

OHIO STATE MEDICAL BOARD

THE COURT OF COMMON PLEAS  
FRANKLIN COUNTY, OHIO

JAN 26 2005

FINAL APPEAL ORDER

DR. JITANDER M. KALIA, M.D., :

Appellant, :

v. :

STATE MEDICAL BOARD OF OHIO, :

Appellee. :

Case No. 04 CVF08-8934

JUDGE SCHNEIDER

TEMPORARILY FILED 10  
WKT

**JUDGMENT ENTRY AFFIRMING THE STATE MEDICAL BOARD'S  
AUGUST 11, 2004 ORDER PERMANENTLY REVOKING  
APPELLANT'S LICENSE TO PRACTICE MEDICINE AND SURGERY IN OHIO**

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the August 11, 2004 Order of the State Medical Board of Ohio which permanently revoked Appellant, Jitander M. Kalia, M.D.'s license to practice medicine and surgery in Ohio. For the reasons stated in the decision of this Court, rendered on January 6, 2005, and filed on January 7, 2004, which decision is incorporated by reference as if fully rewritten herein, it is hereby.

ORDERED, ADJUDGED AND DECREED that judgment is entered in favor of Appellee, State Medical Board of Ohio, and the August 11, 2004 Order of the State Medical Board in the matter of Jitander M. Kalia, M.D., is hereby AFFIRMED. Costs to Appellant.

IT IS SO ORDERED.

\_\_\_\_\_  
JUDGE SCHNEIDER

STATE MEDICAL BOARD  
OF OHIO

2005 JAN 26 A 9:24

FILED  
COMMON PLEAS COURT  
FRANKLIN CO OHIO  
2005 JAN 25 PM 3:38  
CLERK OF COURTS-CV

JIM PETRO (0022096)  
Attorney General

OHIO STATE MEDICAL BOARD

JAN 26 2005

*Submitted via fax 1/11/05 not*

JEFFREY V. GOODMAN (0055566) *returned*  
252 Seneca Avenue  
Warren, Ohio 44481  
(330) 393-3400  
Facsimile (330) 393-3090

Counsel for Dr. Kalia

*Rebecca J. Albers*

REBECCA J. ALBERS (0059203)  
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Counsel for the State Medical Board

STATE MEDICAL BOARD  
OF OHIO

2005 JAN 26 A 9:24

FILED  
COMMON PLEAS COURT  
FRANKLIN COUNTY, OHIO

2005 JAN 7 PM 1:16  
COURT OF COMMON PLEAS, FRANKLIN COUNTY, CIVIL DIVISION

JITANDER M. KALIA, M.D.  
COURT OF COMMON PLEAS

CASE NO. 04CV-8934

APPELLANT,

JUDGE SCHNEIDER

VS.

STATE MEDICAL BOARD OF OHIO,

APPELLEE.

### DECISION ON MERITS OF APPEAL

Entered this 6<sup>th</sup> day of January, 2005.

This action comes before the court upon appeal filed August 26, 2004 by Jitander N. Kalia, M.D. Appellant has appealed the revocation of his license to practice medicine resulting from the decision of the State Medical Board (Board) dated August 11, 2004. The Board, after a hearing, adopted its Hearing Examiner's recommendation to permanently revoke Appellant's license to practice medicine and surgery. Appellant seeks review of the Board's Order under the provisions of Chapter 119. The court has previously denied a stay of the revocation of Appellant's license to practice pending appeal and the belated motion for extension of time. The record has been filed and the Board has moved for judgment on the record. The Court, after considering the record, the grounds for appeal set forth by Appellant, and applicable statutory and case law, finds that the decision of the Board should be affirmed.

### PROCEDURAL HISTORY

Appellant was apprised by letter dated September 10, 2004 that the Board proposed discipline against him as to his medical treatment of four children. The notice

listed two statutory violations. The first was R.C. Section 4731.22(B)(2) (2) "Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease." The second was 4731.22(B)(6) (6)" 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."

Appellant was afforded a hearing on April 5 and 6, 2004 before a Hearing Examiner for the Board. Appellant offered testimony on his own behalf and was cross-examined and testimony by Robert William Mills M.D. was offered as an expert for the Board. The Hearing Examiner also received various exhibits including records as to the four patients identified by the Board.

Appellant received his degree in 1960 and had various medical experiences through the date of his relocation to Warren, Ohio in 1994. Appellant became board certified in pediatrics in 1978 and was recertified in 1992.

The four children involved as to the disciplinary claims are identified as Patients 1, 2, 3 and 4. The charges as to these four patients may be summarized as follows.

Patient 1 was diagnosed by Appellant with attention deficit hyperactivity disorder (ADHD) at the age of 22 months. Appellant prescribed three separate medications to the child beginning with Clonidine, then Ritalin, then Cylert. None of these medicines are normally used on a child this young. On November 19, 1997 the child was taken to a hospital exhibiting symptoms consistent with an adverse reaction to the Cylert. The

symptoms included tachycardia, jerking of the head, tongue thrusting, twitching, restlessness and screaming. Appellant's medical documentation for the hospitalization of the patient was incomplete as to the dosages, the respiratory rate and the patient's weight.

Patient 2 was eight months old and admitted to the hospital on March 8, 2000 with vomiting, lethargy, and dehydration. It was noted by the nursing staff that there was a small amount of blood in the stool. After continuing to deteriorate, the child was transferred to another hospital on March 11, 2000. At that time he was diagnosed with intussusception complicated by perforation of the transverse colon, requiring an ileocollectomy with ileostomy and transverse colonostomy. Additionally, the child had developed bacterial peritonitis as a result of perforation of the bowel. Appellant's records did not record the age of the patient, past medical history, vital signs, or documentation of an adequate physical examination.

Patient 3 was admitted to the hospital on March 26, 1999. Appellant diagnosed acute croup but instead proceeded with treatment more suitable for asthma. Again Appellant's medical records were deficient.

Patient 4 was admitted to the hospital on March 31, 1999. The child was nine months old. His symptoms included vomiting, lethargy, and dehydration. Laboratory results suggested a bacterial infection but Appellant treated the patient for dehydration. Appellant performed a spinal tap which revealed that the patient had meningitis. The child was transferred to another hospital to a pediatric intensive care unit despite Appellant's resistance to the transfer. Appellant's medical documentation again failed to

report the age of the patient, race, and basic vital signs including weight, respiration and blood pressure.

The Hearing Examiner reached several conclusions regarding Appellant's standard of care. She noted that Appellant had prescribed psychotropic medications to Patient 1 when the patient was less than two years old despite the fact that such medications are not recommended for children so young, nor are there specific dosages recommended for a child that weight or age. The Hearing Examiner found upon statements regarding his treatment of Patient 2 as not credible. While Appellant maintained that his treatment of the patient was appropriate, the testimony of the Board's expert and the conclusion of the Hearing Examiner was absolutely contrary. As to the Patient 3, Appellant contended his treatment was appropriate even though the hospital's house physician had to intervene and institute appropriate treatment in order for the child's croup to be controlled. The Hearing Examiner also found Appellant's failure to recognize signs of meningitis as to Patient 4 suggested a serious deficit of medical knowledge on the part of Appellant. The Hearing Examiner also noted that Appellant's attitude and insistence to refuse intervention from other doctors, as well as refusal to acknowledge the deteriorating conditions of his patients indicated that reeducation would not likely benefit Appellant.

#### **Review Standard**

R.C. 119.12 and the multitude of cases addressing that section govern the Court's review of a decision of an administrative agency, such as the Commission. The most

often cited case is that of *Univ. of Cincinnati v. Conrad*<sup>1</sup>. The *Conrad* decision states that in an administrative appeal filed pursuant to R.C. 119.12, the trial court must review the agency's order to determine whether it is supported by reliable, probative and substantial evidence and is in accordance with law.

The Court states at pages 111 and 112 that “In undertaking this hybrid form of review, the Court of Common Pleas must give due deference to the administrative resolution of evidentiary conflicts. For example, when the evidence before the court consists of conflicting testimony of approximately equal weight, the court should defer to the determination of the administrative body, which, as the fact-finder, had the opportunity to observe the demeanor of the witnesses and weigh their credibility. The findings of the agency are not conclusive. Where the court, in its appraisal of the evidence, determines that there exist legally significant reasons for discrediting certain evidence relied upon by the administrative body, the court may reverse, vacate or modify the administrative order. Where it appears that the administrative determination rests upon inferences improperly drawn from the evidence adduced, the court may reverse the administrative order.

The *Conrad* case has been cited with approval numerous times.<sup>2</sup> Although a review of applicable law is de novo, the reviewing court should defer to the agency's factual findings.<sup>3</sup>

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<sup>1</sup> 63 Ohio St. 2d 108, 407 N.E.2d 1265, (1980)

<sup>2</sup> *City of Hamilton v. State Employment Relations Bd.* (1994), 70 Ohio St. 3d 210, 638 N.E.2d 522; *Ohio Historical Soc. v. State Emp. Relations Bd.* (1993), 66 Ohio St. 3d 466, 471, 613 N.E.2d 591

<sup>3</sup> *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St. 3d 619, 614 N.E.2d 748. Rehearing denied by: *Pons v. State Medical Bd.* (1993), 67 Ohio St. 3d 1439, 617 N.E.2d 688.

## ANALYSIS

Appellant has set forth three separate grounds for appeal. Appellant first asserts that the Order of the Board is contrary to law and the manifest weight of the evidence. Appellant also maintains that he did not depart from or fail to conform to the minimum standards of care for similarly situated practitioners under the same or similar circumstances. The third ground for appeal is that the penalty is unreasonable or excessive as it related to the evidence adduced at hearing.

The first matter to observe is that the Court is not trained in the medical field. The deference recognized by case law as to the Board's expertise is therefore warranted. The record in this matter provides more than a preponderance of evidence which supports the Board's determination of permanent revocation. Appellant's decision to medicate a 22 month infant with drugs for treatment for ADHD would appear dubious to even a layperson. The calculation of the dosage to be given and the rapidity of change of medications exacerbated an already questionable regimen. While the Court can observe that Appellant may have had the family's best interests in mind when he attempted to medicate the behavioral symptoms of the child, the established evidence supports the Board's conclusion that Appellant did not meet the standard of care in such treatment. Further review of the records indicates that the treatment or lack thereof of Patient 2 was particularly bothersome. While there was no evidence to suggest that earlier, proper intervention by Appellant, would have eliminated the need for colostomy on a eight month old child, the Court is left to wonder whether proper diagnosis and appropriate intervention would have ameliorated the subsequent problems including the bacterial

peritonitis. The delays in treatment or failure to properly treat Patients 3 and 4 did not result in such significant difficulties as with Patient 2. Nonetheless, the evidence is more than persuasive as to failures on the part of Appellant to conform to the appropriate standard of care as to those two children.

After review of the record, the Court can only conclude that the decision of the Board to permanently revoke Appellant's medical license is supported by reliable, probative, and substantial evidence and is in accordance with applicable law. Were the Court inclined to review the severity of the penalty imposed, the authority to do so would be lacking.<sup>4</sup> Counsel for Appellee shall prepare a Judgment Entry pursuant to Local Rule 25.01.



Judge Charles Schneider

Appearances:

Jeffrey V. Goodman  
252 Seneca Avenue  
Warren, OH 44481  
Attorney for Appellant

Rebecca J. Albers  
Assistant Attorney General  
30 East Broad Street, 26<sup>th</sup> Floor  
Columbus, OH 43215  
Attorney for Appellee

---

<sup>4</sup> In re Eastway (1994), 95 Ohio App. 3d 516, 642 N.E.2d 1135, Appeal denied In re Eastway (1994), 70 Ohio St. 3d 1474, 640 N.E.2d 846

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

DR. JITANDER M. KALIA, M.D. :

Appellant, :

v. :

STATE MEDICAL BOARD OF OHIO :

Appellee. :

Case No. 04 CVF08-8934

JUDGE SCHNEIDER

FILED  
COMMON PLEAS COURT  
FRANKLIN CO. OHIO  
04 NOV 16 PM 3:06  
CLERK OF COURTS

**ENTRY DENYING APPELLANT'S REQUEST FOR STAY  
OF THE AUGUST 11, 2004 ORDER OF THE STATE MEDICAL BOARD**

This matter came before the Court upon Motion of Appellant, Jitander M. Kalia, M.D. requesting a stay of the August 11, 2004 Order of Appellee, State Medical Board. For the reasons stated in the decision of this Court rendered on October 6, 2004, and filed on October 7, 2004, which decision is incorporated by reference as if fully rewritten herein, it is hereby

ORDERED, ADJUDGED AND DECREED that Appellant, Jitander M. Kalia, M.D.'s request for stay of the August 11, 2004 Order of the State Medical Board is hereby denied.

IT IS SO ORDERED.

\_\_\_\_\_  
Date

\_\_\_\_\_  
JUDGE SCHNEIDER

JIM PETRO (0022096)  
Attorney General

*Jeffrey Goodman by Rebecca Albers*  
JEFFREY V. GOODMAN (0055566) *per*  
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(330) 393-3400  
Facsimile (330) 393-3090  
  
Counsel for Dr. Kalia

*phone  
authorization  
11/11/04*

*Rebecca J. Albers*  
REBECCA J. ALBERS (0059203)  
Senior Assistant Attorney General  
Health and Human Services Section  
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(614) 466-8600  
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Counsel for the State Medical Board

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

CIVIL DIVISION

JITANDER M. KALIA, M.D.,	:	OHIO STATE MEDICAL BOARD
Appellant,	:	OCT 18 2004
v.	:	Case No. 04CVF08-8934
STATE MEDICAL BOARD OF OHIO,	:	Judge Schneider
Appellee.	:	

**DECISION DENYING APPELLANT'S MOTION FOR STAY OF BOARD'S AUGUST 11, 2004 ORDER, FILED AUGUST 26, 2004**

Rendered this 6 day of October, 2004.

Schneider, C., J.

2004 OCT -1 AM 9:23  
 CLERK OF COURTS  
 FRANKLIN COUNTY  
 OHIO

I. Stay of State Medical Board's Order

A court may suspend the Board's order as follows:

In the case of an appeal from the state medical board . . . , the court may grant a suspension and fix its terms if it appears to the court that an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal and the health, safety, and welfare of the public will not be threatened by suspension of the order.

O.R.C. 119.12.

"Unusual hardship" has been discussed as follows:

The filing of an administrative appeal does not automatically entitle a party to a stay of execution pending judicial review. Rather, the General Assembly has given trial courts broad discretion when making such determinations, legislating that: "if it appears to the court than an *unusual hardship* to the appellant will result from the execution of the agency's order pending determination of the appeal, the court *may* grant a suspension and fix its terms." R.C. 119.12. As such, when reviewing

## OHIO STATE MEDICAL BOARD

OCT 18 2004

whether a trial court properly granted or denied a motion to stay an administrative order, the standard of review employed is an abuse of discretion. *Carter Steel & Fabricating Co. v. Danis Bldg. Construction Co.* (1998), 126 Ohio App. 3d 251, 254, 710 N.E.2d 299.

When asked to stay an administrative order, courts give significant weight to the expertise of the administrative agency, as well as to the public interest served by the proper operation of the regulatory scheme. See *Hamlin Testing Labs, Inc. v. United States Atomic Energy Comm.* (1964), 337 F.2d 221. To that end, R.C. 119.12 allows the court to "grant a suspension" of an agency order pending appeal if the court determines that "unusual hardship" will result to appellant.

Although R.C. 119.12 does not set forth or proscribe the factors the court may consider in determining whether to suspend operation of an administrative order, those factors have been refined by the courts. The Sixth Circuit, in addition to many other courts, has repeatedly relied upon the following factors as logical considerations when determining whether it is appropriate to stay an administrative order pending judicial review. Those factors are: (1) whether appellant has shown a strong or substantial likelihood or probability of success on the merits; (2) whether appellant has shown that it will suffer irreparable injury; (3) whether the issuance of a stay will cause harm to others; and (4) whether the public interest would be served by granting a stay. See *Hamlin, supra*; *Gurtzweiler v. United States* (1985), 601 F. Supp. 883; *Holden v. Heckler* (1984), 584 F. Supp. 463; *UpJohn Company v. Finch* (1969), 303 F. Supp. 241; *Friendship Materials v. Michigan Brick, Inc.* (1982), 679 F.2d 100; and *Virginia Petroleum Jobbers Assn. v. FPC* (1958), 104 U.S. App. D.C. 106, 259 F.2d 921.

~~Bob Krihwan Pontiac-GMC Truck, Inc. (Franklin 2001), 141 Ohio App. 3d 777; 782-83.~~

## II. Discussion

On August 26, 2004, appellant filed his notice of appeal and his "Motion for Stay of Execution" of the Board's August 11, 2004 order permanently revoking his certificate to practice medicine and surgery in Ohio. Appellant argues that "his medical practice was his sole source of income," that many of his patients "are left without accessible or

## OHIO STATE MEDICAL BOARD

OCT 18 2004

affordable medical care," and that "[g]ood and valid issues exist in this appeal which plaintiff maintains warrant reversal of defendant's action and full reinstatement of plaintiff's license to practice medicine in the state of Ohio."

In response, the Board argues that O.R.C. 119.12 requires "more than the financial hardship and other problems inherent and expected when losing a professional license" and that "Dr. Kalia does pose a threat to the health, safety and welfare of the public."

In this regard, appellant has failed to demonstrate that execution of the Board's order pending appeal would result in "unusual" hardship. Circumstances such as an inability to practice medicine, having a number of financial obligations, and having difficulty in obtaining other employment may constitute a financial hardship but do not constitute an "unusual" hardship under O.R.C. 119.12.

In addition, the evidence indicates that the Board's order revoking appellant's license to practice medicine and surgery was based on a number of serious violations of the applicable standard of care. As such, appellant has failed to show that "the health, safety, and welfare of the public will not be threatened by suspension of the order." Likewise, appellant has failed to demonstrate that a "substantial likelihood that the moving party will ultimately prevail on the merits of the appeal" exists or that "issuance of the stay would serve the public interest."

Thus, the Court declines to exercise its discretion to suspend the execution of the Board's order pending appeal. Therefore, appellant's motion to stay is DENIED. Counsel for appellee shall prepare an appropriate entry and submit the proposed entry to counsel for the adverse party pursuant to Loc. R. 25.01. A copy of this decision shall accompany the proposed entry when presented to the Court for signature.

**OHIO STATE MEDICAL BOARD**

**OCT 18 2004**



\_\_\_\_\_  
 CHARLES A. SCHNEIDER, JUDGE

Copies to:

Jeffrey V. Goodman, Esq.  
 Attorney for Appellant

Rebecca J. Albers, Esq.  
 Assistant Attorney General  
 Attorney for Appellee

IN THE COURT OF COMMON PLEAS  
FRANKLIN COUNTY, OHIO

2004 SEP -9 P 1:36

**DR. JITANDER M. KALIA**  
247 Homewood Ave.  
Warren, Ohio 44483

Plaintiff/Appellant

vs.

**THE STATE MEDICAL BOARD OF OHIO**  
77 South High Street  
Columbus, Ohio 43215-6127

)  
) 040VF08 8934  
)  
) CASE NO:  
)  
) JUDGE:  
)  
)  
)  
) COMPLAINT  
) ADMINISTRATIVE APPEAL  
) O.R.C. 119.12  
)

FILED  
COMMON PLEAS COURT  
FRANKLIN CO., OHIO  
2004 AUG 26 PM 1:32  
CLEMENS COURT CLERK

Now comes Dr. Jitander M. Kalia and for his Complaint against defendant says:

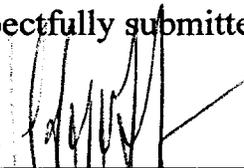
1. Plaintiff is a resident of Trumbull County, State of Ohio, and prior to August 11, 2004 held a valid license to practice medicine in the State of Ohio.
2. Defendant is an administrative board, established under the Ohio Revised Code for the administration of licensure of physicians in the State of Ohio.
3. On or about August 11, 2004, defendant wrongfully and contrary to law permanently revoked plaintiff's license to practice medicine in the State of Ohio.
4. Pursuant to R.C. 119.12, plaintiff hereby appeals the August 11, 2004 decision of the State Medical Board of Ohio, attached as *Exhibit "A."*
5. Plaintiff has filed a *Notice of Appeal* with the State Medical Board of Ohio. *Exhibit B.*
6. As grounds for said appeal, Dr. Jitander M. Kalia assigns the following:
  - a. The Order of the State Medical Board of Ohio is contrary to law and to the manifest weight of the evidence adduced at the hearing of this cause.

- b. The Order of The State Medical Board of Ohio is contrary to law, as respondent/appellant's actions did not depart from or fail to conform to the minimum standards of care for similarly situated practitioners under same or similar circumstances, as demonstrated at the hearing of this cause and as illustrated during the deliberations of the State Medical Board of Ohio.
  - c. The Order of the State Medical Board of Ohio revoking respondent/appellant's license to practice medicine in the State of Ohio is an unreasonable and excessive penalty not supported by the evidence adduced at the hearing of this cause or by Ohio law.
7. Defendant's action has created an unreasonable and substantial hardship upon plaintiff as plaintiff's medical practice was his sole source of income, as a result of which plaintiff has and continues to suffer substantial damages.
8. Defendant's action has further created a substantial hardship upon plaintiff's patients, many of whom are left without accessible or affordable medical care if the revocation of plaintiff's license to practice medicine is not stayed pending review by the court.

**WHEREFORE**, plaintiff prays as follows:

- a. For an ORDER granting plaintiff's appeal and reversing the order of the State Medical Board of Ohio.
- b. For an ORDER reinstating plaintiff's license to practice medicine in the State of Ohio.
- c. For a stay of execution of the State Medical Board of Ohio's August 11, 2004, Order, until such time as this Court has conducted a full review of plaintiff's appeal set forth herein.
- d. For his costs associated with this action and all other relief to which plaintiff is entitled in law or equity.

Respectfully submitted,

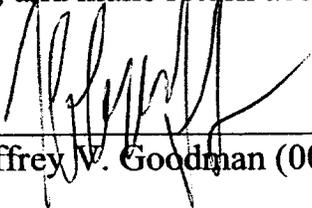
  
\_\_\_\_\_  
Jeffrey V. Goodman (0055566)  
252 Seneca Ave.  
Warren, Ohio 44481  
(330)-393-3400  
Attorney for Jitander M. Kalia

STATE MEDICAL BOARD  
OF OHIO

2004 SEP -9 P 1:36

**INSTRUCTIONS FOR SERVICE**

TO THE CLERK: Please serve a copy of the foregoing Complaint/Appeal upon the defendant at the address contained in the caption of the Complaint via certified U.S. Mail, return receipt requested, and make return according to law.

  
\_\_\_\_\_  
Jeffrey V. Goodman (0055566)

STATE MEDICAL BOARD  
OF OHIO

2004 SEP -9 P 1:37



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.med.ohio.gov](http://www.med.ohio.gov)

August 11, 2004

Jitander N. Kalia, M.D.  
247 Homeward Avenue  
Warren, OH 44483

Dear Doctor Kalia:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Sharon W. Murphy, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 11, 2004, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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 a Notice of Appeal with the State Medical Board of Ohio and 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.  
Secretary

LAT:jam  
Enclosures

CERTIFIED MAIL NO. 7000 0600 0024 5150 2600  
RETURN RECEIPT REQUESTED

Cc: Jeffrey V. Goodman, Esq.  
CERTIFIED MAIL NO. 7000 0600 0024 5150 2587  
RETURN RECEIPT REQUESTED

*Mailed 8-12-04*

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 11, 2004, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Jitander N. Kalia, 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.



Lance A. Talmage, M.D.  
Secretary

(SEAL)

August 11, 2004

Date

**BEFORE THE STATE MEDICAL BOARD OF OHIO**

IN THE MATTER OF

\*

\*

JITANDER N. KALIA, M.D.

\*

**ENTRY OF ORDER**

This matter came on for consideration before the State Medical Board of Ohio on August 11, 2004.

Upon the Report and Recommendation of Sharon W. Murphy, 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 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:

The certificate of Jitander N. Kalia, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

(SEAL)



Lance A. Talmage, M.D.  
Secretary

August 11, 2004

Date

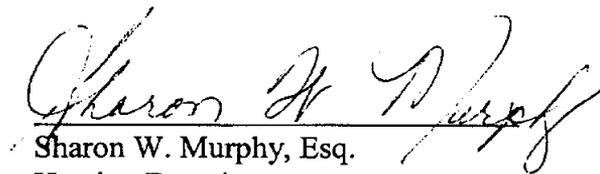
STATE MEDICAL BOARD  
OF OHIO

2004 JUN -9 A 10: 27

BEFORE THE STATE MEDICAL BOARD OF OHIO

**ERRATA SHEET**  
**FOR THE REPORT AND RECOMMENDATION**  
**IN THE MATTER OF JITANDER N. KALIA, M.D.**

The Report and Recommendation in the Matter of Jitander N. Kalia, M.D., was filed on June 2, 2004. On page 1 of the Report and Recommendation, it states, "By letter dated September 10, 2004, the State Medical Board of Ohio [Board] notified Jitander N. Kalia, M.D. \* \* \*." It should state, "By letter dated September 10, 2003, the State Medical Board of Ohio [Board] notified Jitander N. Kalia, M.D. \* \* \*." Additional references to the September 10, 2004, letter occur on pages 5, 15, 23, and 32 of the Report and Recommendation; each should also be amended to state "September 10, 2003." Moreover, on page 7 of the Report and Recommendation, it states, "Patient 1 was discharged on November 11, 1997." It should state, "Patient 1 was discharged on November 20, 1997."

  
Sharon W. Murphy, Esq.  
Hearing Examiner

**REPORT AND RECOMMENDATION  
IN THE MATTER OF JITANDER N. KALIA, M.D.**

The Matter of Jitander N. Kalia, M.D., was heard by Sharon W. Murphy, Esq., Hearing Examiner for the State Medical Board of Ohio, on April 5 and 6, 2004.

**INTRODUCTION**

**I. Basis for Hearing**

A. By letter dated September 10, 2004, the State Medical Board of Ohio [Board] notified Jitander N. Kalia, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio based on his treatment of four pediatric patients. The Board alleged that Dr. Kalia's treatment of those patients constitutes:

- a “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), 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.”

Accordingly, the Board advised Dr. Kalia of his right to request a hearing in this matter. (State's Exhibit 5A).

B. On October 6, 2003, Dr. Kalia submitted a written hearing request. (State's Exhibit 5B).

**II. Appearances**

A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Rebecca J. Albers, Assistant Attorney General.

B. On behalf of the Respondent: Jeffrey V. Goodman, Esq.

## EVIDENCE EXAMINED

### I. Testimony Heard

#### A. Presented by the State

1. Jitander N. Kalia, M.D., as upon cross-examination
2. Robert William Mills, M.D.

#### B. Presented by the Respondent

Jitander N. Kalia, M.D.

### II. Exhibits Examined

#### Presented by the State

- \* 1. State's Exhibits 1A and 1B: Medical records for Patient 1 maintained by Dr. Kalia and by Trumbull Memorial Hospital in Warren, Ohio.
- \* 2. State's Exhibits 2A and 2B: Medical records for Patient 2 maintained by St. Joseph Health Center in Warren and by Tod Children's Hospital in Warren.
- \* 3. State's Exhibits 3A and 3B: Medical records for Patient 3 maintained by Dr. Kalia and by Trumbull Memorial Hospital.
- \* 4. State's Exhibits 4A, 4B, and 4C: Medical records for Patient 4 maintained by Dr. Kalia, by Trumbull Memorial Hospital, and by Tod Children's Hospital.
5. State's Exhibits 5A through 5Q and 5S through 5V: Procedural exhibits.
- \* 6. State's Exhibit 6: Confidential patient key.
7. State's Exhibit 7: Curriculum vitae of Robert William Mills, M.D.
8. State's Exhibits 8 and 8A: Dr. Mills' expert report with addendum.
9. State's Exhibit 9: Certified copies of documents pertaining to Dr. Kalia maintained by the Board, including the Board's December 11, 2002, Entry of Order regarding Dr. Kalia.

10. State's Exhibits 10, 12, 13, and 14: Excerpts from the *Physicians' Desk Reference*.
11. State's Exhibits 15A and 15B: Copies of letters to Dr. Mills from the Board.

(Note: Exhibits marked with an asterisk [\*] have been sealed to protect patient confidentiality).

### SUMMARY OF THE EVIDENCE

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

#### **JITANDER N. KALIA, M.D.**

1. Jitander N. Kalia, M.D., testified that, in 1960, he had received his M.B.B.S. degree in India. Dr. Kalia further testified that, following medical school, he had served for ten years as a medical officer in the Indian Army. Subsequently, he obtained additional medical training in England and Canada. In England, Dr. Kalia received a Diploma in Child Health which, he explained, is a certification from the Royal College of Paediatrics and Child Health. In Canada, Dr. Kalia completed three years of pediatric residency training: one year in Saskatchewan and two years in Nova Scotia. Dr. Kalia testified that he had completed the fourth year of a pediatric residency at City Hospital in Wooster, Massachusetts. (Hearing Transcript Volume I [Tr. I] at 12-13; State's Exhibit [St. Ex.] 9 at 13).

Dr. Kalia stated that he practiced pediatrics in Massachusetts from 1978 to 1994. In 1994, Dr. Kalia relocated to Ohio to accept a position at Warren General Hospital in Warren, Ohio. He opened a private practice in Warren, sharing an office with his wife, Judith Kalia, M.D., a gynecologist. Dr. Kalia testified that he has a large practice. (Tr. I at 12-13; St. Ex. 9 at 13).

Dr. Kalia testified that he had held privileges at St. Joseph Hospital, Trumbull Memorial Hospital, and Tod Children's Hospital in Warren, but that he no longer holds any hospital privileges. (Tr. I at 14).

Dr. Kalia testified that he has been certified by the American Board of Pediatrics since 1978. He stated that the American Board of Pediatrics does not require recertification; nevertheless, Dr. Kalia voluntarily recertified in 1992. (Tr. I at 15-16).

2. Dr. Kalia has one prior disciplinary action by the Board. The Board's action was based on Dr. Kalia's January 14, 2002, misdemeanor conviction for Sexual Imposition, a violation of

Section 2907.06(A)(1), Ohio Revised Code. The offense was based on Dr. Kalia's conduct with a female office employee. More specifically, the facts underlying the charge of Sexual Imposition were that Dr. Kalia hugged the employee against himself, unhooked her bra, grabbed her breasts, and forcibly kissed her. The Board concluded that Dr. Kalia's conviction constituted "[a] plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude," as that clause is used in Section 4731.22(B)(13), Ohio Revised Code." (St. Ex. 9 at 6-32).

On May 8, 2002, the Board issued a notice of opportunity for hearing. (St. Ex. 9 at 28-32). Dr. Kalia requested a hearing. After the hearing, on December 11, 2002, the Board issued an Order suspending Dr. Kalia's certificate for thirty days but staying the suspension. The Board further ordered that Dr. Kalia would be placed on probation for a period of at least two years. Dr. Kalia is currently on probation pursuant to that Order. (St. Ex. 9 at 6-31).

At hearing, Dr. Kalia acknowledged that his misdemeanor conviction had been the result of a jury verdict in Warren Municipal Court. He further testified, however, that the victim in the criminal case had filed a civil case against him and that the civil jury had found in Dr. Kalia's favor. Dr. Kalia testified that the only difference between the two cases was that one was civil and one was criminal. He stated that all of the facts, witnesses and evidence had been the same. (Hearing Transcript Volume II [Tr. II] at 215-216).

### **ROBERT MILLS, M.D.**

3. Robert Mills, M.D., testified that he had received his medical degree in 1987 from the Medical College of Ohio in Toledo, Ohio. Dr. Mills further testified that he had completed a pediatric residency at the Medical College of Ohio in 1990. Dr. Mills received numerous awards during his medical education and residency. Following his residency, Dr. Mills served as a clinical instructor for the Department of Pediatrics at the Medical College of Ohio and worked as a neonatologist for one year. Subsequently, Dr. Mills joined a practice in pediatrics. Dr. Mills was voted to be the Pediatric Teacher of the Year in 1992, 1999, and 2002. He also won the Family Practice Teaching Award in 1993. (Tr. II at 5-7, 109-110; St. Ex. 7).

Dr. Mills testified that he currently practices in a private pediatric practice in Toledo. He is also the Medical Director of Mercy Children's Hospital where he directs the inpatient unit and teaches residents and students as an instructor for the residency program. Dr. Mills was certified by the American Academy of Pediatrics in 1990, and recertified in 1997 and 2002. (Tr. II at 7).

## **PATIENT 1**

### **Allegations regarding Patient 1**

4. In its September 10, 2004, notice of opportunity for hearing, the Board alleged that, in the routine course of his pediatric practice, Dr. Kalia undertook the treatment of Patient 1. (St. Ex. 5A). The Board further alleged that Dr. Kalia's treatment of Patient 1 included the following:

- a. In or about 1997, after diagnosing Patient 1 with Attention Deficit Hyperactivity Disorder, Dr. Kalia prescribed Clonidine to Patient 1 at age approximately 22 months. Two weeks later, Dr. Kalia prescribed Ritalin for her. When Patient 1 was approximately twenty-four months of age, Dr. Kalia prescribed these medications to Patient 1, even though prescribing such medications for a child in that age bracket is inappropriate.

On or about November 19, 1997, following the administration of Cylert which had been prescribed by Dr. Kalia, Patient 1 exhibited symptoms including tachycardia, jerking of her head, tongue thrusting, twitching, restlessness and screaming. Patient 1 was taken to a hospital emergency room, where her condition was diagnosed as an adverse reaction to Cylert.

- b. Dr. Kalia's medical documentation of the hospitalization of Patient 1, as described in paragraph 1.a, is incomplete, lacking information including the date when medications were instituted and the dosages of those medications, a respiratory rate and weight for Patient 1, and documentation of a detailed neurological examination.

(St. Ex. 5A).

### **Medical Records for Patient 1**

5. Patient 1, a female, was born November 24, 1995. Patient 1 first presented to Dr. Kalia's office on December 20, 1996. Her history included Kawasaki's disease in May 1996. (St. Ex. 1A at 13).

Dr. Kalia diagnosed Patient 1 as having Attention Deficit Hyperactivity Disorder [ADHD]. When Patient 1 was twenty-one months old, Dr. Kalia started prescribing drugs to treat her hyperactivity. (St. Ex. 1A at 41b). These included the following:

- On August 27, 1997, Dr. Kalia noted that Patient 1 was hyperactive and not sleeping at night. He prescribed Clonidine, 0.1 milligram at bedtime. (St. Ex. 1A at 41b).

- On September 8, 1997, Dr. Kalia noted that Patient 1 was extremely violent, breaking things, screaming, and hurting herself. Dr. Kalia wrote, “Reluctantly, Ritalin 2.5 mg” three times daily. He did not indicate whether he was discontinuing the Clonidine. (St. Ex. 1A at 41b).
- On September 16, 1997, Dr. Kalia wrote, “Uncontrollable. Sleeps v[ery] little. Pulls on hair. Bangs her head. Effect of Ritalin lasts only ½ hour. Change to Clonidine 0.1 mg [three times per day].” (St. Ex. 1A at 41b).
- On October 14, 1997, Dr. Kalia noted that there was no improvement. He prescribed Cylert 18.75 mg. (St. Ex. 1A at 41b).
- On November 17, 1997, Dr. Kalia noted that Patient 1 “does not sleep with Clonidine.” Dr. Kalia prescribed Adderall 5 mg daily. Dr. Kalia scheduled an appointment for Patient 1 at Belmont Pines, a psychiatric facility, the following day. (St. Ex. 1A at 31a).

On November 19, 1997, Patient 1 presented to the Emergency Department [ER] at Trumbull Memorial Hospital in Warren. Patient 1 exhibited symptoms including tachycardia, jerking of her head, tongue thrusting, twitching, restlessness and screaming. (St. Ex. 1B at 25, 28a, 28b, 29). The ER physician noted that Patient 1’s mother reported that Patient 1 had taken her first dose of Cylert 18.75 mg earlier that day, and that Clonidine had been discontinued the previous day. The mother also reported that Patient 1 had experienced a rapid heartbeat and facial twitching shortly after taking Cylert. Patient 1 was admitted to the hospital, and Dr. Kalia was notified. (St. Ex. 1B at 28a, 29).

Dr. Kalia wrote a “History of Present Illness,” which included the following:

This patient has been treated with Clonidine and Ritalin previously for her hyperactivity. She seemed hyperactive, sleeps barely 2-4 hours a night, and is extremely disruptive to the family and to the parents. The Ritalin was not doing any good to her and Cylert was substituted today. After only one dose of 18.75 mg, the patient started behaving in a very peculiar manner. She started jerking her head, continued to show tongue thrusting movements, plus screaming and seemed to be extremely, extremely restless. She was brought to the ER where a diagnosis of drug reaction to Cylert was made and she was admitted for observation.

(St. Ex. 1B at 25). In the physical examination, Dr. Kalia noted that “the tongue twitches very obvious when she presented to the ER has since resolved.” Under “Nervous System,” Dr. Kalia simply wrote, “no focal abnormality.” He noted that the dose of Cylert was “not so high that much worse can be expected. However, in view of the acuity of the symptoms, the patient will be admitted overnight and observed.” (St. Ex. 1B at 25).

The remainder of the hospitalization was uneventful. Patient 1 was discharged on November 11, 1997. (St. Ex. 1B at 6).

Dr. Kalia saw Patient 1 in his office on December 4, 1997. Dr. Kalia noted that Patient 1 was “extremely, extremely hyperactive.” He added that he had scheduled an appointment with Dr. Kavalosky [sp?] on December 15, 1997. Dr. Kalia prescribed Ritalin 5 mg three times per day and Clonidine 0.1 mg at bedtime. (St. Ex. 1A at 31a).

In January 1998, Dr. Kalia referred Patient 1 to the Trumbull County Board of Mental Retardation and Developmental Disabilities for enrollment in the Early Intervention Program. Dr. Kalia authorized staff there to administer Ritalin to Patient 1. (St. Ex. 1A at 32, 33a, and 33b).

On January 8, 1998, Dr. Kalia noted, “going to Valley Counseling.” The note does not specify who was going to counseling. Dr. Kalia also noted that Patient 1 had been seen by Dr. Kavalosky. He added that Ritalin had been renewed “as it does not help” and increased to every four hours. Dr. Kalia also referred Patient 1 to Fairhaven School for occupational and physical therapy and developmental assessment. The record does not include the results of any consultations. (St. Ex. 1A at 26, 28, 31).

On February 4, 1998, Dr. Kalia noted “ADHD reviewed.” He discontinued the Ritalin, and prescribed Clonidine 0.1 mg three times per day. (St. Ex. 1A at 31b).

### **Testimony of Dr. Mills regarding Patient 1**

6. Dr. Mills testified that, in his care and treatment of Patient 1, Dr. Kalia had failed to conform to the minimal standard of care. In support of that opinion, Dr. Mills testified that Dr. Kalia had prescribed medications inappropriately to Patient 1. Dr. Mills noted that Dr. Kalia had diagnosed Patient 1 as having hyperactivity, and prescribed Clonidine when Patient 1 was only twenty-two months old. Dr. Mills explained that it is highly unusual to prescribe a psychoactive medication to a twenty-two month old child. Dr. Mills further testified that most general pediatricians will not treat a hyperactive child with psychoactive medications before the child is six or seven years old. Dr. Mills explained that children’s behavior naturally calms at that age. (Tr. II at 13-16, 117-118).

Dr. Mills continued that, “twenty-two months is incredibly young to treat a patient with psychoactive medication, be it Clonidine or Ritalin or any of these medications, and is virtually unheard of for a general pediatrician.” He added that it may be acceptable if the physician is a pediatric psychiatrist who has had specific training in prescribing psychoactive medications to someone as young as Patient 1. Nevertheless, Dr. Mills testified that such prescribing is always inappropriate if done by a primary care physician without the supervision and guidance of a physician specially trained in that area. (Tr. II at 16, 112-115).

Dr. Mills testified that he has treated children as young as four or five with Clonidine and that the recommended initial dose of Clonidine for a child of that age is 0.025 mg at bedtime. Dr. Mills added that Dr. Kalia had prescribed 0.1 mg to a twenty-two month old child and that this was an extremely high dose. (Tr. II at 18-21).

7. Dr. Mills testified that Dr. Kalia had also prescribed Ritalin inappropriately to Patient 1. Dr. Mills testified, first, that Dr. Kalia had not allowed enough time to evaluate the effects of Clonidine before he switched to Ritalin. Dr. Mills further testified that, when a child is prescribed Clonidine, the full behavioral effect of the drug might not be seen for three or four months. Dr. Mills acknowledged that the Physicians Desk Reference [PDR], states that Clonidine has a rapid effect, but noted that Clonidine is used to treat hypertension and that, in that setting, Clonidine does have a rapid effect. (Tr. II at 21-22).

Dr. Mills further testified that, like the Clonidine, it is highly unusual to prescribe Ritalin, also a psychoactive drug, to a twenty-two month old child. Dr. Mills referred to the entry regarding Ritalin in the PDR, which states under "Warnings," that "Ritalin should not be used in children under six years since safety and efficacy in this age group have not been established." (Tr. II at 23-24; St. Ex. 14).

8. Dr. Mills noted that Dr. Kalia had prescribed Cylert to Patient 1. Dr. Mills testified that Cylert is a medication that previously was used for attention deficit and hyperactivity. He explained that it has since fallen out of favor due to side effects. Dr. Mills testified that, in 1997, there had been case reports regarding problems with Cylert. Nevertheless, the FDA had not issued a "black box warning" until 1999. (Tr. II at 24-25).
9. Dr. Mills noted that, on November 17, 1997, Dr. Kalia prescribed Adderall to Patient 1. Dr. Mills testified that Adderall is another stimulant medication used to treat attention deficit disorder. Dr. Mills testified that he cannot tell from the records whether Dr. Kalia prescribed Adderall in addition to Clonidine and Ritalin, or if Dr. Kalia had discontinued Clonidine and Ritalin and switched to Adderall. Dr. Mills concluded, nevertheless, that either would be highly unusual for a twenty-two month old child. (Tr. II at 26-28).
10. Regarding Patient 1's hospitalization for a medication reaction, Dr. Mills testified that the symptoms Patient 1 was experiencing could have been an adverse reaction to Cylert. He added that it would be an unusual reaction to Adderall but, because there is no literature regarding the prescription of these drugs to children of this age, he could not rule out that possibility. (Tr. II at 31).
11. Dr. Mills testified that that Dr. Kalia's history and physical for Patient 1's hospitalization did not meet the standard of care for appropriate documentation. Dr. Mills testified that Dr. Kalia had not recorded the timing or doses of the different medications, and had not included necessary vital signs such as a respiratory rate. Moreover, Dr. Mills testified that the history and physical does not include the child's weight, which is vital in caring for a

child this age. Finally, Dr. Mills noted that there is no detailed neurologic examination even though Patient 1 had been admitted with changes in her neurologic status. He stated that Dr. Kalia's notation of "no focal abnormality" is "simply not a good enough neurologic examination in a patient who presents with altered mental status." (Tr. II at 32-34).

Dr. Mills testified that recording the weight is important because, in pediatrics, everything is calculated based on the patient's weight, including the administration of fluids and medications. Therefore, it is important to assure that the patients' weight is readily accessible. Dr. Mills stated that the fact that the weight is recorded in the nurses' notes or elsewhere in the record is not sufficient because it may be difficult to find it in an emergency situation. Dr. Mills testified that the admission history and physical is the most important place that a pediatric patient's weight should be located. (Tr. II at 35).

Dr. Mills added that it is important for the physician to record the weight and vital signs because it is a reflection of what the physician believed to be true at the time the physician formulated his or her conclusions. (Tr. II at 119-123).

Dr. Mills further testified that Dr. Kalia's admission note should have accurately set forth the medications he had prescribed for Patient 1. Dr. Mills added that Dr. Kalia is the only person who knew exactly what had been prescribed and when. Moreover, Dr. Kalia had access to his office records, which he should have used in dictating the admission note. (Tr. II at 35-36).

12. Dr. Mills testified that Dr. Kalia had failed to use reasonable care discrimination in the administration of drugs or failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of a disease. Dr. Mills explained that,

any psychoactive medications in a twenty-two month old, by a primary care pediatrician without additional training, fellowship training or something to that degree, and without direct guidance of a pediatric \* \* \* psychiatrist or a pediatric health care provider with experience in psychoactive medications at this age, would be highly unusual. I've never heard of that from any pediatrician prescribing any psychoactive medications for a twenty-two month old, let alone the fact if he was going to do Clonidine, you have to give it some time to work.

(Tr. II at 39-40). Dr. Mills added that, "you have to know your limits." (Tr. II at 40).

Dr. Mills further criticized Dr. Kalia's rapid cycling of medications. He stated that, in a matter of a few weeks, Dr. Kalia tried Clonidine, Ritalin, Adderall, and Cylert. Dr. Mills testified that, typically, patients who are prescribed new medications are reevaluated after several weeks or a month and, with Clonidine, after three to four months. Moreover, it is important to optimize the dosing of one medication before abandoning it for another. (Tr. II at 40-42).

**Testimony of Dr. Kalia regarding Patient 1**

13. Dr. Kalia testified that he had diagnosed Patient 1 as having ADHD based on complaints that Patient 1 was not sleeping, was disruptive, and was extremely hyperactive. Dr. Kalia testified that Patient 1 was so active that it was difficult to hold her on the examining table. He added that it had been a very troubling case and that the tension in the family caused by Patient 1's behavior had been obvious. (Tr. I at 20-22).

Dr. Kalia disagreed with Dr. Mills' opinion that the prescribing of psychoactive drugs to Patient 1 had been inappropriate for a practitioner of Dr. Kalia's training and expertise. Dr. Kalia testified that the drugs he prescribed to Patient 1 are used regularly by the average pediatrician. Dr. Kalia testified that he has used these drugs frequently in his practice, but never before in a patient younger than three years old. Dr. Kalia testified that he had done so in Patient 1's case because Patient 1's condition was very severe and that it was extremely disruptive to her family. He stated that the family had been begging for help. (Tr. II at 165-167).

14. Dr. Kalia testified that Clonidine is a drug that causes drowsiness, which helps to counteract hyperactivity. Dr. Kalia testified that, despite the fact that the PDR states that Clonidine is not recommended for use in children, his pediatric textbook lists Clonidine as one of the four drugs recommended for use in children with hyperactivity. (Tr. I at 24-26; St. Ex. 13).

When asked whether Clonidine takes effect immediately or takes time to work in the system, Dr. Kalia responded,

I don't know, you know. It has its -- Every drug takes some time to take effect, certainly. But it varies from patient to patient, depending upon the hyperactivity level. And some patients don't respond to it at all. In spite of a very high dose, they don't sleep at all.

(Tr. I at 27).

Dr. Kalia testified that he had started Patient 1 on the lowest dose of Clonidine. He stated that, when the child returned in two weeks, he had switched to Ritalin rather than increase the dose of Clonidine. (Tr. I at 27).

15. In discussing the dose of medications appropriately prescribed to pediatric patients, the following exchange occurred:

Q: (By Ms. Albers) Do you prescribe -- in a pediatric practice, do you prescribe -- How do you prescribe them, by the child's weight, or how do you know the dosage?

- A: (By Dr. Kalia) No, you go by the PDR recommendations most of the time. And also, textbooks will tell you -- guide us in those things.
- Q: Okay.
- A: PDR is knowledge, very, valuable knowledge given to us by the pharmacological companies, but basically these are the books which guide us as to what medicines can be given and cannot be given. So we basically follow our textbooks and our peer articles.
- Q. (By the Hearing Examiner): But the question was how do you know what dose to give pediatric- -
- A: (By Dr. Kalia) Both of these things they show us, but PDR tell us. This is what we depend upon mostly.
- Q: But I don't see in here a dosage for pediatric patients in the PDR.
- A: Yeah, but then, again, you know, the lowest dose, you know, if I -- at an acceptable level of 5, 6 years of age, will be about 5 milligrams.
- Q: How do you know that?
- A: This is the lowest dose, you know, the 5 milligrams.
- Q: How do you know the lowest dose is 5 milligrams?
- A: Unfortunately, the dosages of any of these drugs is not established, okay? The newest drugs which has come, they are coming out with a certain schedule as to how much you should give.
- Q: Who is coming out with the schedule?
- A: There's a new company that come out for hyperactivity, in which they are the only ones who have given certain yardstick as to how much you should give according to weight and all that sort of thing. But most of these times, the Clonidine, Ritalin, the Adderall, all those things, the -- we are realizing a small child with that symptoms may require a bigger dose than a bigger child with minor symptoms. So it is a trial and error in each case, and you have to see a patient many times before you know the dose.
- Q: But if you're going to give a twenty-three month old child a dose of Clonidine, how do you know how much to give on the first dose?

A: It's a small -- Give him the lowest dose and see what it takes.

Q: Lowest dose recommended for what?

A: Lowest dose, 0.1 milligram.

Q: Where did you get the number '0.1 milligram'?

A: That is the smallest tablet which is available.

Q: The smallest dose that's available?

A: Yes.

Q: All right. Thank you.

Q: (By Ms. Albers) So the Ritalin was prescribed 2.5 milligrams, three times a day?

A: Yes.

Q: And is that the -- That's the lowest dose of Ritalin?

A: That is the not the lowest. The lowest established is 5 milligrams, but I give half of that \* \* \* in view of the age.

Q: (By the Hearing Examiner) Why would you -- I'm very confused on this testimony. Why would you give half of the lowest recommended dose in Ritalin \* \* \* but the whole lowest available dose of Clonidine? What is your thinking in making that determination?

A: I can't, you know, very clearly say that, but, you know, it has a -- it has a margin of error, quite a bit of margin of error. The Clonidine has a lot of margin of error. Ritalin, I did not know how much was the margin of error. I had not given it to anybody, very small child like that, and -- but the symptoms were so intense that I felt that my hand was being forced into it. So what I did was since that tablet could be broken, I gave half of the lowest available dose three times a day.

Q: Okay.

A: You do go by a little gut feeling in the -- you know, in day-to-day practice.

(Tr. I at 32-36).

16. Dr. Kalia acknowledged that the PDR states that Ritalin “should not be used in children under six years since the safety and effect in this age group ha[s] not been established.” (Tr. I at 31; St. Ex. 14).

Dr. Kalia testified that physicians often prescribe drugs in a manner other than that delineated in the PDR. Dr. Kalia further testified that, in determining the appropriate drugs to use to treat Patient 1’s ADHD, he had consulted three pediatrics textbooks. He stated that none of the textbooks advised that these drugs could not be given to a child below a particular age. (Tr. II at 173).

17. When asked if he had contacted a pediatric psychiatrist before prescribing psychoactive medications to Patient 1, Dr. Kalia testified that he had referred Patient 1 to Belmont Pines, a psychiatric hospital. Nevertheless, he stated that Belmont Pines had refused to treat her because she was too young. Dr. Kalia further testified that, because referrals often take several months, he had started the medication before making the referral. (Tr. I at 36; Tr. II at 167-168).

18. Dr. Kalia testified that Patient 1 was the first, and possibly the only, child to whom he had prescribed Ritalin and Clonidine at such a young age. He noted that he has treated many children who have ADHD, but that Patient 1 was the most severe. (Tr. I at 36-37).

19. Dr. Kalia testified that he had referred Patient 1 to Dr. Kavalosky, a neurologist, hoping Dr. Kavalosky could guide him, but he did not. Dr. Kalia testified that Dr. Kavalosky had examined Patient 1 and found nothing wrong neurologically. Dr. Kavalosky sent Patient 1 to a developmental center at Tod Children’s Hospital, but the parents did not go. Dr. Kalia testified that he later referred Patient 1 to Fairhaven, a facility for behaviorally challenged and mentally retarded children. Dr. Kalia testified that he had also referred Patient 1 to Psyche Care, another psychiatric facility. He testified that he had been nervous treating Patient 1 due to the severity of her symptoms. Nevertheless, he stated that he had felt obligated to treat her since he could not find help anywhere in the community. (Tr. II at 37-38, 168-169).

Dr. Kalia acknowledged that his medical record for Patient 1 does not contain any documentation from these referral sources to verify his statements. Dr. Kalia stated that he remembers these things. Dr. Kalia explained that Dr. Kavalosky is always late in sending reports, and that psychiatric facilities do not send reports. (Tr. I at 55; Tr. II at 169).

20. Regarding the discrepancy between Dr. Kalia’s office notes and the hospital record for Patient 1, Dr. Kalia testified that he could not explain why Patient 1’s mother reported that Patient 1 had started taking Cylert only on the day of her admission to the hospital. Dr. Kalia stated that patients often give inaccurate reports, and concluded that the mother had been wrong when she reported that Patient 1 had just been given Cylert. Dr. Kalia testified that, according to his office notes, he had discontinued Cylert and started Adderall prior to that date. Nevertheless, Dr. Kalia acknowledged that Adderall would not have

caused the symptoms demonstrated by Patient 1. Moreover, Dr. Kalia acknowledged that his admission note confirms the mother's report and that he had a provisional diagnosis of "drug reaction to Cylert." Dr. Kalia acknowledged that the inaccuracies in his medical documentation is "confusing," but insisted that his office notes are more accurate. (Tr. I at 41-46).

21. Regarding the lack of documentation in his physical examination note, Dr. Kalia testified he had examined Patient 1 and that the findings had been normal. He acknowledged that Patient 1 had been tachycardic, but stated that the tachycardia was insignificant and had been caused by her increased activity. (Tr. I at 46-47).

Dr. Kalia further acknowledged that he had not listed Patient 1's medications in the admission note, and that he had not listed the dates that prior medications had been discontinued. Dr. Kalia explained,

You understand, you know, I go to the hospital. I don't know what time this patient was admitted. In the record it says that this is what she came with. There's a physician on call who manages the patient, unless the thing is very serious or something like that. When I examined her, looking at this chart, all the symptoms had resolved. Basic -- And I took the history. The mom said that I started the Cylert. And I just wrote it down at that time. And the patient -- I send the patient home, and that was that. I did not think anything at all after that.

(Tr. I at 47-48).

Dr. Kalia testified that he had not recorded Patient 1's respiratory rate in the admission note. Dr. Kalia testified that a physical examination should be tailored to the presenting symptoms and that the respiratory rate had not been an important consideration in light of Patient 1's presentation. Dr. Kalia further testified that he had not recorded Patient 1's weight, blood pressure, or temperature because nurses take care of those things. He concluded that they would not necessarily be an important part of a physician's note. (Tr. I at 49, 57; Tr. II at 175-176).

Dr. Kalia acknowledged that Patient 1 had presented with neurological symptoms. He stated that he had done a neurological examination, concluding only that there were "no focal abnormalities." Dr. Kalia explained that focal abnormalities include such things as, "one side is weak, other side is weak, or reflexes are more, or there's paralysis on one side. So this is focal abnormality on one side of the body, or whatever it is, in a particular spot." Dr. Kalia stressed that, because they had resolved by the time he saw her, he had not personally observed any of Patient 1's neurological symptoms. (Tr. I at 49-50).

22. Dr. Kalia testified that, in the end, he had stabilized Patient 1 on Clonidine and that the patient had done very well. He stated that the outcome had been acceptable to the parents,

and their lives had become more manageable. Dr. Kalia concluded that his treatment of Patient 1 had been appropriate. (Tr. II at 174, 177-178).

## **PATIENT 2**

### **Allegations regarding Patient 2**

23. In its September 10, 2004, notice of opportunity for hearing, the Board alleged that, in the routine course of his pediatric practice, Dr. Kalia had undertaken the treatment of Patient 2. (St. Ex. 5A). The Board further alleged that Dr. Kalia's treatment of Patient 2 had included the following.

- a. On or about March 8, 2000, at approximately 6:00 p.m., Patient 2, age eight months, was admitted to the hospital. Patient 2's symptoms included bilious vomiting, lethargy, and dehydration. He also had an ear infection. At approximately 10:00 p.m., after the nursing staff noted a small to moderate amount of blood in Patient 2's stool, Dr. Kalia was consulted. In response, Dr. Kalia ordered a fluid bolus. Nevertheless, Dr. Kalia did not actually examine Patient 2 until approximately 2:00 a.m. on or about March 9, 2000, even though such a time delay is unacceptable for a patient who exhibits illness to this degree. At that time, Dr. Kalia noted that Patient 2 was obtunded with extreme dehydration. Dr. Kalia rendered provisional diagnoses that Patient 2 was suffering from lower respiratory infection, intractable vomiting, and severe dehydration, with a note to rule out meningitis. However, Dr. Kalia failed to perform and/or document an adequate physical examination, including a rectal examination, of Patient 2, despite the fact that blood was noted in his stool. Dr. Kalia ordered a croup tent, Xopenex aerosols, and Rocephin for Patient 2.

On or about March 9, 2000, although Patient 2 continued to have blood in his stool, bilious emesis and lethargy, Dr. Kalia did not take measures to complete a differential diagnosis for Patient 2, including ruling out a bowel obstruction.

On or about March 11, 2000, Patient 2 was transferred to another hospital at the request of his family, where he was diagnosed with intussusception complicated by perforation of the transverse colon, requiring an ileocollectomy with ileostomy and transverse colostomy. Patient 2 had also developed bacterial peritonitis as a result of the perforation of his bowel.

- b. Dr. Kalia's medical records documenting the hospitalization of Patient 2 failed to report several important features, including the age of the patient, a past medical history, vital signs, and documentation of an adequate physical examination.

(St. Ex. 5A).

### **Medical Records for Patient 2**

24. Patient 2, a male, was born June 23, 1999. On March 7, 2000, Patient 2 presented to the ER at St. Joseph Health Center in Warren, Ohio. Patient 2 had a temperature of 104°. He was treated for bilateral otitis media and released. Later that evening, Patient 2 started vomiting. (St. Ex. 2A at 9, 39).

On March 8, 2000, at 2:40 p.m., Patient 2 returned to the ER. Patient 2's mother reported that he had been vomiting "every five minutes." Patient 2 was alert, but listless. The nurses' notes indicate that Patient 2 had a temperature of 100° rectally; his blood pressure was 116/74, his heart rate was 148, and his respiratory rate was 28. Chemistry and CBC studies were within normal limits. A chest x-ray taken revealed clear lung fields with no acute inflammatory process or pulmonary congestion. The ER physician ordered intravenous fluids and Phenergan 12.5 mg intramuscularly. Patient 2 was admitted to the hospital to the service of Dr. Davis with diagnoses of gastroenteritis and persistent vomiting. Patient 2's mother accompanied him to his hospital room. (St. Ex. 2A at 9-11, 36).

The nurses' notes indicate that, on March 8, 2000, at 6:00 p.m., that Patient 2 was lethargic and flaccid, but responded to stimuli. He had vomited twice with moderate amounts of bile green emesis and flecks of blood, and had had one large liquid brown stool. Patient 2's skin was very pale, with dark circles under his eyes. His skin turgor was poor, with a red blotchy rash across the shoulder blades. Phenergan was administered. (St. Ex. 2A at 49).

The nurses' notes further indicate that, at 9:00 p.m., Patient 2 had had a liquid dark brown stool with a small to moderate amount of bright red blood. He also had an emesis of bile color with flecks of blood. Patient 2 was not tolerating Pedialyte, and Dr. Davis was notified. (St. Ex. 2A at 49).

At 10:30 p.m., Dr. Davis had ordered a consult with Dr. Kalia. At 10:45 p.m., Dr. Kalia provided orders via the telephone for administration of intravenous fluids. (St. Ex. 2A at 13-14).

The nurses' notes indicate that, on March 9, 2000, at midnight, Patient 2 had had two episodes of large bile green emesis after drinking one ounce of Pedialyte. It was also noted that there was blood in Patient 2's diaper. At 12:30 a.m., a Phenergan suppository was administered to control Patient 2's vomiting. The nurses' notes further indicate that all urine specimens and diapers were to be saved so that Dr. Kalia could see them. Finally, it was noted that the parents were at the bedside. (St. Ex. 2A at 49-50).

At 1:10 a.m., Dr. Kalia wrote orders for Rocephin, Xopenex, a croup tent, urinalysis and blood work. The nurses' notes indicate that, at approximately 2:00 a.m., Dr. Kalia examined Patient 2 and spoke with his parents. (St. Ex. 2A at 14, 50).

Dr. Kalia wrote a Consultation Note. In the Consultation Note, Dr. Kalia reviewed Patient 2's March 7, 2000, ER visit. He further noted that, after being sent home, Patient 2 had started vomiting. He continued:

HISTORY OF PRESENT ILLNESS: \* \* \* The vomiting became extremely frequent and followed by bile stained vomitus containing suspiciously a minimal amount of blood. (However, this blood was not seen by anybody else.) He continued to have dry heaves and became obtunded. He was brought back to the hospital where he was admitted. An IV was started at around 30 cc an hour. However, he continued to deteriorate. His vomiting continued. His general condition also deteriorated. He became oliguric and the nurses noted some blood on his diaper. However, this blood was noted to be secondary to the diaper rash, as well as perianal dermatitis. The urinalysis had not shown any blood. Needless to say this will be further confirmed while on the floor. There was no diarrhea. No other associated complaint.

PHYSICAL EXAMINATION: General: The patient seems to be dehydrated. The dehydration even after bolus of 200 cc of normal saline seems to be closer to 10%. His obtundation is suspicious. It is either due to the extreme dehydration, meningitis or Phenergan suppositories which this patient has been given while in the hospital, and if condition improves and the effect of Phenergan suppository wears off, and if he still continues to be somewhat sleepy, the diagnosis of meningitis will be entertained and a lumbar puncture done. Meanwhile, I am planning to start him on Rocephin. \* \* \* Chest: The patient is noted to cough repetitively. The cough is dry and shallow. The air entry is good. Breath sounds are vesicular and there is just a few harsh breath sounds, as well as rales heard at the bases. However, the nature of the cough denotes certain low respiratory infection. Abdomen: Normal shape, soft, no tender[ness] anywhere and there is no organomegaly. \* \* \* Nervous System: He is very sleepy, not responsive, but there is no other focal abnormality.

PROVISIONAL DIAGNOSIS:

Lower respiratory infection.  
Intractable vomiting.  
Severe dehydration.  
Rule out meningitis.

PLAN OF TREATMENT: Rehydrate the child and observe. Lumbar puncture will be done if the clinical condition of the child so dictates. Meanwhile, antibiotics of a sufficient dosage to cover meningitis has been started.

(St. Ex. 2A at 20-21).

On March 9, 2000, at 3:00 a.m., the nurses prepared the croup tent. The parents were instructed in its use. (St. Ex. 2A at 50).

At 9:00 a.m., Dr. Kalia noted that Patient 2 seemed “improved.” He stated that Patient 2 was responsive, and no longer very lethargic. He did note, however, that Patient 2’s potassium was 6.1, and stated that it was an effect of acidosis. (St. Ex. 2A at 23).

The nurses’ notes indicate that, at 2:00 p.m., family members gave Patient 2 four ounces of Pedialyte. Patient 2 vomited shortly thereafter. (St. Ex. 2A at 50).

The nurses’ notes indicate that, at 10:00 p.m., Patient 2 had a “liquid brown mucus stool [with a moderate amount] of bright red blood.” Dr. Kalia was notified of the stool. He ordered that the stool be sent for “culture, ova, and parasites.” (St. Ex. 2A at 51).

On March 10, 2000, at approximately 11:30 a.m., Dr. Kalia ordered a flat plate of the abdomen. The film revealed the following: “There are no significant fluid levels. There is no dilatation of the large or small bowel and no free air is identified. No abnormal intra-abdominal calcifications are demonstrated.” (St. Ex. 2A at 16, 37).

Dr. Kalia ordered that fluids be held. (St. Ex. 2A at 16). At 5:30 p.m., the nurses’ notes indicate that Patient 2 vomited a small amount of “thick green mucous and Pedialyte.” Dr. Kalia ordered antibiotics and diet as tolerated. (St. Ex. 2A at 17, 52).

The nurses’ notes indicate that, at 7:00 p.m., Patient 2 vomited a small amount of clear emesis “with thick green mucous and green liquid.” At 8:00 p.m., Patient 2 drank one ounce of Pedialyte and vomited a small amount with “thick shreds of green mucous.” At 9:00 p.m., the nurses reported a “streak of blood on diaper and scant amount [of] blood around rectum.” (St. Ex. 2A at 52).

During the early morning hours of March 11, 2000, Patient 2 continued to vomit green mucous. Patient 2 also had a “small amount of red streaks” in his diaper.” At 11:00 a.m., Patient 2 had vomited a moderate amount of light green fluid. He also appeared to have intermittent bowel pain as he was drawing up his legs and crying. Both Dr. Davis and Dr. Kalia were called and advised of the patient’s continued vomiting and the family’s desire to have Patient 2 transferred to Tod Children’s Hospital. (St. Ex. 2A at 52-53).

At 11:30 a.m., Dr. Davis ordered that Patient 2 be transferred to Tod Children’s Hospital. At 11:50, Dr. Kalia ordered, “OK to transfer to Tods.” (St. Ex. 2A at 17). Dr. Davis explained in his discharge note that,

It was noted on 3/11/2000, after seeing the patient that the patient symptomatically seemed to be improving; however, mother was concerned that the patient was not improving to her liking, therefore, the patient was transferred to Tod’s for further evaluation. I felt and the mother felt that

since the patient was not improving up to her standards that a second opinion or a hospitalization in a hospital which is strictly pediatric may be of some benefit.

(St. Ex. 2A at 7).

25. Patient 2 was admitted to Tod Children's Hospital. Upon admission, the physical examination of the abdomen revealed the following: "The patient's abdomen appeared to be mildly distended. Upon palpation, the patient had some tenderness and also exhibited flexion of hips and knees. There is a sausage-like mass in the right upper and lower quadrant areas. The patient had soft, hypoactive bowel sounds. Abdomen was tympanic to percussion." Moreover, the diaper showed a copious amount of "dark currant jellylike stools" which tested positive for blood. The diagnosis of intussusception was confirmed by ultrasound, and Patient 2 was sent to surgery. (St. Ex. 2B at 397-399).

The surgical notes lists a reason for the surgical consultation as "intussusception with multiple perforations and ischemic necrosis of small and large bowel, cultures positive from peritoneum." The surgery included removal of long segment of the small bowel, the cecum, and the colon. (St. Ex. 2B at 413).

The Discharge Summary lists Patient 2's diagnoses as follows:

1. Intussusception, status post bowel resection secondary to perforation.
2. Peritonitis secondary to enterococcus and bacterioids.
3. Parenteral nutrition.
4. Thrombocytosis.

(St. Ex. 2B at 387).

The Discharge Summary states that, upon admission to Tod Children's Hospital, Patient 2 had had signs and symptoms consistent with intussusception which required surgical intervention consisting of "intussusception reduction, bowel resection (all of the descending colon) and bowel packing X 3." The Discharge Summary further noted that the intussusception had been complicated by perforation and peritonitis. Moreover, after treatment with multiple antibiotics, Patient 2's recovery period had been further complicated by abdominal cytosis and thrombocytosis. Patient 2 was discharged with two ostomies and a bag. (St. Ex. 2B at 388-387).

26. On May 25, 2000, Patient 2 was hospitalized at Tod Children's Hospital for a reversal of the ileostomy. An ileocolon anastomosis was performed, and Patient 2 tolerated the procedure well. (St. Ex. 2B at 31-216).

**Testimony of Dr. Mills regarding Patient 2**

27. Dr. Mills testified that, in his care and treatment of Patient 2, Dr. Kalia had failed to conform to the minimal standard of care. In support of that opinion, Dr. Mills testified, first, that Dr. Kalia had not seen Patient 2 in a timely manner when Dr. Kalia was first consulted by Dr. Davis. Dr. Mills testified that Dr. Davis had consulted Dr. Kalia at 10:30 p.m., and that Dr. Kalia had been contacted by 10:45 p.m., but that Dr. Kalia had not written his first order until 1:10 a.m. Dr. Mills testified that the time lapse was too long for a lethargic eight month old infant with bilious vomiting. Dr. Mills testified that Dr. Kalia should have seen Patient 2 in two hours or less due to the potentially disastrous consequences of missing a diagnosis such as bowel obstruction. (Tr. II at 43-45, 124-131).
28. Dr. Mills explained that bowel obstruction is the most important diagnosis to rule out in a child who presents with bilious vomiting and lethargy. He added that, in such a case, there is an assumption that the diagnosis is bowel obstruction until proven otherwise. Dr. Mills further testified that the single most common cause of bowel obstruction in a child between three and thirty-six months is intussusception, or a telescoping of one section of the bowel into an adjacent section. Dr. Mills added that, if you miss a bowel obstruction, then the outcome can be devastating. Complications can include necrosis of the bowel, perforation, peritonitis, sepsis, multi-organ failure and death. (Tr. II at 45-46, 50-52; Tr. I at 73).

Dr. Mills testified that classic signs and symptoms of intussusception include bilious vomiting, lethargy, bloody stools, pulling legs up, and crying. Nevertheless, not all children present with the same signs and symptoms. He stated that bilious vomiting or lethargy alone is enough to suggest the possibility of a bowel obstruction. Moreover, if a baby has bilious vomiting, lethargy, and bloody stools, it is bowel obstruction until proven otherwise. The standard of care for a child who presents with these symptoms is to immediately rule out a bowel obstruction and intussusception. Dr. Mills concluded that it does not appear from the record that Dr. Kalia ever even considered a bowel obstruction. (Tr. II at 63-66).

Dr. Mills acknowledged that bilious emesis may not necessarily indicate a bowel obstruction and that emesis may be bilious and green in color in a child who has been vomiting for several days. Nevertheless, Dr. Mills testified that it is incumbent upon the physician to assure that the cause is not a bowel obstruction. Dr. Mills added that hallmark symptoms of intussusception and bowel obstruction are bilious vomiting and bloody stools. (Tr. II at 50-52).

Dr. Mills testified that Dr. Kalia should have performed a rectal examination when the nurses reported blood in Patient 2's stools. Noting that Dr. Kalia had requested that the nurses save Patient 2's diapers for Dr. Kalia's inspection, Dr. Mills testified that it may have been a reasonable request if Dr. Kalia had not been physically present to examine Patient 2. He added that, with a potential bowel obstruction, a pediatrician can not wait several hours before making the diagnosis. (Tr. II at 61-62). Dr. Mills concluded that with

bilious vomiting and lethargy in an eight month old child, any “pediatrician should have known that diagnosis without even thinking.” (Tr. II at 67).

29. Dr. Mills testified that it would have been “highly unlikely” that Patient 2’s bloody stools and blood in the diaper would have been caused by a diaper rash. Dr. Mills added that determining the source of the blood in the diaper would not have been difficult. Dr. Mills explained that blood from a diaper rash or from a rectal fissure would have been bright red and sitting “on top of the stool.” Blood that comes from a source higher in the colon will be darker in color and mixed in the stool like jelly. Dr. Mills testified that, if there is a possibility that a patient has an intussusception, a rectal examination should be performed. Dr. Mills concluded that a simple rectal examination would have distinguished blood from the diaper area, blood from the rectum, and blood from the bowel. (Tr. II at 52-55).
30. Dr. Mills noted that the abdominal x-ray had failed to reveal the intussusception. Nevertheless, Dr. Mills testified that a normal abdominal x-ray does not preclude a diagnosis of intussusception because an abdominal film is not an appropriate tool for diagnosing intussusception. He stated that a plain film of the abdomen is a screening film, and it may or may not show signs of obstruction. He stated that, even if the film was normal, this child’s symptoms warranted an evaluation for intussusception. (Tr. II at 55-59, 135-136, 154-155).

Dr. Mills testified that proper tools for diagnosing intussusception include ultrasound and air enema. Dr. Mills testified that intussusceptions generally occur in the right upper quadrant of the abdomen. He stated that an ultrasound will reveal the bowel telescoped into itself. He further testified that a mass can generally be palpated. (Tr. II at 59-60).

31. Dr. Mills further testified that it had been inappropriate to order a croup tent for Patient 2. Dr. Mills testified that a croup tent is an antiquated treatment modality that is no longer used. Dr. Mills added that croup tents are inappropriate, in part, because they fill with mist and make it difficult to view the patient. He stated that it is especially important to visualize patients who are critically ill, such as Patient 2. Therefore, Dr. Mills concluded, even if Dr. Kalia had correctly diagnosed a respiratory infection, a croup tent was not an appropriate treatment. (Tr. II at 47-49, 133-134).

On cross-examination, Dr. Mills was asked to explain why, if a croup tent is an antiquated treatment, the nurses at St. Joseph Hospital did not question Dr. Kalia’s order, there were croup tents available in the hospital, and hospital staff knew how to set up the croup tent. Dr. Mills replied that the nurses may have been accustomed to croup tents because Dr. Kalia ordered them routinely. He added that those things did not indicate that the nurses or the hospital had agreed with Dr. Kalia’s thinking. (Tr. II at 131-133).

32. Dr. Mills further testified that, even if Dr. Kalia had correctly diagnosed a respiratory infection, the use of Xopenex aerosols was inappropriate. Dr. Mills explained that Xopenex aerosols are used to treat asthma and that there was nothing in the record to

indicate that Patient 2 was wheezing, had retractions, or had an asthmatic condition. Moreover, Dr. Mills testified that the use of the Xopenex aerosol on Patient 2 had been inappropriate because it may have masked the bowel obstruction. Dr. Mills explained that tachycardia is a side effect of both Xopenex aerosols and dehydration. Therefore, in a patient who has simple dehydration, as the fluid balance improves, so will the tachycardia. When administering Xopenex aerosol, however, the tachycardia will not improve. Therefore, the physician may assume that tachycardia that continues despite the resolution of dehydration is caused by the Xopenex aerosol, and the physician would not look for the actual cause, the bowel obstruction. (Tr. II at 49-51).

33. When asked if Patient 2 is likely to suffer any long-term consequences from these events, Dr. Mills testified that Patient 2 lost bowel tissue and underwent two surgeries. Moreover, the repeat abdominal surgeries increased the likelihood that Patient 2 will experience future bowel obstructions. (Tr. II at 69-70).
34. Dr. Mills testified that Dr. Kalia had violated the minimal standard of care also by his poor documentation in this case. Dr. Mills testified that Dr. Kalia had not documented Patient 2's age, which is very important in pediatrics. Moreover, Dr. Kalia had not indicated a past medical history, basic vital signs, or an adequate physical examination. (Tr. II at 66-67).

### **Testimony of Dr. Kalia regarding Patient 2**

35. Dr. Kalia testified that, although he had not written orders until 1:10 a.m., he had actually seen Patient 2 much earlier. Dr. Kalia explained that writing orders is not the first thing he does when he sees a patient in the hospital. Dr. Kalia stated that he first examines the patient and the hospital record. Dr. Kalia concluded that, "obviously," he had been at the hospital at least one hour before writing the orders. Therefore, Dr. Kalia concluded that he had seen Patient 1 within two hours of being contacted. (Tr. II at 178-181).
36. Dr. Kalia testified that he had diagnosed Patient 2 as suffering from vomiting, diarrhea, dehydration, and bronchitis. Dr. Kalia also testified that he had believed that Patient 2 was suffering from dehydration and the effects of the Phenergan ordered by the ER physician. (Tr. I at 62, 81). Dr. Kalia testified that he had not considered a differential diagnosis for Patient 2 because Dr. Kalia had thought Patient 2 "just had a vomiting." By the third day, however, Dr. Kalia had become concerned about the continuous bilious vomiting. He stated that, for that reason, he had ordered the abdominal x-ray. When the x-ray was negative, however, he had ruled out a bowel obstruction. (Tr. I at 77-80).

Dr. Kalia testified that, although it is not included in the hospital records, an amended x-ray report was later issued. He further stated that the amended report had identified signs of intussusception. Dr. Kalia concluded that, if he had seen the correct report, he would not

have missed the diagnosis. Dr. Kalia could not explain why the amended report was not included in the records certified by the hospital. (Tr. II at 181-184, 218-219).

37. Dr. Kalia was asked why he had not performed a rectal examination to determine the source of blood in Patient 2's diaper. Dr. Kalia explained that he had not performed a rectal examination because he had not been considering a diagnosis of intussusception. He stated that intussusception is a very rare disease. He also stated that, because Patient 2's buttocks were raw and provided a reasonable explanation for blood in the diaper, he had not wanted to put Patient 2 through the painful rectal examination. Finally, Dr. Kalia testified that he had not performed a rectal examination because a rectal examination may not reveal blood even with a diagnosis of intussusception. He stated that bleeding only occurs during late stage intussusception; therefore, there may not have been any blood. This last explanation, however, was not relevant to the question as to why he had not performed a rectal examination to determine the source of the bleeding that had, in fact, been documented. (Tr. II at 184-191).

[Note, however, that the only reference to a raw buttocks is in Dr. Kalia's Consultation Note which states that, "the nurses noted some blood on his diaper. However, this blood was noted to be secondary to the diaper rash, as well as perianal dermatitis." Dr. Kalia's note does not indicate who had "noted to be secondary to the diaper rash, as well as perianal dermatitis," as there is no such notation in the hospital record. Moreover, although the nurses documented "a red blotchy rash across the shoulder blades," there is no mention of a diaper rash or perianal dermatitis.] (St. Ex. 2A at 20, 49).]

38. Dr. Kalia testified that, during the year 2000, he had been employed by St. Joseph Hospital to care for high-risk pediatric patients. Dr. Kalia explained that the administrator at St. Joseph Hospital had told him that the hospital had been losing money because other doctors would not get up in the middle of the night to treat patients. Therefore, they had hired Dr. Kalia to do so. Dr. Kalia testified that, because of this, he had cared for the most serious patients. (Tr. I at 59-60).

### **PATIENT 3**

#### **Allegations regarding Patient 3**

39. In its September 10, 2004, notice of opportunity for hearing, the Board alleged that, in the routine course of his pediatric practice, Dr. Kalia had undertaken the treatment of Patient 3. (St. Ex. 5A). The Board further alleged that Dr. Kalia's treatment of Patient 3 included the following.
- a. On or about March 26, 1999, Dr. Kalia admitted Patient 3, age fourteen months, to the hospital, having diagnosed her with acute croup, a viral disease. Despite this diagnosis, Dr. Kalia treated Patient 3 with medications, including the antibiotic

Rocephin, Ventolin aerosols, subcutaneous epinephrine, and intravenous aminophylline, which are not effective for the treatment of croup. Moreover, although Dr. Kalia ordered racemic epinephrine aerosols at one point on the day of admission, he cancelled the order shortly thereafter and restarted the Ventolin aerosols. When the house physician examined Patient 3 the morning following her admission, the patient was found to have moderate to severe respiratory distress, and the house physician appropriately altered the patient's treatment to include vaponephrine aerosols and steroids.

- b. Dr. Kalia's medical records documenting the hospitalization of Patient 3 described in paragraph 3.a failed to report several important features, including the age of the patient, past medical history, and basic vital signs including weight, heart rate, and respiratory rate, and the degree or description of respiratory distress.

(St. Ex. 5A).

### **Medical Records for Patient 3**

40. Patient 3, a female, was born on January 24, 1998. Dr. Kalia saw Patient 3 for the first time on February 9, 1998. (St. Ex. 3A at 19, 20a).

On March 26, 1999, Patient 3 was admitted to Trumbull Memorial Hospital. Patient 3 was admitted from an observation unit with an admitting diagnosis of croup. Her chief complaint was "difficulty breathing for one day." In Dr. Kalia's admission note, he stated that she had developed a cough and cold three days earlier and that her symptoms had gradually worsened. Since the previous evening, Patient 3 had been having "extreme difficulty in breathing." She had not eaten or taken fluids and had been whining. She had been given Albuterol which had provided no relief. In the physical examination, Dr. Kalia noted that Patient 3 was pale and had a temperature of 101.7°. (St. Ex. 3B at 4, 34). Dr. Kalia also wrote, in part:

CHEST: The child is obviously croupy. He [sic] does not have the position or the manner of a child with any epiglottitis. Even then, no attempt was made to visualize the epiglottis. PHARYNX: Normal, otherwise. LUNGS: Breath sounds are vesicular. Air entry is fairly good. Slight degree of conducted breath sounds of a croupy nature are heard all over the chest.

(St. Ex. 3B at 34). The provisional diagnosis was, "Acute croup secondary to acute laryngotracheobronchitis." (St. Ex. 3A at 12a, 14).

Dr. Kalia's orders included a croup tent, Ventolin [Albuterol] aerosol treatments every four hours, Rocephin, Tylenol, intravenous fluids, and x-rays. He also ordered epinephrine

subcutaneously. A chest x-ray revealed “findings consistent with history of croup.” (St. Ex. 3B at 12a, 14a, 33).

On March 26, 1999, at 3:55 p.m., Dr. Kalia ordered racemic epinephrine 0.25 ml every four hours as needed. He also discontinued the Ventolin aerosol treatments. Patient 3 received one racemic epinephrine treatment at 5:35 p.m. The nurses’ notes indicate that Patient 3 was “very stridorous.” Sometime later, Dr. Kalia discontinued the racemic epinephrine and ordered Ventolin aerosol treatments every four hours. The nurses’ notes documented that Patient 3 continued to be very stridorous and that Dr. Kalia had been notified. (St. Ex. 3B at 11b, 14b, 32a).

At approximately 7:30 p.m., the nurses notified Dr. LaPolla and the Head Nurse, Lori Sylvester, of Patient 3’s condition and of the nurses’ concerns that Dr. Kalia had discontinued the racemic epinephrine. Dr. LaPolla instructed the nurses to contact him if Patient 3 was transferred. (St. Ex. 3B at 19; Tr. I at 97-99).

Patient 3 received her first Ventolin aerosol treatment at 8:15 p.m. Following the treatment, Patient 3 continued to have stridor. Her apical pulse was 156 and her respiratory rate was 52. At 9:30 p.m., the nurses notified Dr. Kalia that there had been no improvement after the Ventolin aerosol treatment. Dr. Kalia ordered Ventolin aerosol as needed as well as every four hours. (St. Ex. 3B at 11b, 14b, 19a).

The nurses’ notes indicate that, at 9:45 p.m., after another Ventolin aerosol treatment, Patient 3’s breathing was labored with retractions. She was experiencing wheezing, rhonchi, and stridor. At midnight, her breath sounds were diminished and tight with stridor; her apical pulse was 170 and her respiratory rate was 50-60. (St. Ex. 3B at 32a).

On March 27, 1999, at 2:30 a.m., Patient 3 had harsh, diminished breath sounds with inspiratory stridor, a croupy cough, nasal flaring, and intercostal and substernal retractions. Her respiratory rate was 52. The nurses notified Dr. Kalia that Patient 3 had received hourly Ventolin treatments for the past three hours and that there had been no improvement. Dr. Kalia gave no further orders and instructed the nurses to “just watch her.” (St. Ex. 3B at 14b, 19a, 32b).

At 4:00 a.m., Patient 3 continued to experience stridor with flaring and retractions. A nurse noted that, “Stridor can be heard from the hallway outside her room [with] O<sub>2</sub> tent running.” (St. Ex. 3B at 32b).

At 6:05 a.m., the nurses notified Dr. Kalia that Patient 3 was still experiencing stridor with retracting and flaring. Her respiratory rate was 38 to 42, her heart rate was in the 150s, and her temperature was 101.4°. The nurses further advised that Patient 3 was becoming tired due to the respiratory effort. Dr. Kalia “agreed to allow the house officer to evaluate.” (St. Ex. 3B at 11a, 19a).

At 6:25 a.m., the nurses notified the house physician of Patient 3's respiratory distress and requested that the house physician evaluate her. At 6:30 a.m., the house physician examined Patient 3 and found her to be in moderate to severe respiratory distress with stridor and a respiratory rate ranging from the forties to the seventies. The house physician ordered racemic epinephrine aerosol treatments and Solu Medrol intravenously. The house physician also discontinued the Ventolin aerosol treatments. (St. Ex. 3B at 11a, 13a, 19b).

At 7:30 a.m., Dr. Kalia examined Patient 3 and noted that her respiratory distress was only mild. He further noted, "Stridor less marked but wheezing." Sometime later, Dr. Kalia ordered intravenous Aminophylline, continued the racemic epinephrine, and discontinued the already discontinued Ventolin aerosol treatments. (St. Ex. 3B at 11a, 13a, 14a).

At 4:15 p.m., the nurses requested that Dr. Kalia order racemic epinephrine treatments as needed. Dr. Kalia refused. On March 28, 1999, at 12:30 p.m., Dr. Kalia discontinued the racemic epinephrine and ordered Ventolin aerosol every four hours. Patient 3 was discharged home the following day. (St. Ex. 3B at 10a, 10b, 19b).

### **Testimony of Dr. Mills regarding Patient 3**

41. Dr. Mills testified that Dr. Kalia had failed to conform to minimal standards of care in his care and treatment of Patient 3. First, Dr. Mills explained that Patient 3 had been admitted to the hospital with a diagnosis of croup. Dr. Mills testified that Dr. Kalia had treated her as an asthmatic, despite the diagnosis of croup. (Tr. II at 71-72, 81).

Dr. Mills explained that croup can be a very severe, life threatening, illness. He added that the treatment for croup is standard, and medications that treat asthma are of no effect in treating croup. Dr. Mills concluded that Dr. Kalia had "clearly deviated from the standard of care in terms of treatment for croup." (Tr. II at 72).

Dr. Mills explained that croup is a very common condition typically caused by the parainfluenza virus. He stated that croup causes swelling and inflammation of tissues around the vocal cords. With croup, the airway decreases which causes a characteristic cough and an inspiratory sound called stridor. He stated that croup "is an illness of inspiration, meaning that kids have trouble getting their air in." (Tr. II at 73-74).

Dr. Mills further testified that tracheitis is a condition that sometimes complicates croup. It is a secondary bacterial infection of the trachea, or windpipe, rather than the vocal cords. Dr. Mills testified that children who have tracheitis generally appear sicker than children who have croup. They also have high temperatures and elevated white counts with left shift. (Tr. II at 74-76).

Finally, Dr. Mills testified that asthma is a completely different diagnosis; asthma causes constriction of the lower airways, specifically the bronchials, the lower most distal portions

of the airways. As the airways get inflamed, they become smaller and less air passes through. Dr. Mills testified that asthma is a disease of expiration, and children with asthma have trouble getting their air out. They do not get stridor or a croupy cough. Asthmatics instead have a bronchial spastic cough, which originates in the lower airways rather than from around the vocal cords. Dr. Mills testified that it is very easy to differentiate between asthma and croup. (Tr. II at 76-77).

42. Dr. Mills testified that Dr. Kalia had placed Patient 3 at risk by using medications that were not indicated. Dr. Mills testified that Dr. Kalia had used Ventolin or Albuterol, which is an aerosol routinely used for asthmatic conditions. He stated that Ventolin is a beta 2 agonist that dilates the lower airways. Dr. Mills testified that Ventolin has absolutely no effect on the vocal cords. (Tr. II at 72, 73, 77).

Dr. Mills further testified that Dr. Kalia had used subcutaneous epinephrine rather than aerosolized racemic epinephrine. Dr. Mills testified that aerosolized epinephrine is effective on the vocal cords because it constricts the blood vessels which decreases the swelling in the vocal cords. This allows the airway to expand. On the other hand, Dr. Mills testified, subcutaneous epinephrine has no effect on the vocal cords. One of the effects of subcutaneous epinephrine is bronchodilation, which is effective for asthma, but not for croup. (Tr. II at 77-79).

Dr. Mills further testified that Dr. Kalia used Aminophylline to treat Patient 3. Dr. Mills stated that Aminophylline is a medication that was once used to treat asthma. He added that it has never been used to treat croup. In fact, Dr. Mills testified that Aminophylline would be contraindicated in croup due to its many side effects. (Tr. II at 81-82).

Dr. Mills concluded that Dr. Kalia had used the wrong medications for the diagnosis that he himself had documented on his admission history and physical. Dr. Mills testified that it was even more egregious since Dr. Kalia had been giving Ventolin, in the form of Albuterol, prior to admission and the Ventolin had not provided relief. (Tr. II at 80).

43. Dr. Mills further testified that Dr. Kalia had deviated from the standard of care in his documentation of Patient 3's condition. Dr. Mills testified that Dr. Kalia had not charted Patient 3's age, weight, heart rate, or respiratory rate, despite the fact that she had been admitted with respiratory distress. Dr. Mills noted that Dr. Kalia had not documented the details of her respiratory distress, such as whether her chest was retracting, or her ribs were flaring, and whether she was using her accessory muscles to breathe. Dr. Mills testified that it is very important to document how sick the patient is so that the next doctor or nurse can evaluate the change in the patient's condition. Dr. Mills stated that Dr. Kalia's description of breath sounds was not sufficient. (Tr. II at 72, 82-84).
44. Dr. Mills further testified that laryngotracheobronchitis is croup. Therefore, it had made no sense for Dr. Kalia to document a diagnosis of croup secondary to laryngotracheobronchitis. (Tr. II at 84).

45. Dr. Mills testified that the record reflects that the nurses were concerned regarding the care Dr. Kalia provided to Patient 3. He stated that the nurses were so concerned that they contacted another physician, which is unusual for nurses to do. Dr. Mills further testified that the nurse's description of Patient 3's condition, including stridor, retracting, flaring, and elevated respiratory and cardiac rates, gave a good picture of a very sick child. Dr. Mills testified that the picture was of a child approaching respiratory failure. (Tr. II at 87-90, 139-142).

Dr. Mills testified that the care and documentation provided by the house physician was appropriate in this case. He added that racemic epinephrine and Solu Medrol are standard treatments for croup. (Tr. II at 85-87).

### **Testimony of Dr. Kalia regarding Patient 3**

46. Dr. Kalia testified that croup is not always caused by a virus. He stated that croup is a symptom of material tracheitis or acute laryngotracheobronchitis. He stated that it is bacterial in thirty percent of cases, and viral in the rest. (Tr. I at 88-89).

Dr. Kalia testified that, in a small child with croup, it is not possible to distinguish between croup of a viral origin or croup of a bacterial origin. Therefore, Dr. Kalia testified, he had prescribed antibiotics and ordered a croup tent. Dr. Kalia testified that that is the standard treatment for croup, and nothing else is needed. "The rest is just covering all the bases." (Tr. I at 89).

Dr. Kalia testified that the natural course of this disease is three to four days. During that time there will be periodic episodes of respiratory difficulty. During times of difficulty, breathing treatments are appropriate. A croup tent and antibiotics are also appropriate. Dr. Kalia testified that you may need to intubate the child in extreme cases. In this case, the child's condition improved. Dr. Kalia concluded that he had done everything that needed to be done at that time. (Tr. I at 99-100).

47. Dr. Kalia testified that croup can be "a sign of asthma, you know. It looks like a cold." He explained that the asthmatic spasm "extends into the laryngeal area and can manifest as a croup." (Tr. I at 89).

Dr. Kalia testified that he had later diagnosed Patient 3 as suffering from asthma. He stated that Patient 3 had suffered a few more episodes of croup, with coughing, rales and wheezing. Dr. Kalia testified that these are the "tell-tale signs of asthma." Dr. Kalia testified that,

The asthma comes in ways where it is from the time you just cough a little, persistently. \* \* \* One end of the spectrum, the kid just keeps (indicating), like that. At night he coughs a little. When he runs, he coughs a little; or on the

other side, classically, wheezing, difficulty in breathing, coughing, you know, that -- these are the signs of asthma. But in kids there's such gray shades that it has to be done over a period of time. When the cough lasts for a long time, any cold that lasts a long time without any other reason why a cough should persist, then you have -- that is one way you can diagnose asthma.

(Tr. I at 103-104).

Dr. Kalia further testified that,

I must say it is not so important to put a label of asthma. What does it matter -- it's like -- it is like asthma caused bronchitis. Bronchitis -- If I tell you you have bronchitis, it is like my telling you you have fever. The reason is what does the -- what is the fever due to. If it's like anything, bronchitis, it can be asthma, it can be infection, it could be various things, smoke inhalation or in many things, the treatment still remains the same. \* \* \* The definition of asthma is that it appears repetitively over a period of time. Previously there used to be a caution, you should not make a diagnosis of asthma to anybody less than five years of age. I haven't heard that caution anymore. But again, I have not put the label, but I've been treating the bronchitis. I see no other reason which will cause this recurrence of symptoms and this persistence of symptoms except asthma.

(Tr. I at 105-106).

Dr. Kalia testified that making a differential diagnosis is not as important as making a sick child feel better. Dr. Kalia testified that, although acute laryngotracheobronchitis is primarily a viral disease, it can also be caused by bacteria; therefore, he had treated Patient 3 with antibiotics. Dr. Kalia further testified that treatment for croup is supportive, and includes oxygen in a cool mist croup tent. Dr. Kalia explained that it is difficult to give oxygen to a young child through a cannula or face mask, as the child will remove the cannula or face mask. Dr. Kalia testified that there is also an oxygen hood, but he added that the hood provides heated oxygen which causes the child to sweat. Therefore, Dr. Kalia prefers the croup tent. (Tr. I at 194-196).

48. Dr. Kalia disagreed with Dr. Mills' testimony that asthma is a disease of the small airways. Dr. Kalia testified that asthma can cause bronchospasm in an airway of any size, even the large airways. He stated that there are different symptoms with "small-airways asthma" as compared to "large-airways asthma." He further stated that asthma or spasm of the large airways can give rise to croup. (Tr. II at 196-197).

Dr. Kalia testified that he had used Albuterol to treat the spasmodic croup. He stated that he had continued to give Albuterol because Albuterol treats bronchospasm. He added that there are other components to asthma that Albuterol does not treat, such as exudation,

vasodilatation, and congestion. Dr. Kalia testified that he had not expected Patient 3 to get better as a result of the Albuterol treatments because the other problems take time to resolve. (Tr. II at 197).

49. Dr. Kalia testified that Ventolin, epinephrine and Aminophylline are treatments for asthma. He stated that he had used these drugs for Patient 3 because he had believed that Patient 3 had actually been suffering from asthma which was presenting as a croup. He explained that these medications relieve the spasm in the airways. Nevertheless, Dr. Kalia testified that these medications can also be used to treat viral bronchitis and croupy coughs, as their use is not limited to asthma. (Tr. I at 96).

Dr. Kalia testified that Ventolin is Albuterol, a bronchodilator. He stated that it opens the airways. Dr. Kalia testified that the nature of this disease is that, periodically, the patient will experience a croup and have difficulty breathing. At those times, it is appropriate to administer Albuterol. (Tr. I at 90, 95).

Dr. Kalia testified that he had also prescribed Aminophylline for its bronchodilating effect to treat Patient 3's asthma. He stated that, in 1999, Aminophylline had still been used regularly. (Tr. I at 94).

50. Dr. Kalia further testified that he had ordered racemic epinephrine to treat Patient 3 because it is the hospital's protocol. He stated that he had cancelled the order shortly after writing it because he has "no faith" in it. He stated that epinephrine is an old medicine that has many side effects. He stated that it was not necessary in this case and he could not have continued it, "in good faith." (Tr. I at 90-92).

Dr. Kalia also testified that he had ordered epinephrine despite the fact that he does not consider it an appropriate treatment for croup because he had been having problems with the administration at Trumbull Memorial Hospital. Dr. Kalia testified that Dr. LaPolla, the Chief of Pediatrics, had told the nurses to question everything that Dr. Kalia did. (Tr. I at 91).

Dr. Kalia testified that, later on, the house physician had ordered racemic epinephrine. Dr. Kalia stated that he had gone along with it for awhile, but then discontinued the house physician's order. (Tr. at 95).

Dr. Kalia testified that epinephrine is an older medication that has many cardiac side effects. Dr. Kalia testified that Ventolin/Albuterol is a great improvement over epinephrine. Dr. Kalia testified that he doesn't know "why anyone finds any logic at all in giving the racemic epinephrine and not racemic Albuterol." (Tr. 1 at 92).

51. Dr. Kalia testified that, according to his pediatrics textbook, steroids, such as Solu Medrol, are not helpful in acute laryngotracheitis. (Tr. 1 at 100-101).

52. Dr. Kalia disagreed with Dr. Mills' testimony that the use of a croup tent is antiquated. Dr. Kalia testified that the latest pediatric textbook "still says the cardinal principal of that is to treat supportive, put them in cool mist air." Dr. Kalia further testified that other pediatricians he knows also use croup tents. He stated that the use of croup tents is "a regular and accepted treatment in [his] practice in northeastern Ohio." Dr. Kalia concluded that standard of care may differ between Toledo, where Dr. Mills practices, and northeastern Ohio, where Dr. Kalia practices. (Tr. II at 193-194).

53. Dr. Kalia testified that he had documented an adequate physical examination in his admission note. He explained that, because he had written "'good air entry, breath sounds are vesicular' and nothing else," he had indicated that the child was not experiencing any respiratory difficulty. (Tr. II at 196).

Dr. Kalia acknowledged that he had not documented Patient 3's age, but stated that it could be found elsewhere in the hospital chart. Moreover, he testified that he had not documented a respiratory or heart rate, but stated that it could be found in the nurses' notes. Finally, Dr. Kalia stated that Patient 3 had not been in respiratory distress upon admission. Dr. Kalia stated that he had adequately described the child's condition by stating that the breath sounds were "of a croupy nature," and the child's color was good "which meant she could take a deep breath." (Tr. I at 85-88).

54. Dr. Kalia testified that the nurses had requested that the house physician see Patient 3. He further testified that, in addition, the nurses had contacted Dr. LaPolla, the Chief of Pediatrics, and Lori Sylvester, the Head Nurse. Dr. Kalia explained that Dr. LaPolla had instructed the nurses to contact him any time Dr. Kalia admitted a patient. (Tr. I at 97-99).

Dr. Kalia testified that his relationship with Dr. LaPolla had been very bad at that time. He stated that, when Dr. Kalia first moved to Trumbull County, Dr. LaPolla had refused to give him privileges at Trumbull Memorial Hospital because Dr. LaPolla had said there were too many pediatricians in Trumbull County. Dr. Kalia filed a lawsuit against the hospital, which resulted in the granting of his privileges. Dr. Kalia testified that, shortly thereafter, Dr. LaPolla had summarily suspended Dr. Kalia's privileges based on the treatment Dr. Kalia had provided to the first four patients he had seen. Dr. Kalia testified that a reviewing committee had determined that there was no merit to Dr. LaPolla's complaints and had reinstated Dr. Kalia's privileges. (Tr. II at 199-201). Dr. Kalia concluded that it was because of his personal conflicts with Dr. LaPolla that the nurses had challenged his orders. Dr. Kalia denied that Dr. LaPolla's actions could have been based on concerns regarding the care Dr. Kalia had provided to his patients. (Tr. II at 219-220).

55. Dr. Kalia concluded that he had treated Patient 3 appropriately and that his treatment had not fallen below the minimal standard of care. He added that he had followed an appropriate course of treatment with Patient 3 and that his course of treatment had been interrupted by an inappropriate order from the house physician. (Tr. I at 194; Tr. II at 198-199).

## **PATIENT 4**

### **Allegations regarding Patient 4**

56. In its September 10, 2004, notice of opportunity for hearing, the Board alleged that, in the routine course of his pediatric practice, Dr. Kalia had undertaken the treatment of Patient 4. (St. Ex. 5A). The Board further alleged that Dr. Kalia's treatment of Patient 4 included the following.

- a. On or about March 31, 1999, Dr. Kalia admitted Patient 4 to the hospital. He was nine months old at that time. Patient 4 demonstrated symptoms which included vomiting, lethargy and dehydration. Although the admission laboratory results for Patient 4 suggested a bacterial infection, and included an elevated peripheral white blood cell count with a marked left shift, two metamyelocytes, thirty bands, toxic granulations, Döhle bodies, fragmented red blood cells and burr cells, Dr. Kalia failed to treat Patient 4 for a bacterial infection. Instead, Dr. Kalia treated Patient 4 for dehydration with intravenous fluids.

The following morning, Dr. Kalia noted that Patient 4 was better hydrated but still febrile, irritable and ill-appearing. At that time, Dr. Kalia performed a spinal tap, which revealed Patient 4 to have streptococcus pneumonia meningitis. Dr. Kalia placed Patient 4 on Rocephin intravenously and lowered his IV fluids to maintenance level appropriate for this diagnosis. As Patient 4 continued to exhibit nuchal rigidity with opisthotonic posturing, tremors of the arms indicative of focal seizures, and low central spinal fluid [CSF] glucose, other physicians were consulted. Patient 4 was transferred to a children's hospital for admission to a pediatric intensive care unit, although Dr. Kalia resisted the transfer.

- b. Dr. Kalia's medical documentation of the hospitalization of Patient 4 failed to report several important features, including the age of the patient, race, and basic vital signs including weight, pulse, respiration and blood pressure.

(St. Ex. 5A).

### **Medical Records for Patient 4**

57. Patient 4, a male, was born June 22, 1998. (St. Ex. 4A at 3). Patient 4 had had a history of right sided focal seizures since his birth. In February 1999, Patient 4 developed intermittent fevers which had persisted for four weeks. Patient 4 had been diagnosed with bilateral otitis media and had undergone two rounds of antibiotic treatment. (St. Ex. 4A at 32; St. Ex. 4C at 131, 381).

58. Dr. Kalia saw Patient 4 in his office on March 31, 1999. Patient 4 was nine months old at that time. Dr. Kalia noted that Patient 4 had had intractable vomiting for one day and that his temperature was 101.7°. Dr. Kalia further noted that Patient 4 was dehydrated by ten percent, and recommended that he be admitted to the hospital. (St. Ex. 4A at 24b).

Later that day, Patient 4 was admitted to Trumbull Memorial Hospital. The hospital record indicates that, at approximately 12:00 noon, Patient 4's temperature was 101°, his heart rate 180, his respiratory rate 84, and his blood pressure 116/44. (St. Ex. 4B at 46a). In his physical examination note, Dr. Kalia wrote as follows:

Sickly, obviously dehydrated child who looks pale, whiny, listless.  
Dehydration is assessed at around 10%. HEAD: Normocephalic. Fontanelles almost closed. ENT: Ears are normal. Oral mucosa is normal. Thyroid is not enlarged. HEART: Normal. CHEST: Clear. ABDOMEN: Not tender. No masses. GENITALIA: Normal. MUSCULOSKELETAL: Normal.  
Except for generally poor disposition, no focal neurological abnormality.

(St. Ex. 4B at 75). Dr. Kalia listed his provisional diagnosis as "Intractable vomiting with about 10% dehydration." Dr. Kalia did not mention in the note that Patient 4 had suffered seizures since birth. Moreover, Dr. Kalia did not mention that Patient 4 had been having fevers over the previous month or that he had been diagnosed with and treated for bilateral otitis media. (St. Ex. 4B at 75).

Dr. Kalia ordered a complete blood count [CBC] and electrolytes, a bolus of 150 cc normal saline intravenously, followed by Ringer's Lactate with D<sub>5</sub>W at 80 cc per hour for eight hours, Tylenol, and a diet of clear liquids. (St. Ex. 4B at 50).

Hematology studies drawn on March 31, 1999, at 12:14 p.m., revealed the following:

	RESULTS	HIGH/ LOW	REFERENCE RANGE
WBC:	28.3	H	4.3-10.7
RBC:	3.45	L	4.4-6.0
HGB:	8.2	L	14-17
HCT:	24.8	L	42-52
MCV:	71.8	L	80-100
MCH:	23.8	L	27-33
MCHC:	33.1		32-36
RDW:	14.3	H	11.7-13.7
PLT:	893	H	135-435
MPV:	6.5	L	7.4-10.4
BANDS %:	30	H	2-10
SEGS %:	58		36-66

LYMPH %:	8	L	15-44
MONO %:	2		2-8
EOS %:	0		
BASO %:	0		0-1
METAMYE:	2	H	0
Toxic Granulations:	Minimal		
Döhle Bodies:	Minimal		

(St. Ex. 4B at 67-69).

Chemistry studies drawn at 12:14 p.m. revealed:

	RESULTS	HIGH/ LOW	REFERENCE RANGE
NA:	139		137-145
K:	4.3		3.6-4.8
CL:	103		98-108
TCO <sub>2</sub> :	23.6	L	24-33

(St. Ex. 4B at 70).

The hospital record indicates that, at 4:40 p.m., Patient 4's temperature was 102.3°; he was medicated with Tylenol. At approximately 6:00 p.m., Patient 4's temperature was 99.9°, his heart rate 146, his respiratory rate 36. Nevertheless, at 8:40 p.m., his temperature was 102.5°, and he was again medicated with Tylenol. (St. Ex. 4B at 46a, 66a).

At 10:30 p.m., Dr. Kalia increased the IV fluid rate to 100 cc per hour. At 6:00 a.m., Patient 4's fluid intake and output were calculated. During the first twelve hours of Patient 4's admission, his intake was 1436 cc, and his output was 285 cc. He had a positive 1151 cc fluid balance. (St. Ex. 4B at 46b, 49).

The hospital record indicates that, on April 1, 1999, at approximately 6:00 a.m., Patient 4's temperature was 101.4°, his heart rate 180, his respiratory rate 60. (St. Ex. 4B at 46a).

The nurses' notes indicate that, at 7:30 a.m., Patient 4's skin was waxy and pale. He had marked periorbital and facial edema, and he had a frequent moist cough. Dr. Kalia was notified. (St. Ex. 4B at 65a).

At 8:45 a.m., Dr. Kalia saw Patient 4. Dr. Kalia reduced the IV rate to 20 cc per hour. He ordered stat CBC, reticulocyte count, electrolytes, basic chemical profile, serum iron, iron binding capacity, and transferrin saturation. He also ordered one unit packed cells for grouping and matching. At 9:10 a.m., Dr. Kalia performed a lumbar puncture, and sent a sample of cerebral spinal fluid for culture, glucose, proteins, chlorides, cells and gram

stain. Finally, Dr. Kalia ordered Rocephin IV. Later he ordered a urinalysis and increased the IV rate to 100 cc per hour. (St. Ex. 4B at 48-49, 65a).

The cerebral spinal fluid was cloudy and buff. The specimen revealed 3150 red blood cells and 1300 white blood cells, with 74 polycytes and 26 monocytes. The differential count was 100. Glucose was low at less than 10 mg/dl [reference range 40-70], and protein was high at 514 mg/dl [reference range 18-45]. Finally, the cerebral spinal fluid later revealed a heavy growth of streptococcus pneumoniae. (St. Ex. 4B at 71, 73, 74).

At 10:15 a.m., Lori Sylvester, R.N., notified Dr. LaPolla of Patient 4's condition and of her concerns regarding the care Patient 4 was receiving. She requested that Dr. LaPolla see the patient. Ms. Sylvester also contacted other people regarding Patient 4's care. One of those people contacted Dr. McCoy, who was the hospital's Director of the Medical Affairs, and who was in North Carolina at that time. (St. Ex. 4B at 58a; Tr. I at 120).

Hematology studies drawn at 10:35 p.m. revealed:

	RESULTS	HIGH/ LOW	REFERENCE RANGE
WBC:	13.2	H	4.3-10.7
RBC:	3.13	L	4.4-6.0
HGB:	7.3	L	14-17
HCT:	22.7	L	42-52
MCV:	72.3	L	80-100
MCH:	23.4	L	27-33
MCHC:	32.3		32-36
RDW:	14.1	H	11.7-13.7
PLT:	547	H	135-435
MPV:	6.2	L	7.4-10.4
BANDS %:	47	H	2-10
SEGS %:	44		36-66
LYMPH %:	8	L	15-44
MONO %:	0	L	2-8
EOS %:	0		
BASO %:	0		0-1
MYELOCY:	1	H	0
Toxic Granulations:	Mild		
Döhle Bodies:	Mild		
Retic Cnt:	0.4	L	0.5-1.5
Iron:	< 2	L	37-181
TIBC:	225	L	250-455

(St. Ex. 4B at 67).

Chemistry studies drawn at 10:35 p.m. revealed:

	RESULTS	HIGH/ LOW	REFERENCE RANGE
NA:	140		137-145
K:	2.7	L	3.6-4.8
CL:	108		98-108
TCO <sub>2</sub>	25.1		24-33
Glucose	184	H	70-110
BUN	3	L	6-26
Creatinine	0.4	L	0.6-1.5
BUN/Creat	7.5		

(St. Ex. 4B at 70).

At 10:45 a.m., Dr. Kalia ordered latex agglutinations on the cerebral spinal fluid. He also ordered that Patient 4 be isolated. At 11:30 a.m., Dr. Kalia ordered that Patient 4 be NPO [nothing by mouth]. He changed the IV fluids to D<sub>5</sub>RL with 30 mEq KCl to infuse at 40 cc per hour. (St. Ex. 4B at 48, 49).

At 11:40 a.m., Dr. McCoy spoke with Dr. LaPolla by telephone. Dr. McCoy advised Dr. LaPolla to see Patient 4 or to arrange for another physician to see him. A consultation was ordered with S.V. Rao, M.D. (St. Ex. 4B at 47, 58a).

At 12:30 p.m., Patient 4's mother reported that Patient 4 was "making a funny, whistling, gurgling noise." The nurse noted marked nuchal rigidity and an opisthotonic position. His neck was rigid. Dr. Kalia was paged, and Dr. Rao was called to see Patient 4. Patient 4's temperature was 101°, his heart rate 180, his respiratory rate 60, and his blood pressure 96/55. He was sleepy, but oriented, with purposeful motor responses. His pupils were equal and reactive, and his muscle tone arching. (St. Ex. 4B at 59, 65a).

At 1:00 p.m., the nurse noted that Patient 4's neck remained arched. He also demonstrated occasional trembling of the left arm and leg lasting one to two seconds. The nurses' notes state that, at 1:30 p.m., Patient 4 was asleep but aroused with light tactile stimulation. There was "less nuchal rigidity." Patient 4 remained pale. No further trembling had been noted. (St. Ex. 4B at 65b).

At 1:30 p.m., Dr. Rao noted that he had examined Patient 4 and recommended that he be transferred to the ICU at Tod Childrens Hospital. (St. Ex. 4B at 47, 58b). Dr. Rao wrote a Consultation Report, addressed to Dr. Kalia, as follows:

Thank you for this emergency consultation. I must confess that I was not sure why I am being consulted on this case because you are a pediatrician yourself. I

was trying to reach you and talk to you, but meanwhile I got a call from the floor saying that this child is very, very sick and therefore I had to run to the floor. I did review the chart and noted that this child is 9 months old and has been admitted for fever, gastroenteritis and severe dehydration and questionable meningitis. I did notice that you did do a spinal tap and diagnosed him as having pneumococcal meningitis with high protein in the CSF and high cell count. The infesting [sic] bug had been identified as pneumococcus. He also is very severely anemic with a serum iron less than 2 and a normal TIBC.

PHYSICAL EXAMINATION: Briefly, this child does look very, very sick and extremely pale. He did gain 2 pounds of weight since last night. I believe he had 18 cc per hour of lactated ringer's last night and he has been putting out some urine. The enormous weight gain by the next morning is suspicious of syndrome of inappropriate ADH, although I do not have any biochemical values to prove this. This is just a suspicion and one needs to watch out especially because of meningitis. I also noticed that he is getting Rocephin 500 mg IV. He is arching back. There is very severe [tachy]cardia, the heart rate is about 180 per minute and irregular sinus rhythm. There is a grade 2/6 ejection systolic murmur in the upper left sternal border. There are obvious meningeal signs. Anterior fontanel is small and one can feel the pulsation indicating that there is some decreasing pressure in the CSF. There is hepatosplenomegaly.

IMPRESSION: My impression is that this child is extremely sick. He does need to be monitored carefully in the Intensive Care Unit.

RECOMMENDATIONS: My recommendation therefore will be, if you can manage him here with appropriate monitoring equipment and constant supervision, you probably could do this here as far as I am concerned. I would not be able to do this and therefore I am strongly recommending that this child be transferred to Tod intensive care unit where intensive care can be given to him, especially in view of the multiple pathologies that we see in this boy including meningitis, anemia and heart murmur.

I hope this information is helpful to you and once again, thanking you for this emergency consultation with kindest personal regards.

As I mentioned before, I am not sure why I am being consulted. On the floor there had been some discussion with Lori Sylvester, the Head Nurse and Dr. LaPolla on the phone, but I am not yet clear as to why consultation is being sought. In any case, you have asked me and this is my opinion.

Thanking you once again.

On April 1, 1999, at 1:45 p.m., Dr. LaPolla wrote the following in the progress notes:

Asked to come in to consult since [the private] pediatrician not able to be reached for over 55 minutes. Now patient is seizing! Dx. meningitis. I examined child – child opisthotonic and having sudden jerks. Will transfer to Tod Childrens Hospital under care of Dr. [illegible]. Will be sent to I.C.U. Tod.

I have talked to Dr. Rao previously to consult. Also spoke to Dr. Kalia who initially resisted transfer in spite of poor hospital course of patient.

(St. Ex. 4B at 51-52). Dr. LaPolla provided a telephone order that Patient 4 be transferred to Tod Childrens Hospital. (St. Ex. 4B at 47).

At 1:50 p.m., Dr. Kalia gave a telephone order, “OK to transfer.” (St. Ex. 4B at 47). Patient 4 was transferred to Tod Children’s Hospital at 2:35 p.m. (St. Ex. 4B at 65b).

59. Dr. Kalia dictated two discharge summaries in this case, the first on April 23, 1999. In the April 23, 1999, discharge summary, Dr. Kalia first reviewed Patient 4’s hospital course. Dr. Kalia concluded that,

I heard from Dr. LaPolla that the patient was very sick. I offered him consultation which he declined. Dr. Rao was therefore suggested by him who went and saw the patient and later on told me that he had nothing to offer as far as treatment was concerned. At around 1 o’clock I was told that the patient had had a few tremors, however, no nurse had yet noted any frank convulsions. I was also told that the transfer team from Tod Children’s Hospital is already on the way. The patient was transferred to Tod Children’s Hospital where he was given further treatment.

(St. Ex. 4B at 44-45).

Dr. Kalia dictated the second discharge summary on April 26, 1999. In the April 26, 1999, discharge summary, Dr. Kalia stated that he had seen Patient 4 in his office prior to admission. Dr. Kalia further stated that:

[Patient 4] was somewhat listless but he still had a little eye contact. He was a little irritable but there was no other focal abnormality. In view of the fact that he was such a small child, there was no nuchal rigidity and his fontanel had closed. A diagnosis of meningitis was entertained but couldn’t be ascertained one way or the other. In any case of vomiting or fever, this is always a possibility. However, in view of his alertness, the index of suspicion

did not rise very high. His irritability, fever and listlessness were attributed to his dehydration.

Physical examination was negative for any postop infection. The patient was investigated with CBC which, except for elevated segs, was unremarkable. The electrolytes showed isoelectric dehydration. \* \* \*

(St. Ex. 4B at 42). Dr. Kalia continued to review the treatment decisions he had made during the hospitalization. Dr. Kalia concluded,

I received a call from North Carolina by Dr. McCoy who called Dr. LaPolla who apparently was concerned about this patient. When I spoke to Dr. LaPolla, he could not express the cause of his concern and he only told me that the nurses were feeling concerned and the patient was sick. I pointed out that a patient of meningitis is a sick child, however, his vitals are absolutely normal and the final resolution can await a little thought process. Also referred in consultation to let me know if he would like to add anything else to the treatment or change the diagnosis or give me his wisdom. This was declined. He suggested Dr. Rao which I accepted, however, Dr. Rao later told me that he had nothing more to add. He agreed that the patient was a very sick child, not a surprise, however, the patient meanwhile was transferred to Tod Childrens' Hospital without my knowledge or consent. I may point out that whatever the clinical status of this patient was done within my competence. I have the privileges to treat a case of meningitis in the hospital. It did not require any sub specialist intervention at that time and even if Dr. LaPolla was uncomfortable keeping the patient in the hospital it could have been discussed with me. I would not feel safe in keeping a patient in the hospital beyond the nursing care abilities of the nursing staff, however, in this case, nothing very spectacular as a result of the treatment was going on. The only objection to the whole thing is the discourteous way in which the patient was transferred to a hospital as regards to necessity of a needed transfer or something, I will reserve my argument.

(St. Ex. 4B at 42-43).

60. Upon admission to Tod Children's Hospital, Patient 4 was lethargic, fussy and pale. His neck was hyperextended with positive nuchal rigidity. He had a 2/6 systolic ejection murmur, possibly secondary to fluid overload. He had positive "Babinski's" [Brudzinski's sign ??] and positive Kernig's sign. (St. Ex. 4C at 371).

The Discharge Summary from Tod Children's Hospital noted that Patient 4 had transferred from Trumbull Memorial Hospital where he had been "given 2½ [times] maintenance fluids overnight. The patient was noted in the morning to have jerky movements of the left arm and leg, not suppressed by holding the baby." Patient 4 was diagnosed with

pneumococcal meningitis, seizure, and iron deficiency anemia. He was treated with Claforan, Vancomycin, Ferinsol, and Ativan. He also had a neurological consultation. He was discharged thirteen days later on April 13, 1999. (St. Ex. 4C at 360-361, 381-383).

#### **Testimony of Dr. Mills regarding Patient 4**

61. Dr. Mills testified that Dr. Kalia's care and treatment of Patient 4 had fallen below the minimal standard of care. Dr. Mills testified that Dr. Kalia's documentation was inadequate. He further testified that Dr. Kalia's differential diagnosis and monitoring of Patient 4's care was inadequate. Finally, Dr. Mills testified that Dr. Kalia had used poor judgment in the ultimate disposition of Patient 4. (Tr. II at 91-92, 107-108).

Dr. Mills noted that, on March 31, 1999, Patient 4 had had an elevated white blood cell count of 28.3 [normal range was 4.3 to 10.7]. In addition, Dr. Mills testified that the white cell studies indicated a marked left shift. He explained that a left shift means that the patient's bone marrow is producing cells that are fighting a serious bacterial infection or illness. He added that, "Thirty percent bands, in combination with toxic granulation and Döhle Bodies, is highly suspicious for a serious bacterial infection." (Tr. II at 92-94).

Moreover, Dr. Mills testified that the laboratory results on April 1 were even more striking. Dr. Mills testified that the fact that Patient 4's white blood cell count had decreased from 28,000 to 13,000 overnight was of concern to him. Dr. Mills testified that children's white cell counts may decrease as their bodies become overwhelmed with infection. In this case, Patient 4's white blood cell count had dropped by half while the left shift had increased from 30% to 47% bands and the toxic granulations had increased. Dr. Mills testified that it may have been a sign that Patient 4 was becoming overwhelmed with infection to the point that his bone marrow was unable to manufacture sufficient white blood cells to fight the infection. Dr. Mills concluded that it had been an ominous sign. (Tr. II at 95-96, 153-154).

Dr. Mills further explained that the red cell studies indicated that Patient 4 was anemic. He explained that a child's normal red cell count range is lower than that of an adult; nevertheless, 8.2 was still low and Patient 4 was anemic. Dr. Mills further testified that Patient 4's red cell morphology provides hints as to why he had such a low blood count. Dr. Mills explained that, in addition to iron deficiency, there were also fragmented red blood cells and Burr cells, indicating hemolysis or the destruction of red blood cells. He added that hemolysis is often seen in serious bacterial infections. (Tr. II at 94-95).

Dr. Mills disagreed with Dr. Kalia's testimony that severe dehydration and acidosis would cause a left shift of the severity seen in this case. (Tr. II at 153).

62. Dr. Mills also testified that he would not criticize Dr. Kalia for the initial diagnosis of dehydration, even though that was not the correct diagnosis. Dr. Mills testified that Dr. Kalia had performed the lumbar puncture and diagnosed bacterial meningitis appropriately.

Nevertheless, Dr. Mills testified that Dr. Kalia should have suspected bacterial meningitis earlier in his treatment of Patient 4. Dr. Mills testified that Patient 4 had presented with non-specific symptoms, including irritability, fever, and vomiting. Dr. Mills explained that it is well-known that some children with meningitis will present with these symptoms. Dr. Mills added that the lab results had confirmed that the diagnosis was not simple dehydration or viral illness. Moreover, Patient 4's condition did not improve with rehydration. Therefore, Dr. Mills concluded that Dr. Kalia should have realized that his diagnosis was wrong and he should have identified bacterial meningitis earlier. (Tr. II at 102-104, 142-147).

Dr. Mills testified that he also had concerns because, despite the fact that Patient 4's condition had been deteriorating, Dr. Kalia had resisted transferring Patient 4 to an intensive care unit. Dr. Mills testified that Patient 4 had been extremely ill, had been diagnosed with meningitis, and had been having seizures, nuchal rigidity, and opisthotonic posturing. Dr. Mills explained that a baby with opisthotonic posturing will arch his back in an attempt to relieve the irritated meninges. He further explained that, in doing so, the baby is "trying to do whatever he can do to keep the meninges from being stretched." Dr. Mills added that nuchal rigidity and opisthotonic posturing are indications that the baby is severely ill. Moreover, Dr. Mills stated that the standard of care for treatment of Patient 4, who had unstable vital signs, seizures, and opisthotonic posturing, definitely included treatment in an intensive care setting, because Patient 4 was facing a life-threatening illness. (Tr. II at 98-102).

Dr. Mills testified that in young patients less than twenty-four months, there may be no nuchal rigidity at all. Moreover, nuchal rigidity is a late finding in meningitis. He stated that a pediatrician hopes not to reach the stage of nuchal rigidity in a young child because it is an indication of severe illness. Therefore, despite the fact that Dr. Mills would not criticize Dr. Kalia for failing to recognize the bacterial meningitis on the first day of admission, he did criticize Dr. Kalia's failure to react appropriately once nuchal rigidity and opisthotonic posturing developed. Dr. Mills testified that that was an indication of a fairly advanced stage of the illness. (Tr. II at 104-105).

Dr. Mills disagreed with Dr. Kalia's testimony that children at this age can not have nuchal rigidity. Dr. Mills testified that a child this age could have meningitis and not have nuchal rigidity. Therefore, the fact that the child did not have nuchal rigidity would not rule out a diagnosis of meningitis. On the other hand, if a child this age did have nuchal rigidity, it is a "huge positive" sign of meningitis. Dr. Mills reiterated his testimony that Dr. Kalia's resistance to transfer Patient 4 gave him serious concern regarding Dr. Kalia's judgment. (Tr. II at 105-107).

63. Dr. Mills testified that it would have been a violation of the standard of care to have failed to transfer Patient 4 to an intensive care unit. He added that it is the accepted standard of care to treat only stable and uncomplicated cases of meningitis in a pediatric ward. Dr. Mills concluded that Patient 4 had not been one of those patients. (Tr. II at 158-161).

64. Dr. Mills further testified that Dr. Kalia's admission history and physical was inadequate. Dr. Mills testified that, despite the fact that Patient 4 was extremely ill, Dr. Kalia did not document Patient 4's age, race, or basic vital signs. (Tr. II at 97).

Dr. Mills noted that Patient 4 had been severely dehydrated and Dr. Kalia prescribed fluid replacement therapy. Dr. Mills noted, however, that Dr. Kalia had not documented Patient 4's weight from his office records to help determine how much fluid Patient 4 had lost during the course of his illness. (Tr. II at 98).

#### **Testimony of Dr. Kalia regarding Patient 4**

65. Dr. Kalia testified that he feels comfortable handling patients with meningitis. He testified that his care and treatment of Patient 4 had been appropriate, and that the only real issue in this case had been Dr. LaPolla's transferring Patient 4 without Dr. Kalia's knowledge and permission. (Tr. I at 122-123).

66. Dr. Kalia testified that Patient 4's laboratory results had not suggested a bacterial infection. Dr. Kalia testified that Patient 4 had had severe acidosis secondary to dehydration. He stated that, on April 1, after he had corrected the dehydration but before the antibiotics had taken effect, the white blood cell studies "virtually came back to normal." Dr. Kalia acknowledged that, upon admission, Patient 4's hemoglobin and hematocrit had been low. He stated that, even though one would expect the hemoglobin and hematocrit to be high with severe dehydration, Patient 4's had been low because he had also been suffering from severe anemia. (Tr. I at 116-119).

Dr. Kalia testified that severe dehydration and acidosis can give rise to left shift. Dr. Kalia testified that he was not sure if toxic granulations are consistent with that conclusion. Therefore, he admitted that, if toxic granulations are a definite sign of infection, he had missed the significance of it. Dr. Kalia further testified, however, that other than the possibility that he had missed the significance of the toxic granulations, he believes that he had provided appropriate care to Patient 4. (Tr. II at 211-213).

67. Dr. Kalia testified that Patient 4 could have been managed at Trumbull Memorial Hospital. Dr. Kalia testified that he has had years of training to handle cases such as this. Dr. Kalia testified that Patient 4 would not have needed treatment in an intensive care unit until Patient 4 developed complications such as increased intracranial pressure or shock. Dr. Kalia further testified that he had been competent to handle convulsions or low blood pressure at Trumbull Memorial Hospital. (Tr. I at 126-128).
68. Dr. Kalia acknowledged that seizures and opisthotonic posturing present a life-threatening situation. Nevertheless, Dr. Kalia testified that Patient 4 had not had seizures, nuchal rigidity, or opisthotonic posturing. (Tr. I at 124-130).

In denying that Patient 4 had had seizures, Dr. Kalia stated that Patient 4 had merely “twitched a few times.” Dr. Kalia concluded that twitching “is of no consequence to a child.” Dr. Kalia added that Patient 4 could not have had seizures because, if he had had seizures, treatment would have been given and no treatment for seizures was given. (Tr. I at 124-12; Tr. II at 204).

Dr. Kalia further testified that eight month old children can not have nuchal rigidity or opisthotonic posturing. Dr. Kalia concluded that, despite the findings documented by the nurses, Dr. Rao, Dr. LaPolla, and the physicians at Tod Children’s Hospital, findings of nuchal rigidity or opisthotonic posturing are not valid in a child of Patient 4’s age. (Tr. I at 128-130).

Dr. Kalia denied that Patient 4 had exhibited opisthotonic posturing. Dr. Kalia added, “I don’t think Dr. LaPolla knows what is opisthotonic posturing.” (Tr. I at 125). Dr. Kalia further testified that opisthotonic posturing is a sign of decerebrated rigidity and that, if Patient 4 had experienced opisthotonic posturing, he would now be severely impaired. (Tr. II at 203-204). Dr. Kalia added,

The decerebrate posture, opisthotonic is a late -- is a late appearance and denotes severe mental damage. The kid would not have recovered without fault if he had real decerebrating posturing. And also my point is, if he was having convulsions, if he was having decerebrate posturing, why was this kid transferred without a single treatment in that hospital, if Dr. LaPolla was watching it. That is a -- you know, when he’s convulsing, the kid may die in the next few minutes. Why was not treatment given at that time? As I said, the physical findings are not tenable with the set of circumstances.

(Tr. II at 220-221).

69. Dr. Kalia testified that he had not opposed transferring Patient 4 to Tod Children’s Hospital; rather, it was the unprofessional manner in which it was conducted that he found objectionable. Dr. Kalia further testified that he would have transferred Patient 4 if the nurses had told him that they were unable to take care of him. Dr. Kalia continued that the patient had been transferred before he could make that decision on his own. (Tr. I at 119-122, 201-203; Tr. II at 204-205).

Dr. Kalia testified that he had sent a report of the incident to the president of the medical staff, complaining of Dr. LaPolla’s interference with Dr. Kalia’s patients. Dr. Kalia testified that it was not the first time it had happened. (Tr. I at 122).

Regarding Dr. Mills testimony that it is highly unusual that a nurse would contact a doctor other than the patient’s doctor in a case, Dr. Kalia testified that the conflicts between himself and Dr. LaPolla rendered it not so unusual under these circumstances. Dr. Kalia

testified that Dr. LaPolla had previously told the nursing staff to watch out for Dr. Kalia. (Tr. II at 207-208).

70. Dr. Kalia testified that he continues to be Patient 4's treating pediatrician. (Tr. I at 135).

### FINDINGS OF FACT

1. In the routine course his pediatric practice, Jitander N. Kalia, M.D., undertook the treatment of Patient 1. The evidence presented at hearing supports the following allegations regarding the care and treatment provided by Dr. Kalia to Patient 1:

- a. In 1997, Dr. Kalia diagnosed Patient 1 with Attention Deficit Hyperactivity Disorder. Dr. Kalia prescribed Clonidine to Patient 1 at age approximately 22 months, followed two weeks later with a prescription for Ritalin for her, and then Cylert when Patient 1 was approximately 24 months of age, even though prescribing such medications for a child in that age bracket is inappropriate.

On November 19, 1997, following the administration of the Cylert Dr. Kalia prescribed for Patient 1, she exhibited symptoms including tachycardia, jerking of her head, tongue thrusting, twitching, restlessness and screaming. Patient 1 was taken to a hospital emergency room, where her condition was diagnosed as an adverse reaction to Cylert.

- b. Dr. Kalia's medical documentation of the hospitalization of Patient 1, as described in Findings of Fact 1.a, is incomplete, lacking information including the date when medications were instituted and the dosages of those medications, a respiratory rate and weight for the patient, and documentation of a detailed neurological examination.
2. In the routine course his pediatric practice, Dr. Kalia undertook the treatment of Patient 2.
- a. The evidence presented at hearing supports the following allegations regarding the care and treatment provided by Dr. Kalia to Patient 2:
- i. On March 8, 2000, Patient 2, age eight months, was admitted to the hospital and was observed to have symptoms including bilious vomiting, lethargy, dehydration. She also had an ear infection. At approximately 10:00 p.m., Dr. Kalia was consulted after the nursing staff noted a small to moderate amount of blood in Patient 2's stool. When he examined Patient 2, Dr. Kalia noted that Patient 2 was obtunded with extreme dehydration. Dr. Kalia rendered provisional diagnoses that Patient 2 was suffering from lower respiratory infection, intractable vomiting, and severe dehydration, with a note to rule out meningitis. However, Dr. Kalia failed to perform or document an adequate physical examination, including a rectal examination, of Patient 2,

despite the fact that blood was noted in Patient 2's stool. Dr. Kalia ordered a croup tent, Xopenex aerosols, and Rocephin for Patient 2.

On March 9, 2000, although Patient 2 continued to have blood in his stool, bilious emesis and lethargy, Dr. Kalia did not take measures to complete a differential diagnosis for Patient 2, including ruling out bowel obstruction.

On March 11, 2000, Patient 2 was transferred to another hospital at the request of his family, where he was diagnosed with intussusception complicated by perforation of the transverse colon, requiring an ileocollectomy with ileostomy and transverse colostomy. Patient 2 also developed bacterial peritonitis as a result of the perforation of his bowel.

- ii. Dr. Kalia's medical records documenting the hospitalization of Patient 2, as described in Findings of Fact 2.a.i, failed to report several important features, including the age of the patient, a past medical history, vital signs, and documentation of an adequate physical examination.
- b. The evidence presented at hearing did not support the following allegations regarding the care and treatment provided by Dr. Kalia to Patient 2: "Dr. Kalia did not examine Patient 2 until approximately 2:00 a.m. on or about March 9, 2000, even though such a time delay is unacceptable for a patient that exhibits illness to this degree."

The evidence demonstrated that the nurses contacted Dr. Kalia on March 8, 2000, at 10:45 p.m. and notified him that he had been requested to see Patient 2. Dr. Kalia wrote orders for Patient 2 on March 9, 2000, at 1:10 a.m. Dr. Kalia testified that he had examined Patient 2 and reviewed the hospital course prior to writing the orders. Therefore, although the hospital record does not indicate the exact time Dr. Kalia first saw Patient 2, it is likely that he had seen her within the two-hour time limit suggested by Dr. Mills.

3. In the routine course of Dr. Kalia's pediatric practice, Dr. Kalia undertook the treatment of Patient 3. The evidence presented at hearing supports the following allegations regarding the care and treatment provided by Dr. Kalia to Patient 3:
- a. On March 26, 1999, Dr. Kalia admitted Patient 3, age fourteen months, to the hospital with a diagnosis of acute croup, a viral disease. Despite the diagnosis of croup, Dr. Kalia treated Patient 3 with the antibiotic Rocephin, Ventolin aerosols, subcutaneous epinephrine, and intravenous aminophylline. These medications are not effective for the treatment of croup. Although Dr. Kalia ordered racemic epinephrine aerosols on the day of admission, he cancelled the order shortly thereafter and restarted the Ventolin aerosols. When the house physician examined Patient 3 the morning following her admission, she was found to have moderate to severe

- respiratory distress; the house physician appropriately altered the patient's treatment to include vaponephrine aerosols and steroids.
- b. Dr. Kalia's medical records documenting the hospitalization of Patient 3, as described in Findings of Fact 3.a, failed to report several important features, including the age of the patient, past medical history, and basic vital signs including weight, heart rate, and respiratory rate, and the degree or description of respiratory distress.
4. In the routine course of Dr. Kalia's pediatric practice, Dr. Kalia undertook the treatment of Patient 4. The evidence presented at hearing supports the following allegations regarding the care and treatment provided by Dr. Kalia to Patient 4:
    - a. On March 31, 1999, Dr. Kalia admitted Patient 4, age nine months, to the hospital for symptoms including vomiting, lethargy and dehydration. Patient 4's admission laboratory results suggested a bacterial infection, and included elevated peripheral white blood cell count with a marked left shift, two metamyelocytes, thirty bands, toxic granulations, Döhle bodies, fragmented red blood cells and burr cells. Nevertheless, Dr. Kalia failed to treat Patient 4 for a bacterial infection, and treated him instead for dehydration with intravenous fluids.

The following morning, Dr. Kalia noted that Patient 4 was better hydrated but still febrile, irritable and ill-appearing. At that time, Dr. Kalia performed a spinal tap, which revealed Patient 4 to have streptococcus pneumonia meningitis. Dr. Kalia placed Patient 4 on Rocephin intravenously and lowered his IV fluids to maintenance level appropriate for this diagnosis.

As Patient 4 continued to exhibit nuchal rigidity with opisthotonic posturing, tremors of the arms indicative of focal seizures, and low CSF glucose, other physicians were consulted and the child was transferred to a children's hospital for admission to a pediatric intensive care unit, although Dr. Kalia initially resisted the transfer.

- b. Dr. Kalia's medical documentation of the hospitalization of Patient 4, as described in Findings of Fact 4.a, failed to report several important features, including the age of the patient, race, and basic vital signs including weight, pulse, respiration and blood pressure.

### CONCLUSIONS OF LAW

1. The conduct of Jitander N. Kalia, M.D., as set forth in Findings of Fact 1.a, constitutes "[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect prior to March 9, 1999.

2. The conduct of Dr. Kalia, as set forth in Findings of Fact 3.a, “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.
3. The conduct of Dr. Kalia, as set forth in Findings of Fact 1.a, 1.b, 2.a, 3.a, 3.b, 4.a and 4.b, constitutes “[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.

\* \* \* \* \*

Dr. Kalia was willing to admit that he may have made a mistake in missing the significance of the toxic granulation in the diagnosis of Patient 4. Nevertheless, Dr. Kalia remained adamant that the remainder of the care he had provided to Patients 1 through 4 was appropriate. Dr. Kalia’s assertions are unconvincing; not only was the care he provided in many circumstances inappropriate, in some cases it was dangerously deficient.

For example, Dr. Kalia prescribed psychotropic medications to Patient 1 when she was less than two years old. He prescribed these medications despite the fact that they are not recommended for use in children so young. While such prescribing may be appropriate, if given by a pediatrician specifically trained in treating young children with psychotropic medications, Dr. Kalia did so without specific training.

What is even more distressing is the manner in which Dr. Kalia prescribed these medications to Patient 1. Dr. Mills testified that the recommended initial dose of Clonidine for a four- or five-year-old child is 0.025 mg at bedtime; Dr. Kalia prescribed four times that dose to a child less than two years old. When asked how he had determined the appropriate dose of Clonidine for Patient 1, Dr. Kalia testified that he had given the “lowest recommended dose.” He defined the lowest recommended dose as the smallest tablet that is available, despite the fact that Clonidine is not recommended for children that age. Nevertheless, when he prescribed Ritalin, he prescribed one-half the lowest dose available “in view of the age.” Dr. Kalia testified that his rationale for making that determination was simply that the Ritalin tablet could be broken in half and the Clonidine could not.

Dr. Kalia further testified that he had prescribed these drugs, and continued to do so, because he had been unable to find assistance for Patient 1 in the community. Dr. Kalia acknowledged, however, that Dr. Kavalosky had referred Patient 1 to a developmental center at Tod Children’s Hospital, but that Patient 1’s parents had not followed through with the referral. Dr. Kalia had continued to treat Patient 1 despite the family’s failure to go to Tod Children’s Hospital.

Therefore, Dr. Kalia's testimony that he had "felt obligated" to treat Patient 1 because he could not find help anywhere in the community is not persuasive.

Dr. Kalia's prescribing of these drugs was also appalling in light of his documentation. Dr. Kalia's office records state that he had prescribed Clonidine on August 27, 1997; Ritalin on September 8, 1997; Clonidine of September 16, 1997; Cylert on October 14, 1997; and Adderall on November 17, 1997. Nevertheless, when Patient 1 presented to the hospital with a medication related crisis, Dr. Kalia documented that he had prescribed Cylert for the first time on or about November 19, 1997. All of Dr. Kalia's notes for that hospitalization document a medication regimen at odds with his office records. It is clear that Dr. Kalia did not consult his office records when Patient 1 was hospitalized and that he did not reconcile the hospitalization once Patient 1 returned to the office. In fact, Dr. Kalia acknowledged that, after discharge from the hospital, "that was that. [He] did not think anything at all after that."

In the case of Patient 2, Dr. Kalia acknowledged that he had missed the diagnosis of intussusception. Even so, Dr. Kalia steadfastly testified that the decisions he made in caring for Patient 2 were appropriate. For example, Patient 2 presented with bilious vomiting, lethargy, and bloody stools. According to Dr. Mills, these are classic signs of intussusception and bowel obstruction and any pediatrician should take immediate steps to rule out those diagnoses. Nevertheless, Dr. Kalia did not even consider the possibility. Moreover, although the nurses reported bloody stools, Dr. Kalia failed to perform a rectal examination to determine the source of the blood. Dr. Kalia testified that he had not performed a rectal examination because he had concluded that the blood was caused by dermatitis, but Dr. Kalia made that determination without ever examining the bloody stool. Moreover, there is no documentation of perianal dermatitis or dermatitis of the buttocks other than Dr. Kalia's statement that the bleeding had been noted to be caused by dermatitis. Dr. Kalia's testimony was not credible.

As to Patient 3, Dr. Kalia provided rather disjointed testimony regarding the differentiation between asthma and croup. Dr. Mills testimony that Dr. Kalia was treating Patient 3 for asthma when he should have been treating her for croup was convincing. Moreover, Dr. Kalia allowed Patient 3's condition to deteriorate to an alarming state without taking measures to relieve her distress. Patient 3 struggled from 2:30 to 6:30 a.m., with an elevated respiratory rate, stridor, nasal flaring, and intercostal and substernal retractions. A nurse noted that her stridor could be "heard from the hallway outside her room [with] O<sub>2</sub> tent running." Dr. Kalia did nothing to relieve her distress until the nurses demanded that the house officer intervene. The house officer instituted the appropriate treatment and Patient 3's respiratory distress subsided. Even then, Dr. Kalia argued that his treatment had been appropriate and the house physician's inappropriate.

Finally, in the case of Patient 4, Dr. Kalia's failure to recognize the clear signs of a severe bacterial infection was alarming. Moreover, Dr. Kalia's insistence that Patient 4 did not have a seizure and that a child of Patient 4's age can not have nuchal rigidity or opisthotonic posturing, despite the observation and documentation by other physicians and trained medical personnel and despite the other indications of a severe case of meningitis, suggests a serious deficit of medical knowledge on Dr. Kalia's part.

In summary, Dr. Kalia's care and treatment of Patients 1 through 4 repeatedly fell below the minimal standards of care. Dr. Kalia failed to recognize classic signs of serious illness and failed to provide appropriate treatment even when he did correctly diagnose the problem. Moreover, he was extremely careless in documenting the condition of his patients. Finally, rather than attempting to learn from his mistakes, Dr. Kalia dismissed other physicians and medical professionals who attempted to assist and advise him.

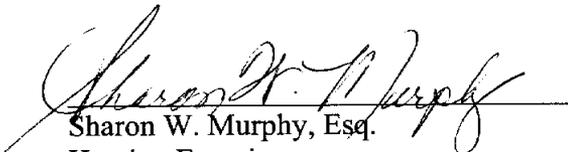
When a physician presents with such poor judgment, the Board must consider whether re-education could be effective in allowing the physician to continue to practice while protecting the public from his continued poor judgment. In this case, however, Dr. Kalia has consistently refused to accept the intervention of others. He has insisted that he is right despite the deteriorating conditions of his patients and despite the repeated efforts of others to enlighten him. For that reason, it is unlikely that Dr. Kalia would benefit from reeducation, and the Board has little choice but to terminate his continued practice in Ohio.

#### **PROPOSED ORDER**

It is hereby ORDERED that:

The certificate of Jitander N. Kalia, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

  
Sharon W. Murphy, Esq.  
Hearing Examiner



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

## EXCERPT FROM THE DRAFT MINUTES OF AUGUST 11, 2004

### REPORTS AND RECOMMENDATIONS

Ms. Sloan announced that the Board would now consider the findings and orders appearing on the Board's agenda. She asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Gregory David Duncan, M.T.; Jitander N. Kalia, M.D.; Robert Noble, M.D.; Douglas Holland Rank, M.D.; Richard Arthur Thompson, M.T.; and Joseph C. Webster, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

Ms. Sloan 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. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

Ms. Sloan 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.

Ms. Sloan 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.

.....

JITANDER N. KALIA, M.D.

.....

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF JITANDER N. KALIA, M.D. DR. KUMAR SECONDED THE MOTION.**

.....

A vote was taken on Dr. Steinbergh's motion to approve and confirm:

Vote:	Mr. Albert	- abstain
	Dr. Talmage	- abstain
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

The motion carried.



# State Medical Board of Ohio

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September 10, 2003

Jitander N. Kalia, M.D.  
4435 Creekside Boulevard  
Vienna, Ohio 44473

Dear Doctor Kalia:

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, permanently 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) In the routine course of your pediatric practice, you undertook the treatment of Patient 1 as identified in the attached Patient Key [Patient Key confidential -- to be withheld from public disclosure].
  - (a) In or about 1997, after you diagnosed Patient 1 with Attention Deficit Hyperactivity Disorder, you prescribed Clonidine to Patient 1 at age approximately 22 months, followed two weeks later with a prescription for Ritalin for her, and then prescribed Cylert to Patient 1 when she was approximately 24 months of age, even though prescribing such medications for a child in that age bracket is inappropriate. On or about November 19, 1997, following the administration of the Cylert you prescribed for Patient 1, she exhibited symptoms including tachycardia, jerking of her head, tongue thrusting, twitching, restlessness and screaming. Patient 1 was taken to a hospital emergency room, where her condition was diagnosed as an adverse reaction to Cylert.
  - (b) Your medical documentation of the hospitalization of Patient 1 described in paragraph (1)(a) is incomplete, lacking information including the date when medications were instituted and the dosages of those medications, a respiratory rate and weight for the patient, and documentation of a detailed neurological examination.
- (2) In the routine course of your practice, you undertook the treatment of Patient 2 as identified in the attached Patient Key.
  - (a) On or about March 8, 2000, at approximately 6:00 p.m., Patient 2, age eight months, was admitted to the hospital and was observed to have symptoms including bilious vomiting, lethargy, dehydration, and an ear infection. At approximately 10:00 p.m., you were consulted after the nursing staff noted a small to moderate amount of blood in Patient 2's stool. In response, you ordered a fluid bolus, but you did not actually

*Mailed 9-11-03*

examine Patient 2 until approximately 2:00 a.m. on or about March 9, 2000, even though such a time delay is unacceptable for a patient that exhibits illness to this degree. At that time, you noted that Patient 2 was obtunded with extreme dehydration, and rendered provisional diagnoses that Patient 2 was suffering from lower respiratory infection, intractable vomiting, and severe dehydration, with a note to rule out meningitis. However, you failed to perform and /or document an adequate physical examination, including a rectal examination, of Patient 2, despite the fact that blood was noted in his stool. You ordered a croup tent, Xopenex aerosols, and Rocephin for Patient 2.

On or about March 9, 2000, although Patient 2 continued with blood in his stool, bilious emesis and lethargy, you did not take measures to complete a differential diagnosis for Patient 2, including ruling out bowel obstruction. On or about March 11, 2000, Patient 2 was transferred to another hospital at the request of his family, where he was diagnosed with intussusception complicated by perforation of the transverse colon, requiring an ileocollectomy with ileostomy and transverse colostomy. Patient 2 had also developed bacterial peritonitis as a result of the perforation of his bowel.

- (b) Your medical records documenting the hospitalization of Patient 2 described in paragraph (2)(a) failed to report several important features, including the age of the patient, a past medical history, vital signs, and documentation of an adequate physical examination.
- (3) In the routine course of your pediatric practice, you undertook the treatment of Patient 3 as identified in the attached Patient Key.
- (a) On or about March 26, 1999, you admitted Patient 3, age 14 months, to the hospital, having diagnosed her with acute croup, a viral disease. Despite your diagnosis, you treated Patient 3 with medications, including the antibiotic Rocephin, ventolin aerosols, subcutaneous epinephrine and intravenous aminophylline, which are not effective for the treatment of croup. Although you ordered racemic epinephrine aerosols at one point on the day of admission, you cancelled the order shortly thereafter and restarted the ventolin aerosols. When the house physician examined Patient 3 the morning following her admission, she was found to have moderate to severe respiratory distress, and he appropriately altered the patient's treatment to include vaponephrine aerosols and steroids.
  - (b) Your medical records documenting the hospitalization of Patient 3 described in paragraph (3)(a) failed to report several important features, including the age of the patient, past medical history, and basic vital signs including weight, heart rate, and respiratory rate, and the degree or description of respiratory distress.

- (4) In the routine course of your pediatric practice, you undertook the treatment of Patient 4 as identified in the attached Patient Key.
- (a) On or about March 31, 1999, you admitted Patient 4, age nine months, to the hospital, for symptoms including vomiting, lethargy and dehydration. Although the laboratory results for Patient 4 upon admission suggested a bacterial infection, including elevated peripheral white blood cell count with a marked left shift, 2 metamyelocytes, 30 bands, toxic granulations, Döhle bodies, fragmented red blood cells and burr cells, you failed to treat Patient 4 for a bacterial infection, treating him instead for dehydration with intravenous fluids. The following morning, you noted that Patient 4 was better hydrated but still febrile, irritable and ill-appearing. At that time, you performed a spinal tap, which revealed Patient 4 to have streptococcus pneumonia meningitis, whereupon you placed Patient 4 on Rocephin intravenously and lowered his IV fluids to maintenance level appropriate for this diagnosis. As Patient 4 continued to exhibit nuchal rigidity with opisthotnic posturing, tremors of the arms indicative of focal seizures, and low CSF glucose, other physicians were consulted and the child was transferred to a children's hospital for admission to a pediatric intensive care unit, although you resisted the transfer.
- (b) Your medical documentation of the hospitalization of Patient 4 described in paragraph (4)(a) failed to report several important features, including the age of the patient, race, and basic vital signs including weight, pulse, respiration and blood pressure.

Your acts, conduct, and/or omissions as alleged in paragraph (1)(a) above, individually and/or collectively, constitute "[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect prior to March 9, 1999.

Further, your acts, conduct, and/or omissions as alleged in paragraph (3)(a) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1), (2), (3), and (4) 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.

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.

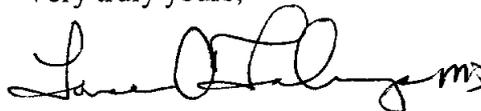
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at 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 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/blt  
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5142 0850  
RETURN RECEIPT REQUESTED

CC: Matthew J. Blair, Esq.  
Blair and Latell  
724 Youngstown Road  
Niles, Ohio 44446

CERTIFIED MAIL # 7000 0600 0024 5140 3693  
RETURN RECEIPT REQUESTED



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

December 11, 2002

Jitander N. Kalia, M.D.  
4435 Creekside Blvd.  
Vienna, OH 44473-8603

Dear Doctor Kalia:

Please find enclosed certified copies of the CORRECTED Entry of Order; the Report and Recommendation of Daniel Roberts, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 11, 2002, 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 a Notice of Appeal with the State Medical Board of Ohio and 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

Anand G. Garg, M.D.  
Secretary

AGG:jam  
Enclosures

CERTIFIED MAIL RECEIPT NO. 7000 0600 0024 5151 0223  
RETURN RECEIPT REQUESTED

Cc: Matthew J. Blair and Terrence Dull, Esqs.  
CERTIFIED MAIL RECEIPT NO. 7000 0600 0024 5151 0230  
RETURN RECEIPT REQUESTED

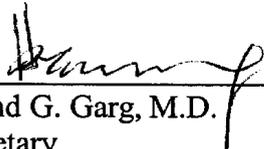
*Mailed 1/8/03*

CERTIFICATION

I hereby certify that the attached copy of the CORRECTED Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Daniel Roberts, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 11, 2002 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 Jitander N. Kalia, 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)

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

December 11, 2002  
Date

**BEFORE THE STATE MEDICAL BOARD OF OHIO**

IN THE MATTER OF

\*

\*

JITANDER N. KALIA, M.D.

\*

CORRECTED ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on December 11, 2002.

Upon the Report and Recommendation of Daniel Roberts, 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:

- A. **SUSPENSION OF CERTIFICATE, STAYED; PROBATION:** The certificate of Jitander N. Kalia, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for a period of thirty days. Such suspension is **STAYED**.
- B. **PROBATIONARY CONDITIONS:** Upon reinstatement, Dr. Kalia'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 and Terms of Criminal Probation:** Dr. Kalia shall obey all federal, state and local laws, and all rules governing the practice of medicine and surgery in Ohio, and all terms of probation imposed by the Warren Municipal Court District, Warren, Ohio, in criminal case number 01CRB1506-01.
  - 2. **Quarterly Declarations:** Dr. Kalia shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution,

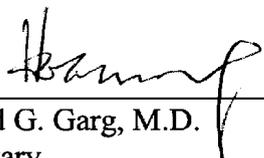
2. **Quarterly Declarations:** Dr. Kalia shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which this Order becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
3. **Appearances:** Dr. Kalia shall appear in person for quarterly interviews before the Board or its designated representative during the third month following the effective date of this Order. Subsequent personal appearances must occur every three 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. **Professional Ethics Course:** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Kalia shall provide acceptable documentation of successful completion of a course or courses dealing with 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 courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which they are completed.
5. **Absence from Ohio:** In the event that Dr. Kalia should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Kalia must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of this period under the Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.
6. **Violation of Probation; Discretionary Sanction Imposed:** If Dr. Kalia violates probation in any respect, the Board, after giving her notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of her certificate.
7. **Tolling of Probationary Period while Out of Compliance:** In the event Dr. Kalia 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.

- C. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Kalia certificate will be fully restored.
- D. **REQUIRED REPORTING BY LICENSEE TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Order, Dr. Kalia shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Kalia shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments.
- E. **REQUIRED REPORTING BY LICENSEE TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, Dr. Kalia shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Kalia shall also provide a copy of this Order by certified mail, return receipt requested, at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Kalia shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt.

**EFFECTIVE DATE OF ORDER:** This Order shall become effective immediately upon the mailing of notification of approval by the Board.

(SEAL)

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

\_\_\_\_\_  
December 11, 2002  
Date

2002 OCT 25 A 9 41

**REPORT AND RECOMMENDATION  
IN THE MATTER OF JITANDER N. KALIA, M.D.**

The Matter of Jitander N. Kalia, M.D., was heard by Daniel Roberts, Attorney Hearing Examiner for the State Medical Board of Ohio, on August 21, 2002.

**INTRODUCTION**

I. Basis for Hearing

- A. By letter dated May 8, 2002, the State Medical Board of Ohio [Board] notified Jitander N. Kalia, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in this state, based on the allegation that Dr. Kalia had been convicted of one misdemeanor count of Sexual Imposition, in violation of Section 2907.06, Ohio Revised Code.

The Board alleged that the judicial finding of guilt constitutes “[a] plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude,” as that clause is used in Section 4731.22(B)(13), Ohio Revised Code.”

Accordingly, the Board advised Dr. Kalia of his right to request a hearing in this matter. (State’s Exhibit 1A)

- B. On May 28, 2002, Matthew J. Blair, Esq., submitted a written hearing request on behalf of Dr. Kalia. (State’s Exhibit 1B)

II. Appearances

- A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Kyle C. Wilcox, Assistant Attorney General.
- B. On behalf of the Respondent: Matthew J. Blair, Esq., and Terrence Dull, Esq.

## EVIDENCE EXAMINED

### I. Testimony Heard

#### A. Presented by the State

Jitander N. Kalia, M.D., as on cross-examination.

#### B. Presented by the Respondent

1. Jitander N. Kalia, M.D.
2. Judith Kalia, M.D.

### II. Exhibits Examined

#### A. Presented by the State:

1. State's Exhibits 1A-1J: Procedural exhibits.
2. State's Exhibit 2: Certified copy of July 17, 2001, Complaint in *State v. Jitander N. Kalia*, Case Number 01CRB1506-01 in the Warren Municipal Court District, Warren, Ohio [*State v. Kalia*].
3. State's Exhibit 3: Certified copy of January 24, 2002, Court Docket and Judgment Entry in *State v. Kalia*.
4. State's Exhibit 4: Certified copy of November 6, 2001, Bill of Particulars in *State v. Kalia*.
5. State's Exhibit 6: Copies of court opinions and Sections 2907.01 and 2906.06, Ohio Revised Code.
6. State's Exhibit 7: September 20, 2002, State's Response to Respondent's Hearing Brief.

#### B. Presented by the Respondent:

1. Respondent's Exhibit B: August 21, 2002, Entry of Appearance for Terrence Dull, Esq., as co-counsel for Dr. Kalia.
2. Respondent's Exhibit C: August 21, 2002, Respondent's Hearing Brief.

3. Respondent's Exhibit D: September 30, 2002, Respondent's Reply Brief.

### **PROCEDURAL MATTERS**

The record in this matter was held open to allow counsel for the parties additional time to address issues concerning the possible admission of Respondent's Hearing Brief and a partial transcript of testimony from *State v. Kalia*. On September 12, 2002, the Attorney Hearing Examiner conducted a telephone conference with counsel for the parties. At that time Counsel for the Respondent withdrew the transcript and the State withdrew its objection to Respondent's Hearing Brief. Accordingly Respondent's Hearing Brief was admitted to the record.

Counsel for the State elected to file a Response to Respondent's Hearing Brief. After a telephone conference conducted by the Attorney Hearing Examiner with counsel for the parties, Counsel for the Respondent was permitted to file a Reply Brief over the objection of Counsel for the State. Accordingly, both documents were admitted, and the record closed on October 1, 2002.

### **SUMMARY OF THE EVIDENCE**

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

#### **Background**

1. Jitander N. Kalia, M.D., testified that he had received his medical degree in India in 1960. He further testified that, subsequent to ten years of service in the Indian Army he had taken additional medical training in England and Canada. Dr. Kalia stated that he had been licensed to practice medicine in Massachusetts in 1978 and has been practicing as a pediatrician since that time. Dr. Kalia noted that he had relocated to Ohio in 1994 to accept a position at Warren General Hospital. He opened a private practice in Warren in 1996. He shares his office with his wife, Judith, Kalia, M.D., who is a gynecologist.<sup>1</sup> (Hearing Transcript [Tr.] at 19-20, 22, 35)
2. Dr. Kalia testified that he and his wife had employed two secretaries, Veronica Carkido and Angela Dejanovic. He explained that he and his wife jointly supervise the secretaries.

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<sup>1</sup> To avoid confusion, Jitander N. Kalia, M.D., will be referred to as Dr. Kalia and Judith Kalia, M.D., will be referred to as Dr. Judith Kalia.

Dr. Kalia testified that Ms. Carkido had worked for them from September 2000 until June 2001. He noted that Ms. Carkido had primarily worked for Dr. Judith Kalia. (Tr. 22-23, 35-37, 39-40)

Dr. Kalia testified that Ms. Carkido's primary duties had been as a secretary and receptionist. He noted that Ms. Carkido would sometimes assist Dr. Judith Kalia by handing her instruments during a procedure. (Tr. 35-36)

### **The Criminal Conviction**

3. On July 17, 2001, Dr. Kalia was charged with Sexual Imposition in violation of Section 2907.06(A)(1), Ohio Revised Code. The complaint alleged that on or about June 13, 2001, Dr. Kalia:

did have sexual contact with Veronica D. Carkido, not the spouse of the said Jitander N. Kalia, or cause Veronica D. Carkido, not the spouse of the said Jitander N. Kalia, to have sexual contact with the said Veronica D. Carkido to have sexual contact with the said Jitander N. Kalia or cause XXX Veronica D. Carkido to have sexual contact and the said Jitander N. Kalia knowing that the sexual contact was offensive to Veronica D. Carkido or one of the other persons, or being reckless in that regard in violation of ORC 2907.06(a)(1) Sexual Imposition M-3.<sup>2</sup>

(State's Exhibit [St. Ex.] 2)

By Bill of Particulars filed November 6, 2001, Dr. Kalia was accused of forcibly hugging Ms. Carkido against himself, unhooking her bra, grabbing her breasts, grabbing the back of her head, and forcibly kissing her. The Bill of Particulars also contained an allegation that the offense had occurred on December 13, 2000, rather than June 13, 2001, as had been alleged in the Complaint. (Tr. 41; St Ex. 4)

During a jury trial in Warren Municipal Court, Ms. Carkido testified that on December 13, 2000, Dr. Kalia had pulled her into an examining room, forcibly kissed her, and unhooked her bra against her wishes. (Tr. 25-28; Respondent's Exhibit [Resp. Ex.] C)

4. On January 14, 2002, Dr. Kalia was convicted of Sexual Imposition in violation of Section 2907.06(A)(1), Ohio Revised Code. (Tr. 20-21, 24-25, 30; St. Ex. 3)

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<sup>2</sup> The inconsistent language and markings are reproduced here as they are in the original.

On January 24, 2002, the court imposed a fine and a jail term of sixty days. The court suspended the jail sentence and placed Dr. Kalia on non-reporting probation. The court ordered Dr. Kalia to:

- commit no new violations of law,
- pay the fine and costs on time,
- have no contact with Ms. Carkido,
- and perform 100 hours of community service within nine months.

(Tr. 33-35; St. Ex. 3)

On February 12, 2002, the court stayed execution of the sentence. (St. Ex. 3)

**Additional Testimony of Dr. Kalia**

5. Dr. Kalia testified that on June 21, 2001, he had received information which had led him to believe that the secretary who had replaced Ms. Dejanovic, Dawn Neeld, had stolen a check from Dr. Judith Kalia, altered it, and attempted to cash it. The Kalias contacted Ms. Carkido and asked her to come in to work the following day to cover for Ms. Neeld because he intended to fire Ms. Neeld. The Kalias also reported the alleged theft to the police. (Tr. 37-40)

Dr. Kalia testified that on June 22, 2001, Ms. Neeld, Ms. Neeld's boyfriend, Ms. Carkido, and Ms. Carkido's husband had appeared together at his office. The group had advised him that Ms. Carkido and Ms. Neeld were quitting their jobs with his practice and that he had been told, "you will be sorry." (Tr. 39)

Dr. Kalia testified that he had never received any complaints or notice that Ms. Carkido had accused him of sexual harassment until he had learned of Ms. Carkido's criminal complaint in July 2001. (Tr. 39-41)

6. Dr. Kalia testified that during December 2000 he would typically come into the office Monday through Friday at about 10:00 AM and remain until the last patient had been seen about 4:00 or 5:00 PM. Dr. Kalia further testified that his wife had usually worked from 9:00 AM until 2:00 or 2:30 PM three days a week and from 11:00 AM until 6:00 PM two days a week. He noted that he was in the office without his wife eight hours or less a week. (Tr. 36-37, 47-48)

7. At hearing, Dr. Kalia denied that he had committed the crime for which he was convicted. He asserted that he had never made any advances towards Ms. Carkido or any other employee. (Tr. 23-24, 28)
8. Dr. Kalia testified that, due to the publicity his criminal case had received, the parents of his patients are well aware of his legal difficulties. He asserted that he has not lost a single patient as a result of Ms. Carkido's allegations. Dr. Kalia stated that he understands how a conviction such as his could be of concern to patients or their parents especially if they were new to the practice. He explained that his patients know him well enough to have confidence in him. He further explained that his patients appear to see the alleged conduct as out of character for him. (Tr. 30-33)

**Testimony of Dr. Judith Kalia**

9. Dr. Judith Kalia testified that she has been married to Dr. Kalia for twenty-six years and that they have been in practice together for twenty-three years. Dr. Judith Kalia testified that she is aware of the criminal complaint filed against Dr. Kalia and the resulting conviction. (Tr. 46-48, 51-52)

Dr. Judith Kalia testified that she had been working in the office on December 13, 2000. She noted that Dr. Kalia and Ms. Dejanovic had also been working that day. She further testified that she does not recall having spoken to Ms. Carkido on December 13, 2000, concerning Dr. Kalia. Dr. Judith Kalia stated that she had never witnessed any of the misconduct alleged by Ms. Carkido. (Tr. 48-49, 53)

10. Dr. Judith Kalia testified that, prior to the charge being filed against Dr. Kalia, Ms. Dejanovic had left their employ and was replaced by Ms. Neeld. Dr. Judith Kalia commented that Ms. Neeld's work had been questionable and that they had placed an advertisement in the paper seeking a replacement. Dr. Judith Kalia further testified that, while in their employ, Ms. Neeld had stolen a check made out to Dr. Judith Kalia and altered it. Dr. Judith Kalia explained that Ms. Neeld had attempted to cash the altered check. The check-cashing clerk noticed the alteration and refused to cash the check. He photocopied it along with Ms. Neeld's driver's license and provided the copies to the Kalias. (Tr. 49-50)

Dr. Judith Kalia testified that she and Dr. Kalia had decided to fire Ms. Neeld for the theft. She explained that at that time Ms. Neeld and Ms. Carkido had worked alternating days. The day following the day on which they had decided to terminate Ms. Neeld was one on which Ms. Neeld had been scheduled to work. As a result she had telephoned Ms. Carkido and had asked her to come in the following day to cover for Ms. Neeld. Dr. Judith Kalia testified that when she had arrived at the office the following day she had

found a note from Ms. Carkido and Ms. Neeld stating that they had resigned. With the note, Dr. Judith Kalia found the office keys that had been issued to Ms. Neeld and Ms. Carkido. (Tr. 50-51)

Dr. Judith Kalia testified that Ms. Carkido never said anything to her in person, over the telephone, or in her resignation note alleging any misconduct on the part of Dr. Kalia. (Tr. 48-49, 51)

### **FINDINGS OF FACT**

On or about January 14, 2002, in the Warren Municipal Court District, Warren, Ohio, Jitander N. Kalia, M.D., was found guilty of one misdemeanor count of Sexual Imposition, in violation of Section 2907.06, Ohio Revised Code.

### **CONCLUSIONS OF LAW**

The judicial finding of guilt of Jitander N. Kalia, M.D., as described in the Findings of Fact, constitutes “[a] plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude,” as that clause is used in Section 4731.22(B)(13), Ohio Revised Code.

\* \* \* \* \*

In preparing this Report and Recommendation the Attorney Hearing Examiner considered the arguments of counsel contained in the exhibits and transcript in the record. The Attorney Hearing Examiner also carefully considered the facts underlying the conviction of Jitander N. Kalia, M.D., as disclosed in the record, and the case law cited by counsel for the parties.

Dr. Kalia stands convicted of Sexual Imposition, a misdemeanor of the third degree. While Dr. Kalia continues to deny having committed the offense, it is uncontested that the testimony on which the jury based its decision in the criminal case had been that Dr. Kalia had kissed Ms. Carkido and unhooked her bra against her wishes.

Dr. Kalia contends that, contrary to the finding of the trial court, the specific acts described by Ms. Carkido in her testimony, even if true, do not constitute the offense of Sexual Imposition. Pursuant to Rule 4721-13-24, Ohio Administrative Code, this issue is not one that is appropriate for the Board to resolve. If Dr. Kalia is successful in his appeal in the courts he may then return to the Board for a modification of the Board’s Order.

Dr. Kalia further argued at hearing that his conduct for which he was convicted did not constitute moral turpitude. In a recent case decided by the Ohio Supreme Court, Justice Cook, in a concurring opinion, noted that moral turpitude is not “precisely defined.” She further noted, however, that moral turpitude is generally characterized “as involving ‘baseness, vileness, or the depravity in private and social duties which [a] man owes to his fellow man, or to society in general.’” *Disciplinary Counsel v. Klaas* (2001), 91 Ohio St.3d 86, 88 (citations omitted).

Moreover, the *Klaas* Court noted that a criminal conviction, of itself, is not sufficient to find moral turpitude. Rather, the court must review the underlying facts “to determine if they manifest the requisite lack of social conscience and depravity beyond any established criminal intent.” The Court concluded that a finding of moral turpitude must be made on a case-by-case basis. *Id.* at 87 (citations omitted).

In *Klaas*, an attorney had been convicted of a crime. The Court reasoned as follows:

We have held that acts of moral turpitude ‘must be measured against the accepted standards of morality, honesty, and justice prevailing upon the community’s collective conscience.’ \* \* \* Additionally, in determining whether the acts of an attorney constitute moral turpitude, we place special emphasis on the status of an attorney in relation to the public at large. Attorneys assume a ‘position of public trust’ and are in a ‘position of responsibility to the law itself, and any disregard thereof by him is much more heinous than that by the layman.’

*Id.* at 81 (citations omitted).

In the present matter, Dr. Kalia was convicted of Sexual Imposition occurring in his office and involving an employee of his practice. Such conduct “manifests the requisite lack of social conscience” to be considered an act of moral turpitude. The conduct is even more offensive given that Dr. Kalia is a physician who holds a position of public trust.

### **PROPOSED ORDER**

It is hereby ORDERED that:

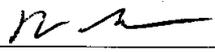
- A. **SUSPENSION OF CERTIFICATE:** The certificate of Jitander N. Kalia, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for thirty days.

B. **PROBATIONARY CONDITIONS:** Upon reinstatement, Dr. Kalia'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 and Terms of Criminal Probation:** Dr. Kalia shall obey all federal, state and local laws, and all rules governing the practice of medicine and surgery in Ohio, and all terms of probation imposed by the Warren Municipal Court District, Warren, Ohio, in criminal case number 01CRB1506-01.
2. **Quarterly Declarations:** Dr. Kalia shall submit quarterly declarations under penalty of Board disciplinary action and/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 the first day of the third month following the month in which this Order becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
3. **Appearances:** Dr. Kalia shall appear in person for quarterly interviews before the Board or its designated representative during the third month following the effective date of this Order. Subsequent personal appearances must occur every three 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. **Course on Personal Ethics:** Dr. Kalia shall provide acceptable documentation of successful completion of a course or courses dealing with personal 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 courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which they are completed.
5. **Absence from Ohio:** In the event that Dr. Kalia should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Kalia must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of this period under the Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

6. **Violation of Probation; Discretionary Sanction Imposed**: If Dr. Kalia violates probation in any respect, the Board, after giving her notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of her certificate.
  7. **Tolling of Probationary Period while Out of Compliance**: In the event Dr. Kalia 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.
- C. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Kalia certificate will be fully restored.
- D. **REQUIRED REPORTING BY LICENSEE TO EMPLOYERS AND HOSPITALS**: Within thirty days of the effective date of this Order, Dr. Kalia shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Kalia shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments.
- E. **REQUIRED REPORTING BY LICENSEE TO OTHER STATE LICENSING AUTHORITIES**: Within thirty days of the effective date of this Order, Dr. Kalia shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Kalia shall also provide a copy of this Order by certified mail, return receipt requested, at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Kalia shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt.

**EFFECTIVE DATE OF ORDER**: This Order shall become effective immediately upon the mailing of notification of approval by the Board.

  
\_\_\_\_\_  
Daniel Roberts  
Attorney Hearing Examiner



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.state.oh.us/med/](http://www.state.oh.us/med/)

## EXCERPT FROM THE DRAFT MINUTES OF DECEMBER 11, 2002

### REPORTS AND RECOMMENDATIONS

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

Dr. Somani 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: Wallace C. Adamson, M.D.; Robin Rae Adamson, P.A.; Brijesh Arya, M.D.; John A. Frenz, M.D.; Jitander N. Kalia, M.D.; Anthony W. Kitchen, M.D.; Joseph Robert Mannino, Jr., D.O.; Kenneth N. Michaelis, L.M.T.; Gary R. Rochon, M.D.; and Michael Carmen Staschak, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Somani	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Agresta	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Mr. Browning	- aye

Dr. Garg advised that he has not read the materials in the matters of Wallace C. Adamson, M.D., Robin Rae Adamson, P.A., and Jitander N. Kalia, M.D.

Dr. Somani 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. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye

Dr. Somani	- aye
Ms. Sloan	- aye
Dr. Davidson	- aye
Dr. Agresta	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye
Mr. Browning	- aye

Dr. Somani 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.

Dr. Somani 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.

.....  
JITANDER N. KALIA, M.D.

Dr. Somani directed the Board's attention to the matter of Jitander N. Kalia, M.D. He advised that no objections were filed to Hearing Examiner Roberts' Report and Recommendation. Dr. Somani advised that Dr. Bhati was Acting Secretary in this case and would recuse himself from discussion and voting.

Dr. Somani continued that a request to address the Board has been timely filed on behalf of Dr. Kalia. Five minutes would be allowed for that address.

Dr. Kalia stated that he understands that the Board is not here to retry the case in which he was convicted of sexual imposition. He suggested that it would be helpful to the Board in its deliberations to have a clear understanding of the circumstances that led to the accusation.

Dr. Kalia stated that a cascade of females overtook him on June 21, 2001. One of his secretaries, Dawn, forged her name on a check made out to his wife and tried to cash it. Once she realized that she had been caught and would be dismissed, she returned to the office after hours, stole all available cash, any samples she could use and some original medical records. Dr. Kalia stated that he assumed that the other secretary, Veronica, was also involved, as they were on extremely good terms, and both called at 2:00 p.m. to tell him of their intention to resign. The next day he reported the matter to the police and informed both secretaries that they had been terminated with cause and that he would object to any unemployment benefits being paid to them.

Dr. Kalia stated that the accusation of stealing aroused a strong response from Veronica's husband, who threatened him with violence for accusing his wife of theft. The husband was subsequently arrested for menacing behavior. Dr. Kalia stated that within a week both Dawn and Veronica accused him of sexual imposition on June 13, 2001. Subsequently, Veronica adjusted the date of the alleged incident to December 14, 2000, presumably so that she could enlist the testimony of a previous secretary, Angela, who was also her good friend. Dr. Kalia continued that Dawn changed her date to May 25, 2001, a day when they were both working so that Veronica could be her witness. There is also a civil suit pending in which they hope to reap financial benefit from this claim.

Dr. Kalia stated that, up until this time, Veronica had caused him no concern. She had been a reliable, happy and obliging secretary, often filling in at short notice for the less-dependable Angela and, later, Dawn. He stated that he had no reason to fire her, except that she had joined with her friend.

Dr. Kalia continued that on January 14, 2002, he went to court, fully believing in the system of justice in this country. He felt certain that a sensible jury of twelve men and women would question the validity of an incident that was first reported to have happened in June, at which time he was supposed to have groped these women in a restaurant. Then the testimony changed to the event happening in December and May. Dr. Kalia stated that he felt sure that the jury would question why a woman who claims to have been subjected to unwanted sexual advances in the office would continue to work happily there for an additional six months, leaving only when she and a friend were fired for theft.

Dr. Kalia stated that he left court convicted and in a state of utter disbelief. Dr. Kalia added that Dawn's accusations were overturned. On August 21, 2002, he made a presentation to the Hearing Examiner of the State Medical Board. Much of the discussion revolved around what constitutes moral turpitude, which is defined as baseness, vileness, or depravity in private or social duties which man owes to his fellow man. The conclusion of the Hearing Examiner stated that the act of which he was accused would be considered an act of moral turpitude, especially because he is a physician and his behavior should rise to a higher standard. However, there was no violation of any physician/patient relationship. He was Veronica's employer. Dr. Kalia stated that it is important for the Board to consider that Veronica continued to work happily in his office for six months after the alleged incident; at times they were the only two in the office working. Veronica evidently did not feel that he had done anything base or vile or depraved, or she would have resigned a long time ago.

Dr. Kalia stated that it was ironic that the judge who convicted him expressly stated to the jury that his being a physician gave him no edge in morality or dependability, yet the Hearing Examiner chose to hold him to an exalted standard in his recommendations of suspension of his license to practice for 30 days and probationary conditions for two years. Dr. Kalia stated that he knows that this is a very mild punishment, compared to what is available to the Board, and must, therefore, reflect the mildness of the offense.

Dr. Somani informed Dr. Kalia that he has one more minute to conclude his statement.

Dr. Kalia stated that losing his license for even thirty days will be catastrophic for his financial solvency and for his patients. This is the middle of winter, when children tend to fall sick more often. The very people who have stuck with him during this whole nightmare will be forced to search for alternate care for their sick children. These people recognize that the behavior of which he was accused was completely out of character for him. They have either decided that he was wrongly accused and convicted, or they can see that it has nothing to do with his work as a doctor. Not only have they continued to bring their children to him for care, but 700 of them also signed a petition asking the hospital to reinstate his privileges. Several of them even made personal presentations before the hospital board. At least 50 people offered to travel to Columbus with him today to speak in his behalf.

Dr. Kalia stated that, financially, he supports three children in college, one of them in medical college. He also supports a wife who is semi-retired from practice with multiple sclerosis. The loss of his license, or even a probationary status for this short time will mean loss of contracts with all insurance companies and Medicaid, upon which he is dependent. It will take many months to be reinstated, if, indeed, he is. If it is the intention of the Board to punish him for this misdemeanor, he assures that loss of hospital privileges and loss of face with all the publicity has been punishment enough. If the Board wishes to teach him a lesson, he would assure the Board that he is a quick learner and has learned it already. Nobody needs to teach him that boorish and obnoxious behavior is a no-no. As in the first 23 years in practice and the last two, there has not been and will not be any other complaint against him.

Dr. Somani again asked Dr. Kalia to conclude.

Dr. Kalia asked the Board to consider that the true effect of suspension is that it will not make anybody's existence better: not his patients, his family or his own. He asked that the Board allow him to continue to practice, uninterrupted. He, his family and his patients will be grateful to the Board.

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

Mr. Wilcox spoke in support of the Hearing Examiner's Report and Recommendation. The bottom line in this case is that Dr. Kalia was convicted of misdemeanor sexual imposition. It involved one of his office employees and occurred during the course of his practice. Sexual imposition is a crime of moral turpitude under the law of Ohio. Mr. Wilcox stated that the Board is not here to retry the facts of this case. The simple fact is that this was actually tried in municipal court, Dr. Kalia was found to be guilty of sexual imposition, a misdemeanor, and the Board isn't here to address those facts again today. Given the facts of this situation, a suspension is appropriate in this case.

**MR. BROWNING MOVED TO APPROVE AND CONFIRM MR. ROBERTS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF JITANDER N. KALIA, M.D. DR. AGRESTA SECONDED THE MOTION.**

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

Dr. Agresta stated that he is not convinced of what happened in this case. He noted that the Board has to accept that Dr. Kalia was convicted of a misdemeanor in court. Obviously there was something presented at court about which the Board does not know. Dr. Agresta continued that, from the information presented at hearing, he's still not convinced in his own mind exactly what happened, which makes it very difficult for him to come up with some kind of decision. Dr. Agresta stated that he has a sneaking suspicion that suspending Dr. Kalia's license is not going to accomplish a whole lot. Dr. Agresta suggested staying the suspension and keeping the rest of the Order intact.

Dr. Talmage agreed with Dr. Agresta. The woman's changing the date of the alleged activity by six months doesn't give him a very comfortable feeling that this whole thing was done well, although the Board has no knowledge of the court proceedings. Dr. Talmage stated that the victim in this case wasn't a patient. He added that that doesn't excuse sexual imposition against anyone, but he believes the Board's particular concern would have been if this did involve a patient. This is an issue in the Municipal Court at this point.

Dr. Talmage stated that he would be in favor of staying the suspension in this case. When the appeal is concluded, the Board may have more insight, but that will be in retrospect.

Dr. Steinbergh stated that she has the same concerns. There are discrepancies in the record as to when the incidents happened. There was a conviction. Dr. Steinbergh stated that it's a concern when the Board doesn't have everything before it. It is always difficult when it's a "he said/she said" case. The fact that the secretary continued to work in the office after the incident concerns her, but the Board isn't here to try the case. The Board doesn't have the evidence to try the case. She added that she has the same concerns as fellow Board members as to what the appropriate disciplinary action should be. Dr. Steinbergh stated that she would be in favor of staying the suspension. She would continue the probationary conditions, as listed, including a course in personal ethics.

**DR. STEINBERG MOVED TO AMEND THE PROPOSED ORDER TO STAY THE  
SUSPENSION, AND TO IMPOSE THE PROBATIONARY TERMS, AS WRITTEN.  
DR. BUCHAN SECONDED THE MOTION.**

Dr. Buchan stated that, based upon the allegations and the record as he reviewed it, he had made a note that a suspension was appropriate, but he had also made a note that a stay of that suspension was not unreasonable, with a two-year probation, as outlined.

Mr. Dilling asked for clarification. He noted that the proposed Order talks about a course on personal ethics. He asked whether that was what Dr. Steinbergh meant when she said, "including a course in personal ethics."

Dr. Steinbergh stated that, as the Board has reviewed personal ethics courses in the past, the physician is sometimes then faced with having someone develop a course, which then addresses exactly the issue of which Dr. Kalia has been accused and convicted. Professional ethics would also be acceptable to her.

Dr. Egner stated that all medical professional ethics courses would include personal ethics and sexual boundary issues.

**DR. STEINBERGH ASKED TO INCLUDE IN HER MOTION AN AMENDMENT TO PARAGRAPH B (4), BY CHANGING THE WORD, "PERSONAL," TO "PROFESSIONAL." DR. BUCHAN, AS SECOND, AGREED.**

Dr. Somani asked Dr. Steinbergh to clarify her amendment.

**DR. STEINBERGH MOVED TO AMEND THE PROPOSED ORDER TO STAY THE 30-DAY SUSPENSION, AND TO IMPOSE THE PROBATIONARY TERMS, AS WRITTEN. SHE FURTHER MOVED TO CHANGE THE LANGUAGE IN PARAGRAPH B (4) TO REQUIRE A COURSE ON PROFESSIONAL ETHICS RATHER THAN PERSONAL ETHICS. DR. BUCHAN, AS SECOND AGREED.**

Dr. Talmage stated that Dr. Kalia did make a statement that the Hearing Examiner tended to imply that he was held to a higher standard. Dr. Talmage stated that he, in fact, thinks that that is true. There are certain trusted people in society who are held to a higher standard because of the respect in which they are held. This type of behavior is more shocking when it involves physicians. The trust people hold in their physicians, and the intimacy with which physicians have to deal with their patients, does put them at a different standard. Dr. Talmage stated that he doesn't want to minimize that impression, because he thinks it is true. He would, however, go along with the amendment in this case.

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

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- abstain
	Dr. Buchan	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Agresta	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. ROBERTS' PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF**

**JITANDER N. KALIA, M.D. DR. TALMAGE SECONDED THE MOTION.** A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- abstain
	Dr. Buchan	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Agresta	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.



# State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: [www.state.oh.us/rmed/](http://www.state.oh.us/rmed/)

May 8, 2002

Jitander N. Kalia, M.D.  
4435 Creekside Boulevard  
Vienna, Ohio 44473-8603

Dear Doctor Kalia:

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, permanently 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 January 14, 2002, in the Warren Municipal Court, Warren, Ohio, you were found guilty of one misdemeanor count of Sexual Imposition, in violation of Section 2907.06, Ohio Revised Code. Copies of the Complaint, Verdict, and Court Docket and Judgment Entry are attached hereto and incorporated herein.

The judicial finding of guilt as alleged in paragraph 1 above constitutes “[a] plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a misdemeanor involving moral turpitude,” as that clause is used in Section 4731.22(B)(13), 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 (30) 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, 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 (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, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

*Mailed 5-9-02*

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, effective March 9, 1999, 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,



Anant R. Bhati, M.D.  
Acting Secretary

ARB/khm  
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5141 8000  
RETURN RECEIPT REQUESTED

Duplicate mailing to: 247 Homewood Ave. S.E.  
Warren, OH 44483

CERTIFIED MAIL # 7000 0600 0024 5141 8017  
RETURN RECEIPT REQUESTED



**VERDICT**

Rev. Code, Secs. 1901.24; 2945.33, .74 to .78; 2945.171

WARREN MUNICIPAL COURT

WARREN, Ob.

STATE OF OHIO

vs

JITANDER N. KALIA

No. 01CRB1506-01

Offense: SEXUAL IMPOSITION

We, the Jury in this case, find the Defendant

Guilty of the offense charged in the complaint.

Each of us said jurors signs his name hereto this 14 day of January 2002

**FILED**  
OFFICE OF CLERK  
JAN 14 2002  
MUNICIPAL COURT  
Warren, Ohio  
NORMA J. NAPOLI, Clerk

- 1 Rosi A. Herion
- 2 John P. Papadakis
- 3 Ruth J. Jamin
- 4 John C. Zebert
- 5 Raymond B. Shroat
- 6 Larry Lewis
- 7 Lisa C. Murray
- 8 Priscilla Bell

STATE OF OHIO  
TRUMBULL COUNTY

I hereby certify that the above entry is a true and correct copy of the same in reference to the attached case, according to the records of the Warren Municipal Court, Warren, Ohio.

NORMA J. NAPOLI, Clerk

Case No. 27400

IN THE WARREN MUNICIPAL COURT DISTRICT OF WARREN, OHIO  
TRUMBULL COUNTY  
COURT DOCKET AND JUDGMENT

Case No. 01-01504-01  
Date 2-21-02

I hereby certify that the above entry is a true & correct copy of the same in reference to the abovesentitled case, according to the records of the Warren Municipal Court.  
Warren, Ohio  
Norma J. Napolet, Clerk  
Deputy Clerk

State of Ohio vs. Jitander, N Kalia 2001 CR B 01506 -01

CHARGES: 2907.06 Sexual imposition;

ARRAIGNMENT DATE: 7/19/01 L INITIAL APPEARANCE - RULE 5A

4 Defendant advised of rights, appeared (With (Without) counsel. Upon being arraigned, defendant pleads NOT GUILTY. Case to be assigned.  
4 Defendant (will) (will not) retain counsel. ( ) Defendant to interview with Public Defender  
Defendant failed to appear. (Capias) (Bond Forfeiture) Ordered.

II. BOND \$ 500

Type of bond: Cash X Personal 10% Surety  
Additional conditions of bond: NO CONTACT WITH COMPLAINING WITNESS

DATE: \_\_\_\_\_ III. PLEA  
Defendant appears (With \_\_\_\_\_ (Without) counsel.  
Defendant entered a plea of (Guilty) (No Contest) Court explains Defendant's rights under Criminal Rule 11.  
Defendant found (Guilty) (Not Guilty)  
Sentence deferred: reason: \_\_\_\_\_

JAN 24 2002 SENTENCE AND JUDGMENT WAS PRONOUNCED AS FOLLOWS:

FINE: \$500 SUSPEND: \_\_\_\_\_ COSTS ASSESSED \_\_\_\_\_  
JAIL: 60 DAYS SUSP. 60 DAYS CREDITED \_\_\_\_\_  
PROBATION: 5 (REPORTING) (NON REPORTING)  
Conditions of probation to include: 1. No violations of law. 2. Pay fines and costs. 3. Meeting terms of Payment Scheduling. (X) NO CONTACT WITH COMPLAINING WITNESS (X) 100 hours Community Service to be set

FILED  
OFFICE OF CLERK  
JAN 24 2002  
MUNICIPAL COURT  
Warren, Ohio  
NORMA J. NAPOLET, Clerk

DATE: JAN 14 2002  
Defendant amends plea to no contest (With \_\_\_\_\_ (Without) counsel.  
X WHEREUPON - trial commenced to (Court) (Jury) (with) Reading (without) counsel. 9 months  
Sentence deferred: reason: \_\_\_\_\_  
Defendant failed to appear for trial (Capias) (Bond Forfeiture) ordered.

SENTENCE AND JUDGMENT WAS PRONOUNCED AS FOLLOWS:

FINE: \_\_\_\_\_ SUSPEND: \_\_\_\_\_ COSTS ASSESSED \_\_\_\_\_  
JAIL: \_\_\_\_\_ DAYS SUSP. \_\_\_\_\_ DAYS CREDITED \_\_\_\_\_  
PROBATION: \_\_\_\_\_ (REPORTING) (NON REPORTING)  
Conditions of probation to include: 1. No violations of law. 2. Pay fines and costs. 3. Meeting terms of Payment Scheduling.

FILED  
OFFICE OF CLERK  
JAN 24 2002  
MUNICIPAL COURT  
Warren, Ohio  
NORMA J. NAPOLET, Clerk

NOV 14 2001 At 8:30 MD re-set jury JAN. 11  
V. OTHER ENTRIES

TERMINATION: ORC 48 (A) motion filed by Prosecutor, accepted, case terminated.  
CONTINUANCE: Case called, upon (State's) (Defendant's) Motion, case is hereby continued.

AMENDED CHARGE: Motion filed by Law Director, granted by court. Complaint amended to (ORC) (ORD)

7/25/01 FURTHER ORDERS: Re-set 8/22 Hwy 43 PT. noting  
8's Jury demand

AUG 22 2001 PRE-TRIAL HELD  
SET FOR TRIAL TJB  
week of 9/10/01

Judge \_\_\_\_\_  
JUDGE GYSEGEM

1/14/02 - set for sentencing 1/24/02 1:30 - Bond w/ cond. con.  
1/8/02 stay of execution and sentence ordered. set status hearing TJB