

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

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*

JAMES A. BRADY, M.D.

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ENTRY OF ORDER

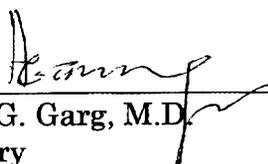
This matter came on for consideration before the State Medical Board of Ohio on June 14, 2000.

Upon the Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the 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.

1. It is hereby ORDERED that the application of James A. Brady, M.D., for a certificate to practice medicine and surgery in Ohio by endorsement of his New York certificate is hereby GRANTED, provided that he otherwise meets all statutory and regulatory requirements.
2. It is hereby further ORDERED that Dr. Brady be REPRIMANDED.

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

(SEAL)



Anand G. Garg, M.D.
Secretary

JUNE 14, 2000
Date

MAY 19 2000

**REPORT AND RECOMMENDATION
IN THE MATTER OF JAMES A. BRADY, M.D.**

The Matter of James A. Brady, M.D., was heard by R. Gregory Porter, Attorney Hearing Examiner for the State Medical Board of Ohio, on April 13, 2000.

INTRODUCTION

I. Basis for Hearing

A. By letter dated February 9, 2000, the State Medical Board of Ohio [Board] notified James A. Brady, M.D., that it had proposed to determine whether to refuse to register, reinstate, and/or take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on the following allegations:

“(1) On or about September 16, 1999, [Dr. Brady] submitted an application for a license to practice medicine and surgery in Ohio. That Application is currently pending.

“(2)(a) Effective on or about July 14, 1999, the New York State Board for Professional Medical Conduct [New York Board] adopted a Consent Agreement and Order which suspended [Dr. Brady’s] license for six (6) months, stayed the suspension, required [him] to complete of 350 hours of community service and fined [him] \$20,000.

“(b) In the Consent Agreement and Order, [Dr. Brady] admitted that, during the period October 25, 1996, through May 18, 1997, while a plastic surgery resident at Columbia Presbyterian Hospital, New York, New York, [he] provided cosmetic surgery care and treatment to ten (10) patients. The surgeries were conducted in private medical offices, and included blepharoplasty (eyelids), maxillary autologous fat injection (facial), abdominal and thigh liposuction and liposuction revision.

“[Dr. Brady] further admitted that [he was] guilty of committing professional misconduct by failing to maintain a record for each patient which accurately reflected the evaluation and treatment of the ten (10) patients.

“[Dr. Brady] further agreed not to contest the allegation that [he] committed professional misconduct by practicing the profession of

MAY 19 2000

medicine with 'negligence on more than one occasion' in [his] care and treatment of the ten (10) patients.

"[Dr. Brady] further admitted that [he] inappropriately completed a triplicate prescription signed by another physician and provided Patient B with the prescription for the controlled substance (Schedule II) Percocet; that [Dr. Brady] failed to appropriately culture Patient B's post-operative wound infection; that [Dr. Brady] performed surgery on Patient D without appropriately monitoring the patient's condition; and that [Dr. Brady] examined Patient F's surgical wounds two or three times in the hospital Emergency Room bathroom."

The Board alleged that the New York Board Consent Agreement and Order, as alleged in paragraph (2), constitutes "[a]ny of the following actions taken by the state agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatry, or the limited branches of medicine in another state, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand"; as that language is used in Section 4731.22(B)(22), Ohio Revised Code."

The Board further alleged that Dr. Brady's acts, conduct, and/or omissions, as alleged in paragraph (2), individually and/or collectively, constitute "a failure to furnish satisfactory proof of good moral character, as required by Sections 4731.29 and 4731.08, Ohio Revised Code."

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

- B. On February 18, 2000, Eric J. Plinke, Esq., submitted a written hearing request on behalf of Dr. Brady. (State's Exhibit 1B)

II. Appearances

- A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Anne B. Strait, Assistant Attorney General.
- B. On behalf of the Respondent: Kevin P. Byers, Esq.

MAY 1 9 2000

EVIDENCE EXAMINED

I. Testimony Heard

James A. Brady, M.D.

II. Exhibits Examined

A. Presented by the State

1. State's Exhibits 1A through 1I: Procedural exhibits.
2. State's Exhibit 2: Certified copies of Dr. Brady's application for an Ohio certificate, and related documents.
3. State's Exhibit 3: Certified copies of documents from the New York State Board for Professional Medical Conduct concerning Dr. Brady. [Note: The pages of this exhibit were numbered in the bottom right corner by the Hearing Examiner after the hearing.]

B. Presented by the Respondent

1. Respondent's Exhibit A: Curriculum vitae of James A. Brady, M.D.
2. Respondent's Exhibits B through H: Copies of letters of support for Dr. Brady.
3. Respondent's Exhibit I: Copy of an April 5, 2000, letter to Dr. Brady from the State of New York Department of Health.

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.

1. James A. Brady, M.D., testified that he obtained his Doctor of Medicine degree in 1992 from the Columbia University College of Physicians and Surgeons. From July 1992 until June 1995, Dr. Brady attended a residency in general surgery at Columbia-Presbyterian Medical Center [CPMC], New York, New York; and, from July 1995 until June 1997, attended a residency in plastic surgery at that same institution. Dr. Brady testified that he has held physician licensure in New York since 1995. (Respondent's Exhibit [Resp. Ex.] A; Hearing Transcript [Tr.] at 9-11)

MAY 18 2000

2. On or about June 23, 1999, the New York State Board for Professional Medical Conduct [New York Board] issued an Amended Statement of Charges, which alleged a number of violations of New York law with regard to Dr. Brady's treatment of ten patients while a plastic surgery resident at CPMC. Subsequently, on or about July 6, 1999, Dr. Brady and the New York Board entered into a proposed Consent Agreement and Order [Consent Agreement]. In that Consent Agreement, Dr. Brady admitted to some of the allegations made in the Amended Statement of Charges, and agreed not to contest certain others. (State's Exhibit [St. Ex.] 3)

In the Consent Agreement, Dr. Brady admitted the following allegations regarding all of the ten patients, Patients B through K:

"A." Dr. Brady was at all relevant times a plastic surgery resident at CPMC, New York, New York. Dr. Brady provided care to Patients B through K.

"A.2." With regard to Patients B through K, Dr. Brady "failed to keep and maintain an appropriate record for the patient, including, but not limited to, failing to keep and maintain an appropriate preoperative record, operative record, and postoperative record for the patient."

(St. Ex. 3 at 4, 11-12)

With regard to Patient B, Dr. Brady admitted the following:

- B. On or about Sunday, May 11, 1997, beginning at about 9 a.m., [Dr. Brady] performed abdominal liposuction surgery on Patient B, a 46 year old female, in the private office of associate attending plastic surgeon Ted Chaglassian, M.D. * * * At the time of the surgery, no other physicians or other health care personnel were present in the office. Previously, [Dr. Brady] had seen Patient B for a preoperative consult on or about Sunday, May 4, 1997, at the same location. Shortly after the surgery, Patient B developed a post-operative wound infection. On or about Sunday, June 1, 1997, [Dr. Brady] saw Patient B to evaluate and treat her post-operative complaints at the same location. Following this visit, [Dr. Brady] made several visits to Patient B's home to treat her postoperative wound infection. At the preoperative consultation, [Dr. Brady] solicited \$700 in cash from Patient B, which he received from her on or about the date of the surgery as a fee for his services.

* * *

MAY 19 2000

4. [Dr. Brady] failed to appropriately culture Patient B's post-operative wound infection.

* * *

6. [Dr. Brady] inappropriately completed a triplicate prescription signed by another physician and provided Patient B with this prescription for the controlled substance Percocet.

(St. Ex. 3 at 4, 12-13)

With regard to Patient C, Dr. Brady made the following admissions:

- C. On or about Sunday, March 2, 1997 beginning about 12 noon, [Dr. Brady] performed a maxillary autologous fat injection procedure for cosmetic purposes on Patient C, a 40 year old female, in [Dr. Chaglassian's office]. No other physicians or other health care personnel were present in the office during the procedure. Previously, on or about February 14, 1997, [Dr. Brady] and plastic surgery resident Jeffrey Scott Yager, M.D., had seen Patient C for a preoperative consultation at that same location. At that preoperative consultation, [Dr. Brady] quoted a fee of \$1,000 for a blepharoplasty, which Patient C subsequently decided not to have performed. On or about the date of the fat injection procedure, [Dr. Brady] received from Patient C a \$100 check made out to cash, which had been solicited at the preoperative consultation, as a fee for his services. The check was deposited into [Dr. Yager's] personal checking account.

* * *

2. [Dr. Brady] failed to maintain surgical consent records of Patient C for the statutory six-year period.

(St. Ex. 3 at 4, 14)

With regard to Patient D, Dr. Brady made the following admissions:

- D. On or about May 7, 1997, after 8 p.m., [Dr. Brady] performed abdominal liposuction surgery on Patient D, a female, in [Dr. Chaglassian's office]. At the time of the surgery no other physicians or other health care personnel were present in the office. [Dr. Brady] received from Patient D \$300 in cash on the day of the

MAY 19 2000

surgery and an additional \$300 in cash within two to four weeks of the surgery, as a fee for his services, for a total of \$600.

1. [Dr. Brady] performed surgery on Patient D without appropriate monitoring of the patient's condition.

(St. Ex. 3 at 4, 15)

With regard to Patient E, Dr. Brady made the following admissions:

- E. On a Friday in or about May, 1997, at approximately 7 p.m., [Dr. Brady] performed a fat injection procedure under both eyes of Patient E, a female, in [Dr. Chaglassian's office]. At the time of the surgery no other physicians or health care personnel were present in the office. On or about the date of the surgery, [Dr. Brady] solicited and received from Patient E \$250 in cash, as a fee for his services.

(St. Ex. 3 at 4, 15)

With regard to Patient F, Dr. Brady made the following admissions:

- F. On or about Sunday, April 27, 1997, beginning at about 8 or 9 a.m., [Dr. Brady] performed abdominal and bilateral thigh liposuction surgery on Patient F, a female, in [Dr. Chaglassian's office]. Plastic surgery resident [Dr. Yager] was in attendance at the surgery. Subsequently, [Dr. Brady] examined Patient F's surgical wounds two or three times postoperatively in the CPMC Emergency Room bathroom. On or about the date of the surgery, [Dr. Brady] solicited and received from Patient F \$300 in cash, as a fee for his services for the abdominal liposuction surgery and \$100 in cash as a fee for his services for the liposuction surgery performed on each thigh, for a total of \$500.

(St. Ex. 3 at 4, 16)

With regard to Patient G, Dr. Brady made the following admissions:

- G. On or about February 7, 1997 at approximately 7 or 8 p.m., [Dr. Brady] performed thigh liposuction revision surgery on Patient G, a 26 year old female, in [Dr. Chaglassian's office]. Plastic surgery resident [Dr. Yager] was also present at the surgery. Previously, approximately a week prior to the surgery, [Dr. Brady] had seen Patient G for a preoperative consultation at the same location. On or about the date of

MAY 19 2000

the surgery, [Dr. Brady] solicited and received from Patient G a \$200 or \$300 check made out to cash or to James Brady, M.D.

(St. Ex. 3 at 4, 16)

With regard to Patient H, Dr. Brady made the following admissions:

- H. On or about Sunday, May 18, 1997, [Dr. Brady] performed abdominal liposuction surgery on Patient H, a 43 year old female, in [Dr. Chaglassian's office], with a second physician assisting, and with a third physician also participating. Previously, in or about May 1997, [Dr. Brady] had seen Patient H for a preoperative consultation at the same location. At the preoperative consultation, [Dr. Brady] solicited, and on or about the date of the surgery received, from Patient H \$2,300 in cash as the total of fees for his services to Patient H and Patient I.

(St. Ex. 3 at 4, 17)

With regard to Patient I, Dr. Brady made the following admissions:

- I. On or about Sunday, May 18, 1997, [Dr. Brady] performed blepharoplasty surgery on Patient I, a 44 year old male, in [Dr. Chaglassian's office]. No other physicians or health care personnel were present in the office during the surgery. Previously, in or about May 1997, [Dr. Brady] had seen Patient I for a preoperative consultation at the same location. At the preoperative consultation, [Dr. Brady] solicited, and on or about the date of the surgery received, from Patient I [sic] \$2,300 in cash as the total of fees for his services to Patient H and Patient I.

(St. Ex. 3 at 4, 17-18)

With regard to Patient J, Dr. Brady made the following admissions:

- J. On or about October 25, 1996, [Dr. Brady] performed bilateral thigh liposuction surgery on Patient J, a female, in [Dr. Chaglassian's office]. Previously, approximately two weeks prior to the surgery, [Dr. Brady] had seen Patient J for a preoperative consultation at the same location. On or about the date of the surgery, [Dr. Brady] solicited and received from Patient J an amount in three figures in cash, as a fee for his services.

(St. Ex. 3 at 4, 18)

MAY 19 2000

With regard to Patient K, Dr. Brady made the following admissions:

K. On or about February 12, 1997, [Dr. Brady] performed bilateral blepharoplasty surgery on Patient K, a 35 year old female, in [Dr. Chaglassian's office]. Plastic surgery resident [Dr. Yager] performed the surgery with [Dr. Brady]. On two occasions prior to the surgery, both [Dr. Brady] and [Dr. Yager] saw Patient K for preoperative consultations at the same location. [Dr. Brady] and [Dr. Yager] solicited and received a \$400 check made out to cash from Patient K, which was a fee for their services. [Dr. Yager] deposited the check into his personal checking account.

1. [Dr. Brady] failed to maintain surgical consent records of Patient K for the statutory six-year period.

3. In the Consent Agreement, Dr. Brady admitted that he had committed professional misconduct, as defined by New York Law, in his care and treatment of Patients B through K "by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient[.]" (St. Ex. 3 at 4, 22-23)

Moreover, Dr. Brady agreed not to contest the New York Board's allegation that he had committed professional misconduct, as defined by New York Law, in his care and treatment of Patient B through K "by practicing the profession of medicine with negligence on more than one occasion[.]" (St. Ex. 3 at 4-5, 21)

4. In the Consent Agreement, Dr. Brady and the New York Board agreed that Dr. Brady's penalty would include the following:

- A six-month stayed suspension
- 350 hours of community service either in Kosovo, with Doctors Without Borders, or in a setting that benefits the underprivileged for which neither Dr. Brady nor the organization receives remuneration.
- A \$20,000.00 fine.

(St. Ex. 3 at 4-8)

The Consent Agreement was adopted by the New York Board on July 8, 1999, and became effective on July 14, 1999. (St. Ex. 3 at 2-3, 10)

5. Dr. Brady testified that he performed his first 300 hours of community service by working in Kingston, Jamaica with plastic surgeons at the University of the West Indies. Dr. Brady testified that he performed the remaining 50 hours at a men's homeless shelter in New York City. (Tr. at 44-45)

MAY 1 9 2000

6. On April 5, 2000, Dr. Brady was notified by the New York Board that he was in full compliance with his Consent Agreement, and that the matter had been closed effective April 4, 2000. (Resp. Ex. I; Tr. at 17-18)
7. Dr. Brady testified that the plastic surgery residency program at CPMC is a two-year program, and that two residents enter the program each year. Dr. Brady entered the program in July 1995 after having completed three years of residency in general surgery at that same institution. (Resp. Ex. A; Tr. at 26)
8. Dr. Brady testified that, while he was a plastic surgery resident at CPMC, he and his co-chief resident, Dr. Yager, had performed cosmetic surgery cases in the private office of Dr. Chaglassian, an attending plastic surgeon at that institution. Dr. Brady further testified that these procedures had been performed outside of the officially-sanctioned residency program. In addition, Dr. Brady testified that fees were charged to the patients who underwent these procedures. Moreover, Dr. Brady testified that “[a]ll of the fees from these cases were used for educational purposes only.” Dr. Brady testified that it had been the understanding of residents and attendings that those funds would be used to attend conferences, to purchase videotapes, and to purchase surgical instruments. Dr. Brady testified that the videotapes and surgical instruments were kept in Dr. Chaglassian’s office, and were available to the residents and the attending staff. (Tr. at 18-19, 28-29, 34)

Dr. Brady acknowledged that “there was some poor judgment along the way by myself certainly and by some of the other people that were involved in this.” Dr. Brady stated that there had been no time set aside during the plastic surgery residents’ working schedule to perform cosmetic surgery cases, and that these cases were always performed on their free time during evenings and weekends. (Tr. at 18-19)

9. Dr. Brady acknowledged that there had not been an appropriate level of supervision by an attending physician when these cosmetic procedures were performed. Dr. Brady testified that “an attending surgeon’s presence in the operating room [had been required] throughout all the important parts of a procedure.” Dr. Brady stated that Dr. Chaglassian might have “stuck around or was around” early in the residents’ experience performing these procedures, but later just told the residents to call if there was a problem. (Tr. at 18-19)

Dr. Brady further acknowledged that he had not kept accurate medical records for his cosmetic surgery patients. Dr. Brady testified, “We had signed informed consents for all the patients, but we didn’t keep charts on these patients. And that was clearly an error in judgment.” (Tr. at 19-20)

10. Dr. Brady testified that the cosmetic surgery patients that he treated had been referred to him a number of ways. Some of them were nurses and administrators at the hospital. In addition, some were referred to Dr. Brady or Dr. Yager by the plastic surgery attendings if

MAY 19 2000

the patients could not afford the attendings' fees. Dr. Brady further testified that one of the patients mentioned in the Consent Agreement had been referred to Dr. Brady for a minor liposuction revision by the former chief resident who had originally performed the liposuction. (Tr. at 35-36)

11. Dr. Brady testified that he and the other plastic surgery residents never portrayed themselves as anything other than residents to the patients. Dr. Brady stated that the patients were aware that they were being treated outside of the officially-sanctioned residency program. (Tr. at 34-35)
12. Dr. Brady testified that there had been no written fee schedule, and the fees that he had charged were for the most part "what was charged by our predecessors." (Tr. at 29)
13. Dr. Brady testified that a "plastic surgery residents fund" had been created sometime in the past by a former chairman of the CPMC Division of Plastic Surgery, Dr. Norman E. Hugo. Moreover, Dr. Brady testified that, at that time, "everything was official. The residents would charge patients for their cosmetic surgery cases, and they were—the funds were given to the department secretary, and they were kept in a plastic surgery fund which was actually administered by the Department of Surgery." Dr. Brady also testified that, when Dr. Hugo was removed as chairman in 1994, "the residents were still there that had the desire to get training and experience, and cosmetic surgery patients still came, because they knew that they would get good care at reduced fees, and it really just went underground after that." (Tr. at 42-43, 51-54)

Dr. Brady testified that he does not know the reason for Dr. Hugo's removal in 1994 as chair of the Division of Plastic Surgery, but speculated that there may have been a conflict between Dr. Hugo and a new chairman of the Department of Surgery. (Tr. at 50)

Dr. Brady testified that, when Dr. Hugo had been chair of the division of plastic surgery, the cosmetic surgery patients had been treated in Dr. Hugo's private office and reduced fees were charged. When Dr. Hugo was removed, he was replaced by Dr. Chiu. Dr. Brady testified when Dr. Chiu took over, there was no attending who was willing to allow cosmetic surgery procedures to be performed in his or her private office by residents. Dr. Brady testified that that meant that such patients had to be admitted to the hospital and treated as inpatients, and that the fees for such treatment would have been exorbitant. In addition, Dr. Brady testified that Dr. Chiu had decided that residents should not be allowed to charge patients fees for the residents' services, and that if they were going to do cosmetic surgery, it must be done in the CPMC operating room. However, Dr. Brady later testified that "[t]here is a lot of history. Dr. Chiu never prohibited plastic—cosmetic surgeries in the attending surgeon's office. It was only charging fees for those cases [that was prohibited]." Finally, Dr. Brady testified that all of this had occurred when Dr. Brady was still a general surgery resident, and that he did not learn all of the details until after he had gotten into trouble with CPMC and the New York Board. (Tr. at 51-56)

MAY 19 2001

Dr. Brady testified that when he became a chief resident in July 1996 his understanding had been “[t]hat we were allowed to do cosmetic surgery cases in [our plastic surgery attending’s office], but Dr. Chiu never had a meeting or understanding with us about plastic surgery cases and charging [fees to patients].” Regarding communication with Dr. Chiu, Dr. Brady further testified as follows:

[T]he office was not the ideal place to do the cosmetic surgery cases.

* * *

You have to do them under local anesthesia, there is no opportunity for any sedation, and that can be uncomfortable for the patients. So when Dr. Yager and myself were starting our chief year in July [1996], we had a meeting with Dr. Chiu, and he asked, well, what can I do to improve the program? And we said can there be a mechanism so that we can use either—there’s an outpatient surgery center that the attendings use—can we have an opportunity to use that at reduced fees for the patients so that they can actually afford to get cosmetic surgery cases done, or alternatively can we * * * create an arrangement with the hospital so that these cases can be done in the operating room at the hospital for reduced fees.

And Dr. Chiu said he’d look into it. Nothing happened. I mean, we even followed up with Dr. Chiu. He said nobody’s interested. The attendings—the other attendings in the division were there at that meeting because they knew it was a concern. We did not want to do cases in the evening and on the weekend. We’d like to have a day set aside to do cases in an operating room which is where, you know, they should be done.

And [the attendings] heard Dr. Chiu’s response, which was basically, you know, I can’t help you, or I’m not going to help you. And that’s when they said you can come and do the cases in our office.

(Tr. at 57-58) Dr. Brady further testified that “Dr. Chiu knew that we were doing cosmetic surgery cases, and he knew that we were doing them in Dr. Chaglassian’s office. He didn’t know that we were charging patients for those cases.” (Tr. at 58-59)

14. Dr. Brady testified that attending plastic surgeons did not perform many cosmetic procedures at CPMC. Dr. Brady stated that CPMC

was charging so much for the operating room and for recovery room fees that our attending plastic surgeons started doing their cosmetic surgery cases at another hospital. They went down to New York Eye and Ear

MAY 19 2010

Hospital which had a much better fee schedule. So not only were [the residents] not able to do [cosmetic] cases there because of the height of the fees, but our attendings weren't either. And since that was the only other place that we could get experience—we weren't allowed to go down to New York Eye and Ear. So even the few cases that we might have gotten experience with were being taken to another hospital.

(Tr. at 72-73) Dr. Brady noted that the residents did not have privileges at New York Eye and Ear Hospital. (Tr. at 73-74)

15. Dr. Brady testified that Dr. Chaglassian never asked for any remuneration from the residents for these cases. Dr. Brady further testified that he had used Dr. Chaglassian's office and supplies with no charge. Dr. Brady stated that both he and Dr. Yager had been given keys to Dr. Chaglassian's operating suite. (Tr. at 35)
16. Dr. Brady testified that he did not perform any procedures in Dr. Chaglassian's office that were not also being performed by the attendings in an office setting. Dr. Brady stated that Dr. Chaglassian's facilities were "like a mini operating room in the surgeon's office." (Tr. at 60)
17. Dr. Brady testified that one of his cosmetic surgery patients, identified as Patient B in the New York Board action, "developed a minor complication and that got blown into a very big deal." (Tr. at 20) Dr. Brady further testified that he had performed an abdominal liposuction on Patient B, and that "[s]he developed an infection at her umbilical wound site." Dr. Brady further testified:

The infection itself was minor. The patient had no fever, minimal erythema. So the treatment was to open the incision. There was some fluid which drained. I irrigated the fluid out and then I gave her antibiotics.

It probably could have been treated just with oral antibiotics, but I wanted to practice just, you know, I guess overkill to make absolutely sure that the infection resolved. So I gave her a dose of intravenous antibiotics, and this was all done in Dr. Chaglassian's office, the same office that the procedures were done in.

And then she lived on Staten Island which was about probably 40 minutes from the hospital. Obviously she was upset about the infection at the site. I felt badly. And then rather than have her come in, because I knew the next couple of days this was either going to resolve rapidly or it was not, and so I wanted to make sure that I was able to see her, so I saw her at home, traveled to Staten Island. Saw her at her home and arranged for a visiting nurse service to give her a couple of doses of antibiotic as well.

MAY 19 2000

Within the next two days it was completely resolved. There was no erythema and the visiting nurse actually documented vital signs. [The patient] never had a temperature above 99. She was never ill. She had a minor wound infection we resolved rapidly with treatment.

(Tr. at 22-23)

Dr. Brady denied that Patient B's wound infection had resulted from deficient care, and stated that it was a known complication of liposuction. Dr. Brady further testified that it had been listed as one of the known risks on the informed consent that the patient had signed. (Tr. at 23)

Dr. Brady testified that, after she developed the complication, Patient B had sought a second opinion from Dr. Lloyd Gayle at Cornell University Hospital. Dr. Brady further testified that Patient B told Dr. Gayle "that she had had surgery done by plastic surgery residents at CPMC, that she had had this complication, [and] that she had been charged for the procedure." Dr. Brady stated that Dr. Gayle informed Dr. Gayle's chairman at Cornell, who informed the chairman at CPMC, which led to an internal investigation of the plastic surgery residency program. (Tr. at 25)

Dr. Brady testified that, in addition to the internal investigation by CPMC, the State of New York also investigated the entire plastic surgery division at CPMC. Dr. Brady testified that the State's investigation eventually led to Dr. Brady's Consent Agreement. Moreover, Dr. Brady testified that "the State determined that cosmetic surgery cases being done by residents with varying amounts of supervision and residents charging patients fees for this cosmetic surgery had been going on for at least 15 years." (Tr. at 25-27)

Dr. Brady testified that he had been personally aware, since his fourth year of medical school, of plastic surgery residents performing cosmetic surgery cases outside of the sanctioned program at CPMC. Dr. Brady testified that during his fourth year of medical school he had helped the plastic surgery chief residents with the same sorts of cases that would later form the basis for the New York Board action. Moreover, Dr. Brady testified that, in his first year of plastic surgery residency, he had assisted his chief resident perform such cases on evenings and weekends. (Tr. at 26-27)

18. Dr. Brady testified that he was suspended from the plastic surgery residency program on the day that he was to graduate. Dr. Brady further stated that the issue of his graduation was heard by a committee at CPMC in the Fall of 1997, after CPMC's internal investigation had been completed. Dr. Brady stated that the hospital committee found against him after that hearing. However, Dr. Brady testified that the committee supported him in his further efforts to graduate from the program and, in May or June 1998, agreed to permit Dr. Brady to graduate after he performed three months of *pro bono* work in the

hospital's surgery clinic. Dr. Brady testified that he did so, and has since received notice from the hospital director informing him that he has graduated from the CPMC plastic surgery residency program effective December 1998. (Tr. at 29-33)

19. Dr. Brady explained that, in New York, a prescription for Percocet must be made on a triplicate form and must be stamped. He further testified that he had lost his stamper for triplicate prescriptions, and had not replaced it because he had not believed that he would need it. Moreover, Dr. Brady testified that, for hospital patients, he could just have one of his junior residents stamp such prescriptions because all the residents were following the patients. (Tr. at 46-49)

Dr. Brady testified that after he performed the liposuction on Patient B, Patient B requested pain medication. She indicated a need for something strong, and Dr. Brady had believed that Percocet was an appropriate medication for her to receive. Because Dr. Brady did not have the stamper, he went to the plastic surgery area where he asked one of the junior residents to stamp the prescription that he had filled out. Dr. Brady stated that he gave the prescription to Patient B but does not believe that Patient B ever filled it. (Tr. at 46-49)

20. On or about July 21, 1999, Dr. Brady began the application process for obtaining Ohio licensure by endorsement of his New York certificate. Among his application forms, Dr. Brady answered "Yes" to several questions on the form entitled "Additional Information—Medicine or Osteopathic Medicine." The affirmative responses concerned actions taken against hospital privileges, by medical education programs including graduate medical education, and by medical licensing authority. Dr. Brady attached a written explanation concerning his positive responses. (St. Ex. 2 at 12-18)

Dr. Brady testified that he had applied for an Ohio certificate in order to attend a six month fellowship in pediatric plastic surgery at Akron Children's Hospital with Dr. James Lehman. Dr. Brady further testified that the fellowship requires that he have an Ohio certificate. Moreover, Dr. Brady testified that he had hoped to begin the fellowship in July 2000, but that it has been pushed back to January 2001 as a result of Board's proposed denial of his application. (Tr. at 11-12)

Dr. Brady testified that, because of the uncertainty concerning his obtaining an Ohio certificate, he has sought and obtained a six month fellowship in pediatric craniofacial surgery in Paris, France, with Dr. Daniel Marchac beginning in July 2000. Dr. Brady testified that Dr. Marchac is a world-renowned craniofacial surgeon, and that his fellowships are highly sought-after. Dr. Brady testified that he succeeded in obtaining admission to this fellowship thanks to support from one of Dr. Brady's former teachers at CPMC, and because there had been a cancellation by one of Dr. Marchac's fellows. Dr. Brady testified that he hopes to enter the Akron fellowship following completion of Dr. Marchac's fellowship. (Tr. at 12-13)

Dr. Brady testified that he would like to come to Ohio to practice after he completes his training. Dr. Brady noted that his wife is a native of Canton, Ohio. (Tr. at 17)

21. Dr. Brady testified that he is not board certified. Dr. Brady testified that he has petitioned the American Board of Plastic Surgery [ABPS] to grant him eligible status, but that the ABPS decided in November 1999 not to consider Dr. Brady's application for board eligibility until the ABPS' meeting in November 2002. However, Dr. Brady testified that he has provided the ABPS with letters of support from former professors and is hopeful that the ABPS will reconsider his situation when it meets in May 2000. Dr. Brady further noted that Board eligibility is a requirement for the Akron fellowship. (Tr. at 13-17)

22. Dr. Brady testified concerning his rationale for pursuing further training:

I would hope that my [curriculum vitae] would bear out that I've always tried to be the best that I can be. And that's what I strove for as a general surgery resident and as a plastic surgery resident, and I don't feel ready yet to resume a career in plastic surgery.

I want to be the kind of physician that I had always anticipated [being], which was the most well-trained, most conscientious physician that I can be. Obviously after all this has happened, I feel very strongly that I need additional training. I want to prove myself again as a plastic surgeon, not only to myself, but to my former teachers and really to society in general because of what's happened.

You know, I want a chance to prove myself again and am willing to get all the training that I possibly can so that I can prove beyond a shadow of a doubt that I possess all the characteristics in a physician that anyone would want for their own physician or for their family.

(Tr. at 33-34)

23. Dr. Brady testified concerning what he has learned from this episode:

The reason I went into medicine was to help people. It was all about service. * * * [W]e were performing a service for patients that wanted these cases, but it clearly wasn't the right way to do things.

I mean, absolutely this was not the way that we were taught to practice medicine[.] * * * The patients that we treated in the hospital and the patients that we treated in these cosmetic surgery cases were treated differently in regards to attending supervision and in regards to creating a

MAY 19 2017

medical record. And I can't give you a good reason for why that was done. That was clearly an error in judgment.

In terms of how I benefited from these cases, I got a great deal of experience doing these cases. But by not—I mean, those rules for how to treat those patients are there for very good reasons. They are there to protect the patients. And by not following those rules, I was compromising those mechanisms to protect patients. That's not why I went into medicine. That's not why I became a doctor. That's certainly not why I became a plastic surgeon. And so this entire experience has been beneficial to me by getting me to focus again on why I'm here, why I'm asking for an Ohio medical license.

It's to get back to service and to provide the very highest standard of care that I possibly can. And to never again under any circumstances compromise a patient's care or their safety because of any inconvenience or any previous practices. The fact that other people do it that way doesn't make it right. It didn't make it right when I did it.

And I have a great deal of remorse for the poor judgment that I showed in the way that these cases were handled and would ask the Ohio Board just for the chance to work with a wonderful physician, Dr. Lehman, and to be part of a wonderful subspecialty of plastic surgery, which is pediatric plastic surgery, which, if given the chance, is what I hope to dedicate my career to. * * * This whole experience both negative and positive has been a way for me to get back to why I became a physician in the first place.

(Tr. at 36-38)

24. Dr. Brady testified that he is currently working as a house physician at Lawrence Hospital, which he described a small community hospital in Bronxville, New York. Dr. Brady stated that he works from three to nine 12-hour shifts at that institution per month. Dr. Brady further testified that he is the medical director for a medical device company called Renaltech International that is in the process of developing a device for hemodialysis. Dr. Brady testified that he works between 40 and 50 hours per week at Renaltech. (Resp. Ex. A; Tr. at 67-69)
25. Dr. Brady submitted several letters of support written on his behalf by colleagues and mentors. Dr. Brady testified that all of the authors of these letters have personal knowledge of Dr. Brady's clinical skills and level of professionalism. These letters portray Dr. Brady as a technically gifted surgeon and a caring and dedicated physician. They further portray Dr. Brady as a person of high moral character. (Resp. Exs. C through H;

Tr. at 43) [Note that the State did not have an opportunity to cross-examine the authors of these letters.]

In addition, Dr. Brady submitted an April 4, 2000, letter to the Board from James A. Lehman Jr., M.D. Dr. Lehman stated that he is the Chief of the Division of Plastic Surgery at Children's Hospital Medical Center of Akron, and is also the Program Director for the Pediatric Plastic Surgery Fellowship at that institution. Dr. Lehman stated that Dr. Brady has been offered a fellowship position in that program, scheduled to commence January 2001. Dr. Lehman further stated that he is aware of, and has carefully reviewed, the disciplinary action taken against Dr. Brady in New York. Dr. Lehman further stated that he believes that Dr. Brady "is a worthy candidate for licensure here in Ohio. He has the aptitude for this specialty and we would welcome the opportunity for him to continue his training in our program. We would readily agree to assist the board in any monitoring which the board may feel is appropriate." (Resp. Ex. B) [Note that the State did not have an opportunity to cross-examine Dr. Lehman.]

FINDINGS OF FACT

The evidence presented supports the following allegations made by the Board in its February 9, 2000, notice of opportunity for hearing in the matter of James A. Brady, M.D.:

1. On or about July 21, 1999, Dr. Brady began the process of applying for a certificate to practice medicine and surgery in Ohio. That application is currently pending.
2. Effective on or about July 14, 1999, the New York State Board for Professional Medical Conduct [New York Board] adopted a Consent Agreement and Order which suspended Dr. Brady's license for six months, stayed the suspension, required Dr. Brady to complete 350 hours of community service, and fined Dr. Brady \$20,000.00.

In the Consent Agreement and Order, Dr. Brady admitted that, while a plastic surgery resident at Columbia-Presbyterian Medical Center, New York, New York, he had provided cosmetic surgery care and treatment to ten patients. The surgeries had been conducted in private medical offices, and included blepharoplasty, maxillary autologous fat injection, abdominal and thigh liposuction, and liposuction revision.

Dr. Brady further admitted that he had been guilty of committing professional misconduct by having failed to maintain a record for each patient which accurately reflected the evaluation and treatment of each of the ten patients.

Dr. Brady further agreed not to contest the allegation that he had committed professional misconduct by practicing the profession of medicine with "negligence on more than one occasion" in his care and treatment of the ten patients.

Dr. Brady further admitted that he had inappropriately completed a triplicate prescription signed by another physician and had provided Patient B with the prescription for the Schedule II controlled substance Percocet; that Dr. Brady had failed to appropriately culture Patient B's post-operative wound infection; that Dr. Brady had performed surgery on Patient D without appropriately monitoring the patient's condition; and that Dr. Brady had examined Patient F's surgical wounds two or three times in the hospital Emergency Room bathroom.

CONCLUSIONS OF LAW

1. The Consent Agreement and Order between James A. Brady, M.D., and the New York State Board for Professional Medical Conduct, as set forth in Findings of Fact 2, constitutes "[a]ny of the following actions taken by the state agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatry, or the limited branches of medicine in another state, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand"; as that language is used in Section 4731.22(B)(22), Ohio Revised Code.
2. The evidence is insufficient to support a conclusion that the acts, conduct, and/or omissions of Dr. Brady, as set forth in Findings of Fact 2, constitute "a failure to furnish satisfactory proof of good moral character, as required by Sections 4731.29 and 4731.08, Ohio Revised Code."

* * * * *

The evidence clearly showed that, while a plastic surgery resident at Columbia-Presbyterian Medical Center, Dr. Brady performed cosmetic surgery procedures on ten patients outside of the officially sanctioned residency program. These procedures were performed in the private operating suite of an attending physician without appropriate supervision, and without patient records being kept.

The evidence also clearly showed that Dr. Brady has been punished for his conduct. Action was taken against Dr. Brady's New York certificate, his graduation from plastic surgery residency was delayed for one and one-half years, and his eligibility for certification by the American Board of Plastic Surgeons has been, at minimum, delayed. The result has been that what had been a promising career was essentially put on hold for three years.

Dr. Brady's testimony at hearing indicates that he understands the seriousness of his misconduct, and has learned from it. He is aware of the importance of good medical recordkeeping, and the danger to patients of cutting corners for the sake of convenience. This, and Dr. Brady's expressed

MAY 1 9 1997

desire to continue to receive training in his specialty, would seem to obviate the need for further retraining or monitoring of Dr. Brady's practice. Moreover, the Hearing Examiner was impressed by Dr. Brady's acceptance of his punishment; he did not express any belief that he had been treated unfairly. Further, Dr. Brady was not the first or only physician to engage in unsanctioned practice in that residency program. This does not excuse Dr. Brady's conduct, of course, but it does explain how such unorthodox practice may have seemed at the time to be acceptable.

PROPOSED ORDER

1. It is hereby ORDERED that the application of James A. Brady, M.D., for a certificate to practice medicine and surgery in Ohio by endorsement of his New York certificate is hereby GRANTED, provided that he otherwise meets all statutory and regulatory requirements.
2. It is hereby further ORDERED that Dr. Brady be REPRIMANDED.

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



R. Gregory Porter
Attorney Hearing Examiner



State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

February 9, 1999

James A. Brady, M.D.
4901 Henry Hudson Parkway, Apt. 8J
Bronx, New York 10471

Dear Doctor Brady:

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 September 16, 1999, you submitted an application for a license to practice medicine and surgery in Ohio. That Application is currently pending.
- (2)(a) Effective on or about July 14, 1999, the New York State Board for Professional Medical Conduct (hereinafter the "New York Board") adopted a Consent Agreement and Order which suspended your license for six (6) months, stayed the suspension, required you to complete of 350 hours of community service and fined you \$20,000.
- (b) In the Consent Agreement and Order, you admitted that, during the period October 25, 1996 through May 18, 1997, while a plastic surgery resident at Columbia Presbyterian Hospital, New York, New York, you provided cosmetic surgery care and treatment to ten (10) patients. The surgeries were conducted in private medical offices, and included blepharoplasty (eyelids), maxillary autologous fat injection (facial), abdominal and thigh liposuction and liposuction revision.

You further admitted that you were guilty of committing professional misconduct by failing to maintain a record for each patient which accurately reflected the evaluation and treatment of the ten (10) patients.

You further agreed not to contest the allegation that you committed professional misconduct by practicing the profession of medicine with "negligence on more than one occasion" in your care and treatment of the ten (10) patients.

Mailed 2/10/00

You further admitted that you inappropriately completed a triplicate prescription signed by another physician and provided Patient B with the prescription for the controlled substance (Schedule II) Percocet; that you failed to appropriately culture Patient B's post-operative wound infection; that you performed surgery on Patient D without appropriately monitoring the patient's condition; and that you examined Patient F's surgical wounds two or three times in the hospital Emergency Room bathroom.

A copy of the New York Board Consent Agreement and Order is attached hereto and fully incorporated herein.

The New York Board Consent Order as alleged in paragraph (2) above, constitutes "[a]ny of the following actions taken by the state agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatry, or the limited branches of medicine in another state, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand;" as that language is used in Section 4731.22(B)(22), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute a failure to furnish satisfactory proof of good moral character, as required by Sections 4731.29 and 4731.08, 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 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.

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

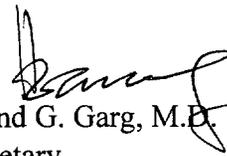
James A. Brady, M.D.

Page 3

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,



Anand G. Garg, M.D.
Secretary

AGG/jag
Enclosures

CERTIFIED MAIL # Z 233 896 558
RETURN RECEIPT REQUESTED

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

**IN THE MATTER
OF
JAMES ANDREW BRADY, M.D.**

CONSENT
ORDER

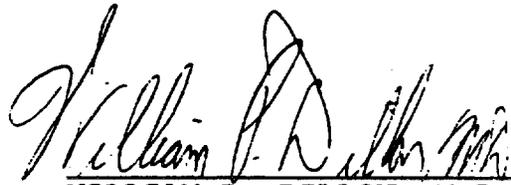
Upon the proposed agreement of JAMES ANDREW BRADY, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 7/8/99



WILLIAM P. DILLON, M.D.
Chair
State Board for Professional
Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
JAMES ANDREW BRADY, M.D.

CONSENT
AGREEMENT
AND
ORDER
BPMC #99-171

STATE OF NEW YORK)
COUNTY OF NEW YORK)

SS.:

JAMES ANDREW BRADY, M.D., (Respondent) being duly sworn,
deposes and says:

That on or about December 21, 1995, I was licensed to
practice as a physician in the State of New York, having been
issued License No. 201779 by the New York State Education
Department.

My current address is 4901 Henry Hudson Parkway, #8J,
Riverdale, NY 10471, and I will advise the Director of the Office
of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional
Medical Conduct has charged me with 31 specifications of
professional misconduct.

A copy of the Amended Statement of Charges is annexed
hereto, made a part hereof, and marked as Exhibit "A".

I admit the truth of only factual allegations A and A2, B,
B4, and B6, C and C2, D and D1, E, F, G, H, I, J, K and K1. I
admit guilt to Specifications 22 (except for Paragraph B5), 23,
24, 25, 26, 27, 28 (except for Paragraph H1), 29, 30, 31 and
agree not to contest Specification 11 only as it applies to
Paragraphs A and A2, B, B4 and B6, C and C2, D, E, F, G, H, I, J,

K and K1, in full satisfaction of the charges against me. Nothing herein shall be construed as an admission of the truth of any factual allegations or specifications contained in the Amended Statement of Charges not specifically mentioned in this Consent Agreement and Order. I hereby agree to the following penalty:

1. A six month stayed suspension;
2. 350 hours of community service, to commence on or before September 1, 1999 and to be completed within ten weeks of commencement, in Kosovo under the auspices of Doctors Without Borders if feasible, or else in another setting that benefits the poor or needy and for which neither Respondent nor any organization or person under whose auspices he performs the community service is remunerated for Respondent's services, subject to the prior written approval of the Director of the Office of Professional Medical Conduct;
3. A \$20,000 fine payable to the New York State Department of Health, half of which is to be paid within one year of the date of issuance of the below order, and the other half of which is to be paid within two years of the date of issuance of the below order.

I further agree that the Consent Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, Respondent shall maintain current registration of Respondent's license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while the licensee possesses his/her license; and

That Respondent shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. Respondent shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall meet with a person designated by the Director of OPMC as directed. Respondent shall respond promptly and provide any and all documents and information within Respondent's control upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of the Consent Order and will continue while the licensee possesses his/her license.

I hereby stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29) (McKinney Supp. 1999).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

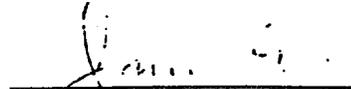
I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this Application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the Application be granted.

DATED _____



JAMES ANDREW BRADY, M.D.
Respondent

Sworn to before me
this 24 day of June, 1999



NOTARY PUBLIC

JACQUELINE A. MOONEY
Commissioner of Deeds
City of New York-No. 9-1427
Certificate Filed in New York County
Commission Expires November 13, 1999

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 6/24/99

Robert L. Conason

ROBERT L. CONASON, ESQ.
Attorney for Respondent

DATE: 6-29-99

Paul Stein

PAUL STEIN
Associate Counsel
Bureau of Professional
Medical Conduct

DATE: July 6, 1999

Anne F. Saile

ANNE F. SAILE
Director
Office of Professional
Medical Conduct.

IN THE MATTER
OF
JAMES ANDREW BRADY, M.D.

AMENDED
STATEMENT
OF
CHARGES

JAMES ANDREW BRADY, M.D., the Respondent, was authorized to practice medicine in New York State on December 21, 1995 by the issuance of license number 201779 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent, at all times described below a plastic surgery resident at Presbyterian Hospital, provided care and treatment to Patients B, C, D, E, F, G, H, I, J and K (all patients are identified in Appendix A), as specified below in paragraphs B through K. The allegations set forth in paragraphs A-1 and A-2 each apply individually to Patients B through K.

1. Respondent, with intent to deceive, concealed from his employer Presbyterian Hospital that he solicited and received a fee from the patient, knowing that he did not have the necessary permission for outside employment, and knowing that as a resident physician he was not allowed to collect fees from patients.
2. Respondent failed to keep and maintain an appropriate record for the patient, including, but not limited to, failing to keep and maintain an appropriate preoperative

record, operative record, and postoperative record for the patient.

B. On or about Sunday, May 11, 1997, beginning at about 9 a.m., Respondent performed abdominal liposuction surgery on Patient B, a 46 year old female, in the private office of associate attending plastic surgeon Ted Chaglassian, M.D., on the sixth floor of the Atchley Pavilion, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York, New York 10034. At the time of the surgery, no other physicians or other health care personnel were present in the office. Previously, Respondent had seen Patient B for a preoperative consultation on or about Sunday, May 4, 1997 at the same location. Shortly after the surgery, Patient B developed a post-operative wound infection. On or about Sunday, June 1, 1997, Respondent saw Patient B to evaluate and treat her post-operative complaints at the same location. Following this visit, Respondent made several visits to Patient B's home to treat her postoperative wound infection. At the preoperative consultation, Respondent solicited \$700 in cash from Patient B, which he received from her on or about the date of the surgery as a fee for his services.

1. Respondent performed surgery on Patient B without appropriate monitoring of the patient's condition.
2. Respondent inappropriately administered 5 mg. of the controlled substance Valium to Patient B from a supply

returned by a previous patient.

3. Respondent failed to timely and appropriately treat Patient B's post-operative wound infection.
4. Respondent failed to appropriately culture Patient B's post-operative wound infection.
5. Respondent administered the controlled substance Valium to Patient B without keeping a proper record.
6. Respondent inappropriately completed a triplicate prescription signed by another physician and provided Patient B with this prescription for the controlled substance Percocet.
7. Respondent, with intent to deceive, asked Patient B and her lawyer to provide him with a letter stating that no money was exchanged for his surgical services, when Respondent knew that this was false.
8. Respondent, with intent to deceive, initially told the Presbyterian Hospital chief of plastic surgery that Respondent received no payment from Patient B, when Respondent knew this to be false, and did not correct his statement until advised to do so by his attorneys.
9. Respondent, with intent to deceive, initially told the former Presbyterian Hospital chief of plastic surgery that Respondent received no payment from Patient B, when Respondent knew this to be false, and did not correct his statement until advised to do so by his attorneys.

C. On or about Sunday, March 2, 1997 beginning about 12 noon, Respondent performed a maxillary autologous fat injection procedure for cosmetic purposes on Patient C, a 40 year old female, in a private medical office on the sixth floor of the Atchley Pavilion, Columbia Presbyterian Medical Center (CPMC), 161 Fort Washington Avenue, New York, New York 10034. No other physicians or other health care personnel were present in the office during the procedure. Previously, on or about February 14, 1997, Respondent and plastic surgery resident Jeffrey Scott Yager, M.D. had seen Patient C for a preoperative consultation at the same location. At that preoperative consultation, Respondent quoted a fee of \$1,000 for a blepharoplasty, which Patient C subsequently decided not to have performed. On or about the date of the fat injection procedure, Respondent received from Patient C a \$100 check made out to cash, which had been solicited at the preoperative consultation, as a fee for his services. The check was deposited into plastic surgery resident Jeffrey Scott Yager, M.D.'s personal checking account.

1. Respondent performed surgery on Patient C without appropriate monitoring of the patient's condition.
2. Respondent failed to maintain surgical consent records of Patient C for the statutory six-year period.

D. On or about May 7, 1997, after 8 p.m., Respondent performed abdominal liposuction surgery on Patient D, a female, in a private medical office on the sixth floor of the Atchley Pavilion, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York, New York 10034. At the time of the surgery no other physicians or other health care personnel were present in the office. Respondent received from Patient D \$300 in cash on the day of the surgery and an additional \$300 in cash within two to four weeks of the surgery, as a fee for his services, for a total of \$600.

1. Respondent performed surgery on Patient D without appropriate monitoring of the patient's condition.

E. On a Friday in or about May, 1997 at approximately 7 p.m., Respondent performed a fat injection procedure under both eyes of Patient E, a female, in a private medical office in the Atchley Pavilion, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York, New York 10034. At the time of the surgery no other physicians or other health care personnel were present in the office. On or about the date of the surgery, Respondent solicited and received from Patient E \$250 in cash, as a fee for his services.

1. Respondent performed surgery on Patient E without appropriate monitoring of the patient's condition.

- F. On or about Sunday, April 27, 1997, beginning at about 8 or 9 a.m., Respondent performed abdominal and bilateral thigh liposuction surgery on Patient F, a female, in a private medical office in the Atchley Pavilion, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York, New York 10034. Plastic surgery resident Jeffrey Scott Yager, M.D. was in attendance at the surgery. Subsequently, Respondent examined Patient F's surgical wounds two or three times postoperatively in the CPMC Emergency Room bathroom. On or about the date of the surgery, Respondent solicited and received from Patient F \$300 in cash, as a fee for his services for the abdominal liposuction surgery and \$100 in cash as a fee for his services for the liposuction surgery performed on each thigh, for a total of \$500.
- G. On or about February 7, 1997 at approximately 7 or 8 p.m., Respondent performed thigh liposuction revision surgery on Patient G, a 26 year old female, in a private medical office on the sixth floor of the Atchley Pavilion, Columbia Presbyterian Medical Center, 140 West 168th Street, New York, New York 10034. Plastic surgery resident Jeffrey Scott Yager, M.D. was also present at the surgery. Previously, approximately a week prior to the surgery, Respondent had seen Patient G for a preoperative consultation at the same location. On or about the date of the surgery, Respondent solicited and received from Patient G a \$200 or \$300 check made out to cash or to James Brady, M.D.

H. On or about Sunday, May 18, 1997, Respondent performed abdominal liposuction surgery on Patient H, a 43 year old female, in the private office of associate attending plastic surgeon Ted Chaglassian, M.D. on the sixth floor of the Atchley Pavilion, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York, New York 10034, with a second physician assisting, and with a third physician also participating. Previously, in or about May 1997, Respondent had seen Patient H for a preoperative consultation at the same location. At the preoperative consultation, Respondent solicited, and on or about the date of the surgery received, from Patient H \$2,300 in cash as the total of fees for his services to Patient H and Patient I.

1. Respondent administered the controlled substance Valium to Patient H without keeping a proper record.

I. On or about Sunday, May 18, 1997, Respondent performed blepharoplasty surgery on Patient I, a 44 year old male, in the private office of associate attending plastic surgeon Ted Chaglassian, M.D. on the sixth floor of the Atchley Pavilion, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York, New York 10034. No other physicians or health care personnel were present in the office during the surgery. Previously, in or about May 1997, Respondent had seen Patient I for a preoperative consultation at the same

location. At the preoperative consultation, Respondent solicited, and on or about the date of the surgery received, from Patient I \$2,300 in cash as the total of fees for his services to Patient H and Patient I.

1. Respondent performed surgery on Patient I without appropriate monitoring of the patient's condition.

J. On or about October 25, 1996, Respondent performed bilateral thigh liposuction surgery on Patient J, a female, in a private medical office on the sixth floor of the Atchley Pavilion, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York, New York 10034. Previously, approximately two weeks prior to the surgery, Respondent had seen Patient J for a preoperative consultation at the same location. On or about the date of the surgery, Respondent solicited and received from Patient J an amount in three figures in cash, as a fee for his services.

K. On or about February 23, 1997, Respondent performed bilateral blepharoplasty surgery on Patient K, a 35 year old female, in the private office of associate attending plastic surgeon Ted Chaglassian, M.D. on the 6th floor of the Atchley Pavilion, Columbia Presbyterian Medical Center, 161 Fort Washington Avenue, New York New York. Plastic surgery resident Jeffrey Scott Yager, M.D. performed the surgery with Respondent. On two occasions prior to the surgery, both Respondent and

plastic surgery resident Jeffrey Scott Yager, M.D. saw Patient K for preoperative consultations at the same location.

Respondent and plastic surgery resident Jeffrey Scott Yager, M.D. solicited and received a \$400 check made out to cash from Patient K, which was a fee for their services. Plastic surgery resident Jeffrey Scott Yager, M.D. deposited the check into his personal checking account.

1. Respondent failed to maintain surgical consent records of Patient K for the statutory six-year period.

SPECIFICATIONS

FIRST THROUGH TENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) (McKinney Supp. 1998) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. Paragraphs A and A1 insofar as they apply to Patient B, and Paragraphs B and B7-9.
2. Paragraphs A and A1 insofar as they apply to Patient C, and Paragraph C.
3. Paragraphs A and A1 insofar as they apply to Patient D, and Paragraph D.
4. Paragraphs A and A1 insofar as they apply to Patient E, and Paragraph E.
5. Paragraphs A and A1 insofar as they apply to Patient F, and Paragraph F.
6. Paragraphs A and A1 insofar as they apply to Patient G, and Paragraph G.
7. Paragraphs A and A1 insofar as they apply to Patient H, and Paragraph H.
8. Paragraphs A and A1 insofar as they apply to Patient I, and Paragraph I.
9. Paragraphs A and A1 insofar as they apply to Patient J, and Paragraph J.
10. Paragraphs A and A1 insofar as they apply to Patient K, and Paragraph K.

ELEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) (McKinney Supp. 1999) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

11. Paragraphs A and A2; B and B1-6; C and C1-2; D and D1; E and E1; F; G; H and H1; I and I1; J; and K and K1.

TWELFTH THROUGH TWENTY-FIRST SPECIFICATIONS

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(20) (McKinney Supp. 1998) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following:

12. Paragraphs A and A1-2 insofar as they apply to Patient B, and Paragraphs B and B1-9.
13. Paragraphs A and A1-2 insofar as they apply to Patient C, and Paragraphs C and C1-2.
14. Paragraphs A and A1-2 insofar as they apply to Patient D, and Paragraphs D and D1.
15. Paragraphs A and A1-2 insofar as they apply to Patient E, and Paragraphs E and E1.

16. Paragraphs A and A1-2 insofar as they apply to Patient F, and Paragraph F.
17. Paragraphs A and A1-2 insofar as they apply to Patient G, and Paragraph G.
18. Paragraphs A and A1-2 insofar as they apply to Patient H, and Paragraphs H and H1.
19. Paragraphs A and A1-2 insofar as they apply to Patient I, and Paragraphs I and I1.
20. Paragraphs A and A1-2 insofar as they apply to Patient J, and Paragraph J.
21. Paragraphs A and A1-2 insofar as they apply to Patient K, and Paragraphs K and K1.

TWENTY-SECOND THROUGH THIRTY-FIRST SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) (McKinney Supp. 1999) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in the facts of the following:

22. Paragraphs A and A2 insofar as they apply to Patient B, and Paragraphs B and B5-6.
23. Paragraphs A and A2 insofar as they apply to Patient C, and Paragraphs C and C2.
24. Paragraphs A and A2 insofar as they apply to Patient D, and Paragraph D.

25. Paragraphs A and A2 insofar as they apply to Patient E, and Paragraph E.
26. Paragraphs A and A2 insofar as they apply to Patient F, and Paragraph F.
27. Paragraphs A and A2 insofar as they apply to Patient G, and Paragraph G.
28. Paragraphs A and A2 insofar as they apply to Patient H, and Paragraphs H and H1.
29. Paragraphs A and A2 insofar as they apply to Patient I, and Paragraph I.
30. Paragraphs A and A2 insofar as they apply to Patient J, and Paragraph J.
31. Paragraphs A and A2 insofar as they apply to Patient K, and Paragraphs K and K1.

DATED: New York, New York
June 27, 1999



ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical
Conduct