

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In the matter of:

RICHARD A. KADER, D.O.

CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon the Board's receipt of a report from the Medical Practitioner Review Panel (the "Panel") detailing findings and recommendations made by the Panel at the conclusion of its investigation of respondent Richard Kader, D.O. Specifically, the Panel commenced an investigation upon receipt of a report from respondent's medical malpractice insurer that a payment of \$1,000,000 was made on respondent's behalf to settle a civil malpractice action wherein it was alleged that respondent failed to timely refer R.N., a 53 year old male, to a urologist for blood found in the urine and failed to timely diagnose bladder cancer, resulting in the patient's death.

The Panel reviewed available information, to include respondent's medical records for patient R.N., information provided by respondent's civil malpractice carrier to include expert reports prepared during the pendency of the litigation, and testimony

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offered by respondent when he appeared before the Panel, represented by Timothy M. Crammer, Esq., on December 18, 2015.

The Panel found that Dr. Kader treated R.N., in his capacity as a family practice physician, from 2004 through his death in 2009. In the period between September 1, 2005 and September 14, 2007, evidence of microhematuria was found on three separate office visits in a seven month span (from September 1, 2005 through April 21, 2006). Evidence of gross hematuria was subsequently found on two office visits which occurred on February 6, 2007 and September 14, 2007. Notwithstanding those findings, respondent failed to conduct follow-up testing to further investigate the findings of hematuria, failed to consider a diagnosis of bladder cancer and failed to refer R.N. to a urologist after any of the five office visits. Respondent first referred R.N. to a urologist on October 26, 2007, after R.N. was found to have a bladder mass when he was evaluated for abdominal pain at a hospital emergency room on October 23, 2007. On referral, R.N. was diagnosed with high-grade bladder cancer.

Based on review of all available information, to include the medical records respondent maintained for R.N., the Panel concluded that respondent engaged in gross negligence when caring for R.N. for the following reasons:

1. By April 21, 2006, respondent had evidence of three positive findings of trace blood in R.N.'s urine, to include one

urine which had been sent for microscopic analysis and had been found to have a clinically significant high concentration of blood (5-10 red blood cells per high powered field). Not later than the April 21, 2006, respondent should have considered a differential diagnosis of bladder cancer, conducted further work-up to evaluate the cause of R.N.'s persistent hematuria, and referred R.N. to a urologist for evaluation, and his failure to have done so constituted gross negligence.

2. Respondent's continued failure to thereafter consider a differential diagnosis of bladder cancer, conduct follow-up testing and to refer R.N. to a urologist -- particularly after gross hematuria was found on an office visit on February 6, 2007 - also grossly deviated from the standard of care for a family physician.

3. On several office visits, respondent diagnosed Urinary Tract Infections ("UTIs") and treated those UTIs with antibiotics, notwithstanding the absence of any evidence to support a diagnosis of a UTI. Respondent thereafter failed to conduct any follow-up testing (i.e., on subsequent office visits) to determine whether the diagnosed UTIs had resolved.

Separate and apart from the findings of gross negligence, the Panel found that respondent's medical records were not sufficiently detailed, and failed to include significant

information which he claimed (when testifying before the Panel) that he discussed with R.N.

The Board herein adopts all of the findings and conclusions set forth above which were made by the Panel. The Board thus finds that cause for disciplinary sanction against respondent exists pursuant to N.J.S.A. 45:1-21(c) (engaging in gross negligence, malpractice or incompetence) and N.J.S.A. 45:1-21(h) (based on independent findings that Dr. Kader failed to prepare medical records that met requirements of the Board's record-keeping regulation, N.J.A.C. 13:35-6.5). The parties desiring to resolve this matter without the need for additional administrative proceedings, and the Board being satisfied that good cause exists for entry of this Order:

IT is on this 9th day of March, 2016

ORDERED and AGREED:

1. Respondent Richard A. Kader, D.O., is hereby formally reprimanded for having engaged in gross negligence in providing care to patient R.N., for the reasons set forth above.

2. Respondent is hereby assessed a civil penalty in the amount of \$7,500, which penalty shall be payable in full, by certified check or money order (or any alternative payment method deemed acceptable by the Board) at the time of entry of this Order.

3. Respondent shall, within eight months of the date of entry of this Order, complete: (1) a comprehensive course in the

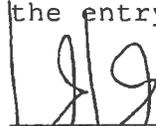
diagnosis and treatment of genitourinary problems; and (2) a course in medical record keeping. Respondent shall be required to secure written pre-approval from the Medical Director of the Board for any course(s) he may propose to take to satisfy the requirements herein, which he may seek by providing all available information concerning any proposed course(s) to the Medical Director of the Board. The Medical Director shall review said information and determine whether the proposed course is or is not acceptable to the Board. For the medical record keeping course only, respondent need not secure written approval provided that he attends a medical record keeping course that is presently approved by the Board (a list of such courses has been made available to respondent). Respondent shall be responsible to ensure that documentation of successful completion of both courses taken to satisfy the requirements of this paragraph is forwarded by the course provider(s) to the Board. In the event that respondent fails to successfully complete the course work required herein in a timely fashion (that is, in the event the Board does not receive documentation of successful completion of approved courses within eight months of the date of entry of this Order), respondent shall be deemed to have failed to comply with the requirements of this Order, and his license may then be immediately suspended by the Board for failure to comply with the terms of this Order. In the event an Order of immediate suspension for failure to comply with

the terms of this Order is entered, respondent's license shall thereafter continue to be actively suspended until such time as he successfully completes the required course work, documentation thereof is submitted to the Board, and written notice of reinstatement is provided by the Board to respondent.

NEW JERSEY STATE BOARD OF
MEDICAL EXAMINERS

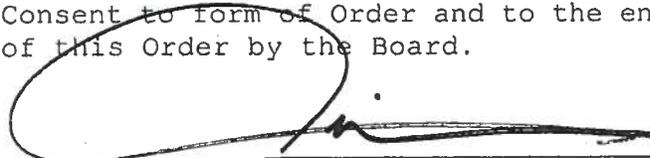
By: 
Stewart A. Berkowitz, M.D.
Board President

I represent that I have carefully read and considered this Order, understand its terms, agree to comply with said terms and consent to the entry of the Order by the Board.


Richard A. Kader, D.O.

Dated: 3/4/2016

Consent to form of Order and to the entry of this Order by the Board.


Timothy M. Crammer, Esq.
Counsel for Dr. Kramer

Dated: 3/4/16

**NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which revokes or suspends (or otherwise restricts) a license,
- (2) Which censures, reprimands or places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.