On October 3, 2006, a Disciplinary Appeals Board convened to conduct a hearing in connection with the discharge of Venkanna Kanna, M.D., at the VA Medical Center in Chillicothe, OH. The appellant was a full-time permanent employee who had completed his probationary period at the time of the discharge. The charges upon which the action is based, in whole or in part, involved issues of professional conduct and competence and the appeal was timely filed. Therefore, I find the Board properly concluded they had jurisdiction over this appeal.

The appellant was charged with (1.) Patient Abuse by intentional omission of care 2.) Disrespectful conduct towards patients (3) Failure to provide efficient service when dealing with the public (4) Disrespectful conduct towards co-workers.

In considering the testimony provided, and the egregious nature of the charges that were sustained, the Board concluded the discharge was appropriate. It is my decision to execute the decision of the Disciplinary Appeals Board. A copy of the approved Board Action is enclosed.

This is the final administrative action in this matter.

  
Gerald M. Cross, MD, FAAFP  
Acting Principal Deputy Under Secretary for Health

Enclosure

Exhibit # 1

CLT  EMP

Docket No. H2006-338-0039

RECEIVED  
DIRECTOR'S OFFICE  
07 JAN -9 PM 1:09  
VA MEDICAL CENTER  
CHILICOTHE, OH 45601



### BOARD ACTION

*INSTRUCTIONS — Prepare on copy for Field Station and one copy for Central Office for all employees for whom Board Action is forwarded to Central Office for review of filing in Board Action Folder.*

1. EMPLOYEE/APPLICANT'S NAME KANNA, VENKANNA	1A. EMPLOYEE'S POSITION Staff Physician	1B. EMPLOYEE'S GRADE AND STEP Physician/11	1C. NAME OF STATION VAMC, Chillicothe, OH
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#### INITIATING BOARD

2. NAME OF BOARD (Check one) <input type="checkbox"/> PROF. STD. BOARD <input checked="" type="checkbox"/> DISCIPLINARY <input type="checkbox"/> PHYSICAL STANDARDS	3. STATION OF BOARD VAMC, Chillicothe, Ohio	4. DATE October 3, 2006
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5. FINDINGS

#### INTRODUCTION

On October 3, 2006, a Disciplinary Appeals Board, appointed by the Under Secretary for Health, was convened to conduct a hearing on the removal of Venkanna Kanna, M.D., Medical Service, VA Medical Center, Chillicothe, Ohio. Appellant was notified of this removal decision by letter dated May 26, 2006, from Douglas A. Moorman, Medical Center Director. The penalty was based on nine charges.

#### JURISDICTION

The Board has determined that they do have jurisdiction in this issue. Dr. Kanna was a full-time, nonprobationary employee of the VA Medical Center, Chillicothe, Ohio, at the time of his removal. Dr. Kanna did timely request an appeal of the adverse action taken against him. The Board has determined that charges 3a, 4a, and 5a, Patient Abuse by intentional omission of patient care on three different occasions, concerns a matter of professional conduct and/or competence. However, the Board has determined that charges 3b, 4b, and 5b; Disrespectful conduct towards patients on three different occasions; charges 3d and 4 c; disrespectful conduct towards co-workers on two different occasions; and charge 3c, failure to provide efficient service when dealing with the public do not concern a matter of professional conduct and/or competence. If at least one charge is determined to be a matter of professional conduct and competence, the Board does have authority to hear Dr. Kanna's appeal in the matter of his removal and to consider the appropriateness of both charges and the penalty assessed. This case involved a major adverse action (removal) arising out of a question of professional conduct or competence.

#### ANALYSIS AND FINDINGS

1. Stipulations: During the hearing, all parties stipulated to the fact that Venkanna Kanna, M.D., has been employed with the Department of Veterans Affairs for a period of 21 years. It was further stipulated that during this period of employment, all proficiencies, including the final proficiency dated January 2006, were rated as either satisfactory or highly satisfactory.

2. Findings:

On September 18, 2003, tab 4f, Evidence File, Agency Exhibit 1, the Chief of Staff issued a Memorandum to all MOD Staff Physicians, instructing that it was mandatory that all staff MOD's see and complete the evaluation on all patients who arrive in the Admission's area prior to 6:30 .m., even if it is necessary to remain beyond 7:00 p.m.

There were three incidents involving Dr. Kanna's care of patients within a short period of time (January 28 through February 1, 2006). Due to these incidents, the Medical Center Director, Douglas Moorman, convened an Administrative Board of Investigation. This AIB, determined that disciplinary action due to the actions of Dr. Kanna was appropriate.

According to Mr. Moorman, Dr. Kanna's behavior during the short period above, was not isolated to these incidents. Mr. Moorman testified, (transcript, Moorman's testimony page 188) that during his tenure as Medical Center Director, the Patient Advocates and others had advised him that Dr. Kanna was not cooperative in resolving patient complaints. Mr. Moorman was concerned with these reports and talked with both the Chief of Staff and with Dr. Jane-Wit, Dr. Kanna's first line supervisor, concerning Dr. Kanna's continuing behavior and action taken to correct the behavior. (Moorman testimony pages 189-191.)

Charge 3. On February 1, Dr. Kanna was assigned as the Medical Officer of the Day. He was paged at approximately 4:51 p.m. (1651) to see a patient. He did not arrive at the Admission Area until 5:50 p.m. (1750). After examining one patient, he was advised by Staff Nurse LM that there were more patients to be seen. Staff Nurse LM reports that he said words to the effect, "I am hungry and weak, I am going to eat." He then left the Admissions Area. Staff Nurse LM reported the situation to Evening Nursing Supervisor MB. The supervisor, who located Dr. Kanna in the break room behind the nurse's station eating, advised him that he had to see the patients, to which he responded with words to the effect, "I am eating." Dr. Kanna later returned to the Admission Area just before 7:00 p.m. At that time he was again reminded by Staff Nurse LM that there were five patients to be seen. He was also reminded by Staff Nurse LM of the order of the Chief of Staff on September 18, 2003, via memorandum, which states that "it is mandatory that staff MOD's complete all patients that arrive in the Admission's area prior to 6:30 p.m., even if it is necessary to remain beyond 7 p.m." He responded with words to the effect of "I did not sign any memorandum and I will not see any more patients." Further more, he did not inform the oncoming MOD about the patients who had not been seen, merely handing the oncoming MOD the keys and pager while he was examining a patient and left the area. When questioned regarding this matter, Dr. Kanna initially denied being paged, denied being advised there were patients to be seen, and denied being reminded of his responsibility to see all patients arriving prior to 6:30 p.m. He later testified that he was aware that there were patients to be seen, but he did not promote quality healthcare services for our veteran patients, did not promote good public relations, and did not promote good customer service. Additionally, he created a hardship for the oncoming MOD by not treating patients waiting to be seen. Dr. Kanna was charged with:

a. Patient abuse by intentional omission of care. His conduct is in violation of Policy Memorandum No. 11-19, Patient Abuse, dated June 30, 2005, paragraph 3, which states, in part, "Patient abuse is defined as acts against patients which involve intentional omission of patient care . . ." This was evidenced by his failure to examine patients in the Admission Area awaiting treatment.

b. Disrespectful conduct towards patients. His conduct in the matter was in violation of Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), which states, in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of acceptable work behavior. The following are considered improper . . disrespectful conduct. . ."

c. Failure to provide efficient service when dealing with the public. His conduct in this matter was in violation of Policy Memorandum No. 05-17, Employee Responsibility and Conduct,

dated August 3, 2004, paragraph 4k(3), which states, in part, "Dealing With the Public: "Employees are . . . prompt in serving the . . . veterans . . ."

d. Disrespectful conduct towards co-worker (MOD). His conduct in this matter was in violation of Policy Memorandum No. 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), which states in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of acceptable work behavior. The following are considered improper. . . disrespectful conduct . . ."

Discussion: There is no conflict regarding whether Dr. Kanna was assigned as MOD and as such was his responsibility to see patients reporting to the Admissions Area during the period 4:30 p.m. to 7:00 p.m. There is also in evidence, a Memorandum from the Chief of Staff instructing staff MOD physicians to see all patients arriving before 6:30 p.m. even if this required the staff MOD physician to remain beyond 7:00 p.m.

Board Exhibit B-9, log of patients reporting to the Admissions Area on February 1, 2006, shows that there were five patients who reported to the Admissions Area between the hours of 4:35 p.m. and 6:00 p.m. One of these patients, who arrived at 4:35 p.m., was handled by phone with Dr. Kanna at 5:25 p.m.. Mace Testimony page 59. The log indicates that Dr. Kanna also saw a patient at 5:50 p.m. who had arrived in the Admission Area at 4:10 p.m. Additionally, the log indicates that another patient arrived at 5:05 p.m. during the period Dr. Kanna was in the Admissions Area but was not seen by Dr. Kanna.

According to the testimony of Leroy Mace, R.N., he first paged Dr. Kanna at 4:30 p.m., or around that time, to inform him that patients were ready to be seen. Mace Testimony page 58. Board Exhibit B-10, the record of calls to the MOD pager, shows a call from the Admissions Office at 4:51 p.m.. Dr. Kanna's testimony was the page was received at 4:50 p.m. Kanna Testimony page 318. The log of patients indicates that the one patient seen by Dr. Kanna on February 1, 2006, was seen at 5:50 p.m. Dr. Kanna provided no explanation about the delay in seeing that patient.

It was the testimony of Marilyn Barthlemas, Nursing Supervisor, that Mr. Mace contacted her about 5:15 p.m. and told her that he had paged Dr. Kanna as had the other nurse in the Admissions Area and that Dr. Kanna had not reported to the Admissions Area to see patients. Ms. Barthlemas testified that she went to the Admissions Area about 5:45 p.m. and tried to page Dr. Kanna again. Barthlemas Testimony page 86. The pager log, Exhibit B-10, does not show any other pages from the Admissions Area during that period. Dr. Kanna did testify that sometimes Admission Area personnel call directly to the MOD room. Those calls would not show up on the pager log. Kanna Testimony pages 322-323. Ms. Barthlemas testified that she did see Dr. Kanna come to the Admissions Area about 5:45 p.m., but that she did not talk with him. Barthlemas Testimony page 86.

After Dr. Kanna saw the one patient, Mr. Mace testified that he advised Dr. Kanna that there were more patients to be seen. Dr. Kanna responded that he was hungry and need to go eat. Mace Testimony pages 24-25. Dr. Kanna testified that he saw the one patient and told the staff at the nursing desk that he was hungry and going to eat. Dr. Kanna testified that he was not told by anyone that there were more patients to be seen. Kanna Testimony pages 326-329.

Ms. Barthlemas testified that she found Dr. Kanna in the break room of the Admissions Area eating at approximately 6:20 p.m., and that she spoke with Dr. Kanna advising him that there were more patients to be seen. It was Ms. Barthlemas' testimony that Dr. Kanna replied that he

was weak and that he had to eat. Barthlemas Testimony page 95.

Dr. Kanna testified that he has never eaten in the break room of the Admissions Area but frequently eats in the MOD room. Kanna Testimony pages 326-327. Dr. Kanna further testified that he did not remember seeing or speaking to Ms. Barthlemas on the evening of February 1, 2006. Kanna Testimony page 339.

Dr. Kanna testified that when he came to the Admissions Area around 7:00 p.m. to turn the pager over to the oncoming MOD that Leroy Mace told him that there were four patients waiting to be seen. Kanna Testimony page 339. Dr. Kanna also testifies that Mr. Mace seemed upset so he just left. He didn't consider staying to see the patients because Dr. Rivera was already seeing patients.

Mr. Mace testified that when Dr. Kanna came to the Admissions Area at approximately 7:00 p.m., he advised that there were patients to be seen. He also reminded Dr. Kanna of the Chief of Staff Memorandum of September 2003 that said he was responsible for all patients checking in before 6:30 p.m. Dr. Kanna responded that his time was up and he wasn't going to see any more patients. Dr. Kanna also told Mr. Mace that he didn't sign the Memorandum. Mace Testimony pages 25 and 26.

Dr. Rivera testified that when he came on duty at approximately 7:10-7:15 p.m., there were four rooms already filled and that nurses seemed to be upset. He stated that the first patient he saw was a little upset since she had been waiting for so long. The second patient was also upset about waiting. Rivera Testimony pages 417 and 418.

Testimony from Dr. Rivera, Rivera Testimony page 418, indicated that there is a separate rack of charts for patients to be seen by the MOD. In addition, there is the check in log which is also available to the MOD. Board Exhibit B-9.

After full review of the evidence and testimony, the Board has determined that Dr. Kanna failed in his responsibility to see the patients reporting to the Admissions Area before 6:30 p.m. The conflicting testimony between Dr. Kanna and Marilyn Barthlemas was not considered a mitigating factor in Dr. Kanna's failure to see the patients reporting to the Admissions Area. Also, the Board does not believe that the lack of evidence of exactly how and when Dr. Kanna was paged to come to the Admissions Area is mitigating. When Dr. Kanna became aware of the patients, whether it was at 6:00 p.m. or as late as 7:00 p.m., he had the obligation to see the patients and chose to leave the patients to be seen by the MOD. Further, as the MOD, it is the Board's opinion that Dr. Kanna had the responsibility to check the log or chart rack to determine if patients were waiting.

Dr. Kanna was charged with the violation of four policies as a result of the above events.

The first charge is "Patient abuse by omission of care". Policy Memorandum No. 11-19, Patient Abuse, dated June 30, 2005, paragraph 3, states, in part, "Patient abuse is defined as acts against patients which involve intentional omission of patient care . . ." The Board has determined that Dr. Kanna's actions in not seeing the patients were intentional and that he did not provide appropriate care for these patients.

The second charge is "Disrespectful conduct towards patients." Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), states, in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of

acceptable work behavior. The following are considered improper . . . disrespectful conduct. . . " Dr. Kanna's attitude and behavior toward these patients can be considered improper and could be considered disrespectful.

The third charge is "Failure to provide efficient service when dealing with the public." Policy Memorandum No. 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4k(3), which states, in part, "Dealing With the Public: "Employees are . . . prompt in serving the . . . veterans . . ." Dr. Kanna's conduct in choosing not to see the patients waiting in the Admissions Area during his assigned tour could not be considered providing efficient or prompt service.

The fourth charge is "Disrespectful conduct towards coworkers (MOD)." Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), states, in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of acceptable work behavior. The following are considered improper . . . disrespectful conduct. " Dr. Kanna's actions in not seeing the patients and leaving all patients to be seen by the oncoming MOD were certainly disrespectful as was his actions in not responding to the requests of the nurses in the Admissions Area. The charge concerned Dr. Kanna's conduct toward the MOD. However, the Board has also considered his conduct toward the other employees.

The Board has determined that all four charges are sustained.

Charge 4. On February 4, 2006, Dr. Kanna was the assigned MOD. He received a call from the laboratory reporting a critical lab value of potassium 7.2 on inpatient GFW. At approximately 6:50 p.m. he called the ward advising Staff Nurse DH of the critical lab value and to wait until the oncoming MOD came on duty. . . to do nothing right then . . . rather than taking action himself. Staff Nurse DH reported he called again about ten minutes later, advising her to transfer the patient to the Intensive Care Unit (ICU). At that time, he failed to take action to manage this life-threatening situation. He did not warn the oncoming MOD of the situation. When questioned regarding the situation, Dr. Kanna testified that he recalled a patient with that last name but he did not recall being informed of the lab value. He further testified that he understood the seriousness and potentially fatal consequences in delaying the treatment. His actions in this matter did not promote quality healthcare services for our veteran patients. He is charged with:

a. Patient abuse by intentional omission of care. His conduct is in violation of Policy Memorandum No. 11-19, Patient Abuse, dated June 30, 2005, paragraph 3, which states, in part, "Patient abuse is defined as acts against patients which involve intentional omission of patient care . . ." This was evidenced by his failure to manage an inpatient with a life-threatening lab value.

b. Disrespectful conduct towards patients. His conduct in the matter was in violation of Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), which states, in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of acceptable work behavior. The following are considered improper . . . disrespectful conduct. "

c. Disrespectful conduct towards co-workers (medical staff). His conduct in this matter was in violation of Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), which states, in part, "Work Attitudes and Work Behavior:

An employee will live up to common standards of acceptable work behavior. The following are considered improper . . . disrespectful conduct. "

Discussion: There was some confusion on the part of Donna Henry, RN, the staff nurse who was caring for the patient on the ward before the transfer to ICU, as to whether she called Dr. Kanna concerning the patient's elevated potassium level or whether Dr. Kanna called her to inform her of the potassium level. Upon cross-examination and after reviewing the Report of Contact completed by Ms. Henry on February 1, 2006, (Board Exhibit B-8), Ms. Henry testified that Dr. Kanna could have called her either after he was informed of the critical potassium level by the lab or in response to her page. Ms. Henry cross-examination, pages 151 and 152. ~~It was Dr. Kanna's testimony that Ms. Henry called him while he was in the MOD room to inform him of the critical potassium level. Dr. Kanna testimony page 331.~~

Dr. Kanna also testified that he asked Ms. Henry about the patient's condition including his vital signs. Dr. Kanna testimony page 332. ~~It was Ms. Henry's testimony that Dr. Kanna gave no instructions except to transfer the patient to ICU. He did not ask about the patient's condition or status. Donna Henry testimony page 157.~~

What isn't in conflict is that there were two telephone conversations between Ms. Henry and Dr. Kanna and the essence of both conversations. During the first conversation between the two, ~~Dr. Kanna instructed Ms. Henry to wait to for the oncoming MOD and to tell him of the patient and the critical potassium level.~~ During the second conversation, from a few minutes to ten minutes later, ~~Dr. Kanna instructed Ms. Henry to transfer the patient to ICU. It is Dr. Kanna's testimony that he requested Ms. Henry do an EKG.~~ Ms. Henry testifies that she was told to transfer the patient to ICU. However, Dr. Kanna testified that his rationale for transferring the patient was due to "the circumstances way things were going for me and all the doctors in the institution, it is an emotional burden, what will my chief do tomorrow, something like that, not really thinking, I cannot explain." Dr. Kanna testimony page 332. ~~Dr. Kanna testified that he did not review the EKG or check on the patients' cardiac rhythm.~~

Dr. Kanna testified that he did inform Dr. Rivera, the oncoming MOD, of the patient. Dr. Kanna testified that Dr. Rivera was already seeing patients and that he informed that there was a patient coming from 211AB and that he had a high potassium. Dr. Kanna's testimony page 340. Dr. Rivera testified that Dr. Kanna had told him that there was a patient being transferred to ICU, but not tell him about the critical potassium level. ~~The first Dr. Rivera heard of the critical potassium was when the ICU nurse called him regarding the patient. Dr. Rivera testimony page 419.~~

The Board has determined from testimony and review of the evidence that Dr. Kanna did not appropriately react to the information of the patient's critical potassium. His first reaction was ~~instructing the nurse to just wait and notify the oncoming MOD. He did not ask any questions concerning the patient or his status. He made no attempt to see the patient.~~ By his own testimony, ~~Dr. Kanna states that his decision to reverse his instruction and transfer the patient to the ICU was made due to the concern about the review of his supervisor rather than concern over the patient's condition.~~ The Board also has determined Dr. Kanna did not appropriately notify Dr. Rivera of the patient's condition when he assumed the MOD duties.

Dr. Kanna has been charged with three violations of Policy relating to the above incident.

The first charge is "Patient abuse by omission of care". Policy Memorandum No. 11-19, Patient Use, dated June 30, 2005, paragraph 3, states, in part, "Patient abuse is defined as acts against patients which involve intentional omission of patient care . . ." The Board has

determined that Dr. Kanna's actions were intentional and that he did not appropriately care for this patient.

The second charge is "Disrespectful conduct towards a patient." Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), states, in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of acceptable work behavior. The following are considered improper . . . disrespectful conduct." Dr. Kanna's attitude and behavior toward this patient can be considered improper and could be considered disrespectful.

The third charge is "Disrespectful conduct towards coworkers (medical staff)." Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), states, in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of acceptable work behavior. The following are considered improper . . . disrespectful conduct. . ." Dr. Kanna did not take appropriate measures when speaking with the staff nurse Donna Henry nor did he give her appropriate instructions to transfer the patient. Additionally, Dr. Kanna did not appropriately inform Dr. Rivera of the patient's condition. His actions could be considered disrespectful.

The Board has determined that all three charges are sustained.

Charge 5. On January 28, 2006, patient LW was admitted for chest pain under Dr. Kanna's care. The patient's history and physical were completed by another physician. Dr. Kanna made no entry in the patient's chart the following day. The patient was discharged on January 31, 2006. At the time of discharge, he failed to provide specific discharge instructions for follow-up with the primary care provider and he failed to recommend further diagnostic testing as suggested by the community provider responsible for transferring the patient to our medical center. When questioned regarding this matter, Dr. Kanna acknowledged he should have ordered specific care for the patient. Dr. Kanna was charged with:

a. Patient abuse by intentional omission of care. His conduct is in violation of Policy Memorandum No. 11-19, Patient Abuse, dated June 30, 2005, paragraph 3, which states, in part, "Patient abuse is defined as acts against patients which involve intentional omission of patient care . . ." This was evidenced by his failure to provide discharge instructions for follow-up with the primary care provider nor did he recommended further diagnostic testing at the time of discharge.

b. Disrespectful conduct towards patients. His conduct in this matter was in violation of Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), which states, in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of acceptable work behavior. The following are considered improper . . . disrespectful conduct. "

Discussion: As a part of their decision on this charge, the Board reviewed the patient's chart, Board Exhibit B-6. The patient had known cardiac disease and had many risk factors. He was admitted with an abnormal EKG and elevated CPK and CPK MB. Dr. Kanna testified that the enzyme elevations were likely from cardiac ischemia. Kanna Testimony pages 404-406. Despite this, the patient had no further cardiac work up prescribed. The board considered this well below an acceptable standard of care.

Dr. Kanna has been charged with two violations of Policy relating to the above incident.

The first charge is "Patient abuse by intentional omission of care." Policy Memorandum No. 11-19, Patient Abuse, dated June 30, 2005, paragraph 3, states, in part, "Patient abuse is defined as acts against patients which involve intentional omission of patient care . . ." Dr. Kanna's failure to provide discharge instructions for follow-up with the primary care provider and his failure to recommend further diagnostic testing at the time of discharge is considered intentional omission of patient care. Dr. Kanna did violate the policy.

The second charge is "Disrespectful conduct towards patients." Policy Memorandum No., 05-17, Employee Responsibility and Conduct, dated August 3, 2004, paragraph 4j(2), states, in part, "Work Attitudes and Work Behavior: An employee will live up to common standards of acceptable work behavior. The following are considered improper . . . disrespectful conduct. " Dr. Kanna's conduct in the treatment of this patient could be considered disrespectful.

The Board has determined that both charges are sustained.

## OTHER FACTORS CONSIDERED

There was considerable testimony concerning the lack of progressive discipline given to Dr. Kanna before the issuance of a proposed removal on May 26, 2006. The appellant's representative spent a significant amount of time cross-examining the Medical Center Director, Mr. Moorman, about this subject. Moorman testimony pages 226-234. Additionally, Mr. Moorman testified that since Dr. Kanna was put on notice in February 2006, he wasn't aware of any other "transgressions". Moorman testimony page 255. There was testimony that Dr. Kanna had been verbally counseled regarding his less than optimal behavior toward patients at various times. Dr. Kanna was charged with three violations of Patient Abuse in accordance with Policy Memorandum 11-19. The Title 38 -Table of Penalties, Tab 4s in the Evidence File, recommends a range of penalties from Reprimand to Discharge for the first offense of patient abuse. With three sustained charges of patient abuse in a very short time frame, the discharge penalty without previous discipline is appropriate.

The Board heard testimony from the Medical Center Director, Mr. Moorman, regarding the ethnicity of the providers and the Chief of Staff at the Chillicothe VA Medical Center. Mr. Moorman stated that he felt that the lack of action addressing Dr. Kanna's conduct was due to ethnicity being honored before medical center business. Moorman testimony page 253. The Board did not consider these comments when making their final decision on the charges, but does feel that Mr. Moorman's comments were not reflective of the diversity embraced by the VA.

Additionally, the Board discovered a technical error on the SF-50, Notice of Personnel Action, documenting Dr. Kanna's removal. Human Resources coded this action using a Title 5 authority, 5 U.S.C. 75 POSTAPPT. The correct authority is 38 U.S.C. Chap 74. The Board recommends that this technical error be corrected. However, this error by Human Resources had no bearing on the issues of Dr. Kanna's removal.

6. AFTER CAREFUL CONSIDERATION OF ALL FACTORS, THE BOARD RECOMMENDS THAT THE EMPLOYEE BE (Check one and explain in detail under item 9)			7. RECOMMENDED GRADE AND STEP
<input type="checkbox"/> APPOINTED	<input type="checkbox"/> PROMOTED	<input type="checkbox"/> GIVEN SPECIAL ADVANCEMENT	8. PHYSICAL EXAMINATION <input type="checkbox"/> APPROVED <input type="checkbox"/>
<input type="checkbox"/> NOT APPOINTED	<input type="checkbox"/> DECLARED INELIGIBLE	<input checked="" type="checkbox"/> OTHER (Please specify) Removal Sustained	
	<input type="checkbox"/> NOT PROMOTED		

9. OTHER RECOMMENDATIONS AND ADDITIONAL REMARKS TO SUPPORT RECOMMENDATIONS IN ITEM 6

**DECISION**

After full review of all evidence and testimony in this matter, the Board has found that the action taken was appropriate and has sustained the removal action of Venkanna Kanna, M.D., from his employment with the VA Medical Center, Chillicothe, Ohio.

10. SIGNATURE OF INITIATING BOARD MEMBERS (All signatures must be dated)

A. CHAIRMAN <i>Warrent L. Blackburn, Jr.</i> WARRENT L. BLACKBURN, Jr., M.D. 11/13/06	B. MEMBER <i>Michael E. Mahler</i> MICHAEL E. MAHLER, M.D. 11/13/06
C. MEMBER	D. MEMBER
E. SECRETARY <i>Arthur G. Robins</i> ARTHUR G. ROBINS, M.D. 11/06/2006	

11. Certification of initiating board technical adviser that board action is completed and has been reviewed for adherence to all legal and technical requirements before being forwarded to approving authority.

SIGNATURE <i>Cheryl McNeil</i> CHERYL MCNEIL	DATE 11/1/06
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**REVIEWING BOARD**

12. REVIEWING BOARD RECOMMENDATIONS AND REMARKS

13. SIGNATURES OF REVIEWING BOARD MEMBERS (All signatures MUST be dated)

A. CHAIRMAN	B. MEMBER
C. MEMBER	D. MEMBER
E. SECRETARY	

**ACTION BY APPROVING AUTHORITY**

14. ACTION <input checked="" type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	15. DATE 2 JAN 2007	16. SIGNATURE AND TITLE OF APPROVING AUTHORITY <i>Gerald M. Cross</i> GERALD M. CROSS, M.D. FA/EP, Acting Principal DUSH
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