



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

Nunc Pro Tunc May 11, 2016

In the matter of:

MALINI B. RAO, M.D.
License No. 25MA08864300

ORDER GRANTING PARTIAL
SUMMARY DECISION AND
SUSPENDING LICENSURE

Overview

For the reasons set forth below, the New Jersey State Board of Medical Examiners (the "Board") herein grants, in part, the Attorney General's motion for summary decision in this matter. Based thereon, and after considering oral arguments of counsel regarding penalty, we order that Respondent Malini B. Rao's license to practice medicine and surgery in the State of New Jersey be suspended for a period of three years, two years of which are to be served as an active suspension; impose additional sanctions to include, without limitation, a civil penalty of \$30,000; and award costs in the amount of \$20,000.

Following review of the record and consideration of legal arguments advanced by the parties, we have concluded that no genuine issues of material fact exist regarding the core allegations against Dr. Rao. Succinctly stated, Dr. Rao deliberately and purposefully failed to document a significant --

potentially life-threatening -- complication which occurred when she unsuccessfully attempted to place two epidural catheters in a laboring patient identified as N.R.¹ Dr. Rao was fully aware that the catheters had sheared inside her patient, and that she had not been able to remove the catheters intact from N.R.'s back. She nonetheless made a decision not to contemporaneously document what had occurred in N.R.'s chart. Approximately five weeks later, after the retained catheters had been found and removed by a subsequent treating physician, Dr. Rao continued to spin her web of deception by entering a chart note wherein she brazenly and falsely asserted that the catheters had been removed.

Dr. Rao's election not to document the complications that occurred in N.R.'s patient chart not only constituted a marked deviation from the most fundamental of ethical norms, but also compromised her patient's health and well-being. N.R. continued to complain of back pain after delivering her infant on June 22, 2012, but was discharged from Christ Hospital two days later without any health care provider appreciating that her continued pain was being

¹ We point out from the outset that the basis for the sanctions which we have herein assessed is not that a complication occurred, and that we have not made any findings whether or not Dr. Rao engaged in negligence and/or gross negligence based on the complications alone. Rather, the predicate for our findings (as to Count 1) - to include our findings that Dr. Rao engaged in gross negligence - is Dr. Rao's failure to have forthrightly and candidly documented the complications which occurred in N.R.'s hospital chart immediately after the procedure, and her subsequent preparation of a false chart entry, more than one month after the procedure occurred, suggesting that the catheters had in fact been fully removed.

caused by the retained catheters in her back. N.R. continued to suffer for a period of approximately one month, but again no subsequent treating physician(s) had cause or reason to suspect that her pain was related to or caused by retained catheters, and, even more significantly, to recognize or appreciate that N.R. was at risk of suffering significant debilitating injuries or even of dying from potential complications related to the retained catheters, to include the risk of possible infection. The ultimate discovery of the retained catheters occurred by chance alone, during an exploratory laminectomy performed by a subsequent treating surgeon. Had the catheters not then been found and removed, it appears likely that N.R. would have suffered far more grave complications, particularly given that the removed catheters were found to be infected with methicillin-resistant staphylococcus aureus ("MRSA").

Additionally, we have concluded that there are no genuine issues of material fact concerning the allegations in Count 2 of the Administrative Complaint. It is clear and beyond dispute that Dr. Rao lied when completing her 2013-2015 biennial license renewal application, by failing to disclose that she had been arrested on April 21, 2013. While standing alone Dr. Rao's untruthful response to the application question would not support a sanction of the magnitude ordered herein, when considered in conjunction with her conduct regarding patient N.R., Dr. Rao's record of deceptive

conduct forms a more than ample predicate to support the suspension of her medical license.

We set forth below in greater detail a summary of the procedural history of this matter, the specific findings of fact which we have made to support grant of the motion for summary decision, and the basis for our penalty determinations.

Procedural History

On September 22, 2015, the Attorney General of New Jersey, by Senior Deputy Attorney General Joan D. Gelber, filed a two count administrative complaint against respondent Malini B. Rao, M.D., alleging generally that Dr. Rao had engaged in grossly negligent and deceptive conduct warranting disciplinary action by the Board. Count 1 of the Complaint is predicated upon Dr. Rao's treatment of an obstetrical patient, identified by initial only as N.R. As noted above, it is alleged that two catheters sheared when Dr. Rao attempted, on June 22, 2012, to administer epidural anesthesia. It is further alleged that, at the time of the procedure, Dr. Rao failed to timely complete a Consent to Anesthesia form, failed to inform patient N.R. of the retained foreign bodies, failed to chart any such discussion, failed to timely document the anesthesia complications which occurred, entered a critically false chart note on July 25, 2012, and entered a false "anesthesia note" on July 26, 2012 purporting to document a personal assessment of N.R.

Within Count 2, the Attorney General alleged that Dr. Rao was arrested on April 21, 2013 by New Jersey Transit Police for Theft of Services and Hindering Apprehension. Less than three months later, she falsely answered "no" to questions on the biennial renewal licensure form asking whether, since her last renewal (July 2011), she had been arrested, charged or convicted of any crime or offense. While Dr. Rao was found guilty of downgraded offenses a year later, the charges in Count 2 are not based on Dr. Rao's arrest or conviction, but upon her failure to have disclosed those events to the Board and her submission of a false response to questions posed on the biennial renewal application.

On November 4, 2015, respondent, through her counsel Michael Keating, Esq., filed an Answer to the Complaint, admitting certain allegations of the complaint and denying others, and denying all alleged violations of law.

On April 4, 2016, the Attorney General filed a motion seeking entry of summary decision on all charges within the administrative complaint. The motion was supported by a brief and by documents offered in an appendix, to include a transcript of Dr. Rao's sworn testimony offered before a Preliminary Evaluation Committee on May 27, 2015.² Dr. Rao filed a brief in opposition to

² The following documents were included within the Attorney General's Appendix:

Exhibit 1: January 2, 2014 letter from Abbott S. Brown, Esq. to Board of Medical Examiners regarding patient N.R.

Exhibit 2: October 2, 2014 letter from Dr. Rao to the Board.

Exhibit 3: Medical Board subpoena to Dr. Rao requiring appearance before a Board Committee and production of records.

Exhibit 4: Christ Hospital chart excerpts from patient N.R.'s admission, June 21, 2012

Exhibit 5: Christ Hospital chart excerpts from patient N.R.'s admission, July 23, 2012.

Exhibit 6A: January 7, 2016 Certification of Marvin Friedlander, M.D. re: surgery on patient N.R.

Exhibit 6B: Dr. Marvin Friedlander's transcription of handwritten notations on photographs taken during the surgery of patient N.R.

Exhibit 6C: Dr. Friedlander's Operative Report of July 24, 2012 surgery at Christ Hospital on patient N.R.

Exhibit 6D: Photocopies of the nine images taken during the July 24, 2012 surgery, with handwritten identification.

Exhibit 6E: Color photographs of the nine images taken during the July 24, 2012 surgery.

Exhibit 6F: Christ Hospital Surgical Pathology Report re: July 24, 2012 surgery on patient N.R.

Exhibit 7: Dr. Rao's "Anesthesia Note - Late Entry for June 22, 2012 1AM," from the July 23, 2012 Christ Hospital Chart, with Dr. Rao's transcription.

Exhibit 8: Dr. Rao's July 26, 2012 "Anesthesia Note" in the July 23, 2012 Christ Hospital chart, Physician's Progress Notes, with Dr. Rao's transcription.

Exhibit 9: September 11, 2014 deposition of patient N.R. by Michael J. Keating, Esq, N.R. v. Christ Hospital, M Rao, M.D., et als., Superior Court, Law Division - Hudson County, Dkt. HUD-L-4896-13, excerpts.

Exhibit 10: Dr. Rao's Certified Responses to Biennial Registration Renewal Questions for cycle July 1, 2011 - June 30, 2013.

Exhibit 11: May 27, 2015 transcript of Dr. Rao's appearance before the Board of Medical Examiners, Preliminary Evaluation Committee.

Exhibit 12: Dr. Rao's November 4, 2015 Answer to the Attorney General's Administrative Complaint.

the motion dated May 5, 2016, however she did not offer any certifications refuting any of the facts which the Attorney General asserted as the basis for the summary decision motion.

The matter was set down for oral argument of counsel before the Board on May 11, 2016. Senior Deputy Attorney General Gelber appeared for complainant, and Michael J. Keating, Esq., Dughi Hewit & Domalewski, appeared for respondent. Respondent did not appear at the hearing. During the course of argument, Mr. Keating advised the Board that Dr. Rao had relocated her medical practice from New Jersey to Dubai, Arab Emirates, for personal reasons.

Following oral argument, we concluded that cause existed to grant partial summary decision. We then affirmatively elected, *sua sponte*, to dismiss the remaining charges in the Administrative Complaint (i.e., those charges on which summary decision was denied), and proceeded to conduct a penalty phase hearing.³

³ We chose to dismiss all charges within the Administrative Complaint on which summary decision was denied, and proceed directly to a penalty phase hearing, based on our collective recognition that the charges which were sustained on the motion for summary decision were the most serious and disturbing allegations made against Dr. Rao, and based on our corollary recognition that the public interest would not be served by deferring any final determinations upon penalty until the conclusion of plenary proceedings on the remaining charges. Additionally, we do so to promote the goals set forth at N.J.A.C. 1:1-12.5(e) of avoiding unnecessary litigation or expense. Our election to *sua sponte* order the dismissal of all non-resolved charges was made without prejudice to reintroduction and refiling of any or all such charges, if the Attorney General elects to refile.

Findings of Fact

Upon conducting a comprehensive review of the documents submitted in support of the Attorney General's motion, we find the following facts to be established by the record offered in support of the motion for summary decision, and not subject to genuine dispute:

1. On June 22, 2012, respondent Malini B. Rao, M.D., was an attending anesthesiologist at Christ Hospital, and was on call for obstetrical anesthesia. At approximately 1:00 a.m., Dr. Rao was called by Dr. Kwaku Boamah, N.R.'s obstetrician, to administer epidural anesthetic analgesia for N.R. in the Labor and Delivery Suite.

2. N.R.'s hospital record for her June 21-June 24, 2012 admission includes a "Consent for Anesthesia Form." N.R.'s signature appears on the Consent Form, however the signature was neither witnessed nor dated. The Consent Form fails to specify the procedure for which consent was obtained. Dr. Rao's signature appears at the bottom of the Consent form (in the portion entitled "Physician's Certification," which requires the physician to certify that he or she explained the specified operation or procedure and the attendant risks to the patient). The signature, however, appears to be dated July 27, 2012 and includes a

handwritten statement "late entry" (the handwriting appears to be Dr. Rao's) (Exhibit 4, p. 13a).

3. Dr. Rao made two unsuccessful attempts to place an epidural catheter in N.R.'s epidural space. She first attempted to insert a catheter into the patient's lower lumbar spinal region at L1-L2. Dr. Rao was unable to pull out the catheter's metal guide wire, and the catheter sheared in the epidural space. Dr. Rao was unable to retrieve the catheter intact from N.R.'s lower lumbar spinal region. Dr. Rao attempted to place a second catheter into the patient's lower lumbar spinal region, making an initial insertion in the L2-L3 space. Once again, the catheter sheared in the epidural space and Dr. Rao was unable to retrieve the catheter intact. Dr. Rao was fully aware, at the time she performed the procedure, that one or both catheters had sheared and that portions of the catheter(s) had not been retrieved and remained inside the patient (see Exhibit 2, p. 6a; Exhibit 11, T 19:20 - 21:15, Exhibits 6A, 6B, 6C, 6D, 6E, 6F).⁴

⁴ When appearing before the PEC, Dr. Rao asserted that she believed that only one of the two epidural catheters had sheared, albeit in two places (See Exhibit 11, T 41: 3 - 15). We point out that Dr. Rao's "belief" is belied by the objective evidence found at the time Marvin Friedlander, M.D. performed surgery, specifically Dr. Friedlander's discovery and removal of two distinct catheters, both with catheter tips in place (See Exhibits 6A, 6B, 6C, 6D, 6E and 6F). We further note that Dr. Rao's testimony before the PEC was inconsistent with her initial written statement to the Board, wherein she stated in writing that she encountered the "same complication" on both attempts to introduce an epidural catheter into N.R.'s epidural space. (Exhibit 2, p. 6). Even assuming, however, that Dr. Rao in fact believed that only one of the two catheters she attempted to place in N.R.'s epidural space had sheared,

4. Following the second failed attempt to place the epidural, some conversation occurred between Dr. Rao and N.R., following which patient N.R. advised Dr. Rao that she did not want her to continue to attempt to place an epidural. Dr. Rao failed to document any details regarding that conversation in N.R.'s hospital chart (Exhibit 11, T 21:16-19; Exhibit 9, T 42:19 - 44:21).

5. N.R.'s entire patient record for her Christ Hospital admission -- from June 21, 2012 through discharge on June 24, 2012 -- does not include any entries by Dr. Rao (apart from the Consent to Anesthesia form referenced in ¶2 above). There is no anesthesia record in N.R.'s chart, no chart entry by Dr. Rao memorializing the complications which occurred when she attempted to administer the epidural, nor any chart entries memorializing the substance of any conversation(s) that she may have had with patient N.R. and/or any other care provider(s), to include N.R.'s obstetrician and/or Dr. Rao's Department chief. Additionally, the record is devoid of any entries whatsoever (i.e., by any other health care providers) memorializing the fact that one or two catheters had sheared when Dr. Rao attempted to administer the epidural, and/or that Dr. Rao had not been able to remove the full catheter tubing(s) from the patient's back (Exhibit 4).

her failure to have documented that complication in N.R.'s patient record, and her subsequent preparation of a false chart note wherein she asserted that both catheters had been removed, is fully established by the documentary evidence offered in support of the Attorney General's motion for summary decision.

6. Regardless whether Dr. Rao did or did not contemporaneously prepare a written anesthesia note (see discussion at p. 17, *infra*), Dr. Rao consciously and purposefully decided not to document the complications which occurred in N.R.'s chart. When appearing before a Preliminary Evaluation Committee ("PEC") of the Board on May 27, 2015, Dr. Rao testified that "the next morning" she informed her chief of anesthesia what had occurred, specifically discussed what to chart, and then followed his advice that she "should not reveal [her] mistake because there's a chance nothing would happen to her." Dr. Rao further stated: "in hindsight, as I mentioned, it was a failure to accept the professional responsibility and a mistake I will never do again." (Exhibit 11, T 30: 7 - 21).⁵

7. N.R. complained of back pain at the epidural site and swelling after the delivery of her baby. Those complaints are memorialized, variously, in Nurses' Notes, the pain medication list and the obstetrician's progress notes for June 23 and 24, 2012.

⁵ As noted *infra*, we cannot, on the motion for summary decision, establish the truth of Dr. Rao's claim that she advised her "chief of anesthesia" what had occurred, nor can we make any findings regarding her claim that she was told by the "chief" not to chart what occurred. Obviously, were we to accept Dr. Rao's testimony, we would have significant concerns regarding the advice provided and conduct of her (thus far unidentified) "chief of anesthesia," as his or her conduct also would have been inconsistent with basic ethical norms and would have placed N.R. at risk of harm. We are constrained to note, however, that Dr. Rao failed to produce any certifications or other evidence to support her testimonial claim.

Notwithstanding those complaints, N.R. and her baby were discharged from the hospital on June 24, 2012 (Exhibit 4).

8. After N.R. delivered her baby, Dr. Rao did not have any contact with N.R. during N.R.'s June 2012 Hospital admission (Exhibit 11, T 25: 12 -15). Dr. Rao thus did not make any effort, post-delivery and pre-discharge, to determine whether the retained catheter(s) could have been removed, nor did she make any referral to ensure that N.R. received proper follow-up care and evaluation.

9. On July 23, 2012, N.R. was re-admitted to Christ Hospital for evaluation of complaints of continued right-leg pain and weakness, and back pain after delivery of her baby. (Exhibit 5).

10. An MRI performed on July 24, 2012 was highly suggestive of an epidural lumbar abscess at L1-L3. Based thereon, respondent's surgeon, Dr. Marvin Friedlander, emergently took N.R. to the operating room for a laminectomy for evacuation and debridement of abscess. (See Exhibit 6A, 6C).

11. On July 24, 2012, Dr. Marvin Friedlander and Dr. Douglas Bradley performed an exploratory laminectomy (Exhibit 5, 6A, 6C). Dr. Rao was not the anesthesiologist during that procedure, and Dr. Rao had no direct involvement with N.R.'s care during the course of N.R.'s second hospital admission between July 23, 2012 and July 27, 2012 (Exhibit 5, Exhibit 11, T 31: 19-23, 33: 1-3).

12. In the course of performing the laminectomy, Dr. Friedlander found segments of two catheters in N.R.'s body, with their catheter tips. Within his operative report, Dr. Friedlander described one catheter as extending into the epidural space, approximately 20 cm in length, with an intact tip surrounded by purulent material. His operative report also details his finding a second epidural catheter, approximately 30 cm in length, extraspinally, with its tip, folded and compressed in the axilla of the L1 nerve root, compressing the root (Exhibit 6C). Photographs of the retained catheters were taken by the operating surgeons (Exhibit 6E). The hospital surgical pathology report detailed the finding of two catheters (Exhibit 5, 38a). Culture sticks were taken during the surgery (Exhibits 6A, 6C). The hospital pathology lab reported that the culture sticks were infected with MRSA (Exhibit 5, 40a).

13. On July 25, 2012, Dr. Rao entered the following note in N.R.'s hospital chart:

7/25/12 9:00 A.M. Anesthesia Note - Late entry for June 22, 2012 1 A.M. I was called to place an epidural catheter for Ms. N[-] R[-] on the morning of June 22, 2012 @ 1 A.M. The back was prepped with betadine drapes, sterile aseptic technique. Sterile ASA monitors were applied. The patient was in the sitting position L3-L4 space was palpated. 3 ML 1% Lidocaine infiltrated. Loss of resistance to air technique used with 18 g Tuohy needle to locate epidural place at 8 cm skin. Catheter (epidural catheter) was threaded. The stylette was attempted to be removed with the Tuohy needle in situ. Resistance was met when attempting to remove the

stylette. The Catheter and Tuohy needle were removed.
Vital signs stable throughout.

A second epidural kit was then opened. 3 ml plain 1% Lidocaine infiltrated at L4-L5 space. Loss of resistance to air technique was used with 18g Tuohy needle to locate epidural place at lower level (L4 L5 space). Epidural catheter was threaded. The stylette was attempted to be removed again with the Tuohy needle in place. Resistance was again met when attempting to remove the stylette. The Catheter and Tuohy needle were removed. Vital signs stable throughout.

At this time the patient refused additional attempts for an epidural catheter. The obstetrician Dr. Boamah was notified. Additional IV analgesic was administered. Healthy baby delivered at 4 a.m. same morning. Rao 7/25/12 9 a.m.

[emphasis added]

(Exhibit 7)

14. Dr. Rao's July 25, 2012 note fails to document that either and/or both of the two catheters she placed in N.R. had sheared, instead stating in both instances that the "catheter [was] removed." Dr. Rao's note was prepared in a manner that would cause a reader to infer that both catheters had been removed in full, without any shearing having occurred.

15. Dr. Rao testified before the PEC that the references to injection sites in the note were incorrect, and that the correct injection sites were L1-2 and L2-3, respectively (rather than L3-L4 and L4-L5) (Exhibit 11, T 19: 20-22). Dr. Rao specifically conceded that her July 25, 2012 note was inaccurate, stating:

"And I will accept [that the chart note] was inaccurate and wrong. It was my professional failure to

not document the broken catheter. I will accept it was a professional failure not to accept the full responsibility of my complication and document it. (Exhibit 11, T 28:1-6).

Dr. Rao further explained her reasons for not documenting the complication was because she "did not feel it necessary to reveal the fact," and testified that she was "hoping and praying nothing would happen to her with the retained fragment of epidural catheter." (Exhibit 11, T 29: 9 - 18).

16. On July 26, 2012, Dr. Rao added another note to patient N.R.'s chart, timed at 11:00 a.m. and captioned "anesthesia note," which note reads as follows:

Patient postop day 2 for decompressive laminectomy following drainage of an epidural abscess
1) c/o significant pain 6-8/10
2) mobility increased today - pt ambulated from room to restroom.
3) decreased strength on right lower extremity
4) sensory function intact
Culture from catheter tip positive for MRSA
A/P
1) 6-8 weeks iv antibiotics for MRSA
2) Discharge home soon
Rao

(Exhibit 8)

17. On or about April 20, 2013, Dr. Rao was arrested after boarding a transit train without paying (Exhibit 11, T: 46-1 - 49:11).

18. On July 11, 2013, Dr. Rao completed her biennial license renewal application (seeking to secure renewal of her license for the 2013-2015). When doing so, Dr. Rao falsely

answered "no" to the following question: "since your last renewal, have you been arrested, charged or convicted of any crime or offense."⁶

While we find the above facts to be established for purposes of deciding the motion for summary decision, we note that there are factual issues in dispute which cannot presently be resolved. Those issues include the following:

1. The extent and level of detail of any conversation which occurred between Dr. Rao and N.R. prior to N.R.'s signing the Consent to Anesthesia Form.

2. The extent and level of detail of any conversation that occurred between N.R. and Dr. Rao, after Dr. Rao made two unsuccessful attempts to place the epidural. Additionally, we cannot presently make any findings regarding the ability (or lack thereof) that N.R. may have had at that time to comprehend any statements Dr. Rao may have made, recognizing that N.R.'s level of

⁶ Dr. Rao offered testimony before the PEC that she was advised by her counsel (who she did not then identify) that "there [was] no need to reveal this to anybody" because the offense was "getting expunged." (Exhibit 11, T 49:12 - 50:3). We have reviewed that testimony, and do not find that it explicitly dealt with the temporal question when any such advice may have been provided, and whether it was in fact sought prior to the time that Dr. Rao responded to the Board's application question on July 11, 2013. We also note that Dr. Rao could have, when opposing this motion, provided specific corroboration through a certification or affidavit of the unidentified attorney(s) corroborating her testimony, but no such affidavit or certification was offered in opposition to the motion. Given those findings, we decline to find that Dr. Rao's failure to disclose can be explained or condoned based on any claim that she was acting pursuant to advice of counsel.

cognition could have been diminished because she had been administered anesthesia.

3. Whether Dr. Rao prepared a contemporaneous note for N.R.'s hospital chart on June 22, 2012, which note later was lost or misplaced.⁷

4. Whether Dr. Rao verbally informed any other physician(s) -- to include Dr. Boamah and/or the Chief of the Department of Anesthesia -- and/or any nurse(s) about the complications which had occurred.

5. Whether Dr. Rao performed an examination of patient N.R. during her second hospitalization, prior to entering the "anesthesia" note identified in finding of fact #16 above.

Conclusions of Law/

Determinations on Motion for Summary Decision

On a motion for summary decision, a moving party must establish that "there is no genuine issue as to any material fact

⁷ Dr. Rao testified, when appearing before the PEC, that she prepared a written anesthesia note at approximately 2:00 a.m. on June 22, 2012, and that she inserted the note in N.R.'s chart (Exhibit 11, T 19: 9 - 14). She further testified that, when N.R. came back for the laminectomy procedure, she "took it upon [herself] to follow her very closely in that hospital admission, and I went through the whole chart and realized that it had somehow been lost, misplaced." (Exhibit 11, T 19: 5 - 10).

While we cannot at this juncture, establish whether or not Dr. Rao in fact wrote a contemporaneous chart note following her failed attempt to administer epidural anesthesia, that factual issue in no way precludes us from being able to find that Dr. Rao deliberately and purposefully elected not to chart and memorialize that a catheter(s) had sheared in N.R.'s back, and that she had been unable to retrieve the catheter(s). See *supra*, finding of fact #7.

challenged" and that the movant is "entitled to prevail as a matter of law." N.J.A.C. 1:1-12.5. As further clarified in Brill v. Guardian Life Ins. Co. of America, 142 N.J. 520 (1995), when the evidence is so one-sided that one party must prevail as a matter of law, summary decision should be granted. Applying those standards, we resolve the motion for summary decision as follows:

Count 1, ¶ 22(a)⁸: Summary decision is granted in part and denied in part. Specifically, summary decision is granted on the allegations that Dr. Rao's failure to timely complete the June 22, 2012 Consent to Anesthesia form, in the absence of emergency circumstances, constituted a failure to prepare a proper patient record, in violation of N.J.A.C. 13:35-6.5, in turn constituting a violation of N.J.S.A. 45:1-21(h). Summary decision is denied on the portion of the allegation that Dr. Rao engaged in repeated acts of negligence in violation of N.J.S.A. 45:1-21(d), as that determination is in part dependent on resolution of the disputed issue regarding the extent of any conversation which may have occurred between Dr. Rao and N.R. preceding N.R.'s signing of the Consent Form.

⁸ ¶ 22(a) of Count 1 of the Administrative Complaint alleges:

Respondent's failure to timely complete the June 22, 2012 Consent to Anesthesia form, in the absence of emergency circumstances, constitutes negligence and failure to prepare a proper patient record; N.J.A.C. 13:35-6.5, in violation of N.J.S.A. 45:1-21(d) and (h)

Count 1, ¶ 22(b)⁹: Summary decision is granted in part and denied in part. Summary decision is granted on the charge that Dr. Rao's failure to document any conversation she may have had with N.R. advising her of the retained foreign bodies constituted gross negligence and professional misconduct, in violation of 45:1-21(c) and (e).¹⁰ Summary decision is denied on the remainder of the claims in ¶22(b), as all remaining claims are dependent on resolution of issues regarding the extent and detail of any conversation that may have occurred between Dr. Rao and N.R. following the failed attempts to administer epidural anesthesia.¹¹

⁹ ¶Paragraph 22(b) of Count 1 of the Administrative Complaint alleges:

Respondent's failure to inform the patient during the June 22, 2012 admission of the retained foreign bodies, and to document such failure, constitutes gross negligence and professional misconduct; N.J.S.A. 45:1-21(c) and (e).

¹⁰ The failure to document any conversation that occurred with N.R. constitutes gross negligence and professional misconduct for the same reasons that Dr. Rao's failure to document the complications which occurred establishes gross negligence. See discussion regarding our grant of summary decision on charges alleged in Count 1, ¶22(c), *infra*.

¹¹ As noted above, we cannot presently make findings regarding the extent and detail of any conversation that may have occurred between Dr. Rao and N.R. following Dr. Rao's failed attempts to administer epidural anesthesia. Given that recognition, we cannot sustain the charges in ¶22(b) to the extent that the Attorney General is alleging that Dr. Rao failed to inform N.R. of the retained foreign bodies and that her failure to do so constituted gross negligence and professional misconduct, but we are able to sustain the charges to the extent they are focused on Dr. Rao's failure to have documented that she informed N.R. of any retained foreign bodies.

Count 1, ¶ 22(c)¹²: Summary decision is granted in full on all allegations within ¶22(c). We point out that we sustain the allegation that Dr. Rao's failure to document the complications which occurred clearly constitutes gross negligence, based on our collective expertise as practicing physicians. Specifically, we find and conclude that Dr. Rao's failure to have documented that a catheter(s) had been retained in N.R.'s epidural space materially compromised the ability of all subsequent care providers to make accurate and informed decisions regarding the genesis of N.R.'s pain complaints and regarding needed care, in turn placing N.R. at grave risk of substantial injury and/or death.

Count 1, ¶23¹³: Summary decision is granted in full on all allegations within ¶23. The note Dr. Rao entered on July 25, 2012, while properly dated, included statements which were false and

¹² ¶ 22(c) of Count 1 alleges:

Respondent's failure to document the anesthesia complications timely, in this circumstance, constitutes a material omission from the chart, creating a false patient record, in violation of N.J.A.C. 13:35-6.5; said conduct constituted gross negligence, professional misconduct and a failure to comply with a rule of the Board; N.J.S.A. 45:1-21(c), (e) and (h).

¹³ ¶23 of Count 1 alleges:

Respondent's addition of her "late June 22, 2012" note, falsely claiming removal of one or both catheters, constitutes misrepresentation and deception and professional misconduct; N.J.S.A. 45:1-21(b), (e) and (h) and failure to maintain the continuing requirement of good moral character; N.J.S.A. 45:9-6.

misleading. Dr. Rao knew the note was false at the time she wrote the note.

Count 1, ¶24:¹⁴ Summary decision is denied in full on all allegations within ¶24. As noted above, the issue whether Dr. Rao in fact performed any examination of N.R. prior to entering the July 26, 2012 "anesthesia note" is in dispute. That issue of fact is relevant, even recognizing that we have found that Dr. Rao had no direct physician-patient relationship with N.R. during N.R.'s second hospital admission.¹⁵

Count 2, ¶6:¹⁶ Summary decision is granted on the allegations within Count 2, ¶6 that Dr. Rao's conduct constituted

¹⁴ ¶ 24 of Count 1 alleges:

Respondent's entry of the July 26, 2012 "anesthesia note," when she had no physician-patient relationship to N.R., constitutes misrepresentation and deception and professional misconduct; N.J.S.A. 45:1-21(b) and (e) and (h).

¹⁵ When appearing before the P.E.C., Dr. Rao testified that she conducted an examination of N.R. out of a "sense of concern and guilt." N.R.'s deposition testimony contradicts that claim and supports a finding that no examination occurred. Resolution of the question whether or not Dr. Rao in fact performed any examination, which is a critical underlying fact necessary to resolve the allegations made in ¶24 of Count 1, thus requires credibility determinations, which we decline to make on a motion for summary decision.

¹⁶ The specific charges alleged in paragraph 6 of Count 2 are that respondent's conduct (specifically, her lack of candor when completing her biennial renewal application) constituted "misrepresentation and deception, professional misconduct and failure to comply with a rule of the Board; N.J.S.A. 45:1-21(a), (b) (e) and (h).

misrepresentation and deception, and professional misconduct, in violation of N.J.S.A. 45:1(a), (b) and (e).¹⁷

Penalty

Following our announcement of our determination to grant partial summary decision in this matter, we proceeded to conduct a penalty phase hearing. Although Dr. Rao had been provided notice that, in the event summary decision was entered, the Board would proceed immediately to conduct a penalty phase hearing, she neither appeared for the hearing nor offered any mitigation evidence.¹⁸ Instead, we considered oral arguments of counsel alone, and accepted a certification of costs submitted by the Attorney General. Mr. Keating urged that the Board view this case as a record keeping case, and represented that patient N.R. did make a complete recovery without permanent consequences. He also asserted that Dr. Rao had relocated to Dubai for personal and family reasons, and he suggested that her mistakes had been "inadvertent."

¹⁷ The charge that Dr. Rao's conduct constituted a violation of a law or regulation administered by the Board, in contravention of N.J.S.A. 45:1-21(h), is subsumed by the other charges made within Count 2.

¹⁸ Mr. Keating requested that Dr. Rao be afforded additional time to submit an affidavit for Board consideration on the issue of mitigation, which request was opposed by S.D.A.G. Gelber. We denied respondent's motion to postpone the mitigation hearing, finding that Dr. Rao had been provided written notice that the Board would proceed to conduct a penalty phase hearing on May 11, 2016, and that no showing had been made why Dr. Rao could not have prepared an affidavit or certification for Board consideration in advance of that date.

S.D.A.G. Gelber pointed out that accurate charting is critical to responsible medical practice, and urged the Board to impose significant sanctions to redress Dr. Rao's deliberate misconduct.

We conclude that the established record fully supports the imposition of significant disciplinary sanctions. Dr. Rao repeatedly engaged in deceptive acts. She did so initially, on June 22, 2012, when she failed to document that one or two catheters had sheared in N.R.'s back and could not be retrieved. She did so again on July 25, 2012, when she elected to continue her charade by knowingly preparing a false and misleading chart note. In an unrelated context, Dr. Rao did so when submitting her application for licensure renewal to this Board, by failing to honestly disclose an arrest which occurred a scant three months prior to the date on which she submitted her application.

In the N.R. case, Dr. Rao fundamentally compromised not only her own integrity, but also the integrity of N.R.'s medical record. Even more significantly, however, her actions manifested a shocking indifference for the health and well-being of her patient. In a transparent attempt to evade personal responsibility and liability for the complications which occurred, Dr. Rao attempted to cover-up her conduct by not charting - and then falsely charting -- what had occurred. While she may have elected to do so with the "hope" that N.R. would not suffer any complications, N.R. was clearly at risk of suffering substantial complications, to include

without limitation, problems such as spinal stenosis, nerve root compression, subcutaneous effusion and infection. Dr. Rao's actions clearly put N.R. at heightened risk, fundamentally compromised the ability of N.R.'s subsequent care-givers to make informed and appropriate decisions about necessary medical treatment, and caused N.R. to suffer needlessly.

At its core, the evidence before us demonstrates that Dr. Rao repeatedly elected to put her own self-interest above that of her patient, and did so knowing that her actions placed her patient in harm's way. Dr. Rao's actions were deliberate, and manifest a fundamental deviation from the most rudimentary of moral and ethical standards that apply to all licensees.

We expressly reject the suggestion made by Dr. Rao's counsel that this case should be viewed as a "record keeping" case alone. Dr. Rao's failure to chart that she had been unable to remove a sheared catheter(s) was far from an innocent mistake made by an overburdened practitioner - rather, it was a deliberate election, motivated by self-interest alone, made with abject apathy for the well-being of her patient.

We conclude, on balance, that a three year license suspension, of which a minimum of two years are to be served actively, is fully warranted and supported in this instance. Given our awareness that Dr. Rao is presently practicing in a foreign jurisdiction, we expressly will add a "tolling" provision to our

Order, as our intent is that Dr. Rao be required to refrain from any medical practice, whether in New Jersey or elsewhere, for a minimum period of three years. Therefore, no period of time during which respondent practices medicine in any jurisdiction shall be credited toward the period of suspension in New Jersey.

We additionally conclude that a monetary penalty is supported, and assess an aggregate penalty of \$30,000. We point out that the bulk of that penalty is apportioned for the multiple violations found within Count 1 of the Complaint. Finally, we award costs, to include attorneys' fees, in the aggregate amount of \$20,000.¹⁹

WHEREFORE, it is on this 17th day of June, 2016:

ORDERED nunc pro tunc May 11, 2016:

1. The license of Malina B. Rao, M.D. is suspended for a period of three years, commencing on May 11, 2016. At a minimum, the first two years of said suspension shall be served as a period of active suspension. The remaining one year of the suspension may

¹⁹ The Attorney General had sought a cost award of \$25,333.87, to include an attorney's fee award of \$23,662.50. We found all costs and attorneys' fees set forth within S.D.A.G. Gelber's certification (marked as D-1 in evidence during the penalty phase hearing) to have been reasonable, and that the level of resources that were committed to the pursuit of this case were fully justified given the significant public interest in this matter. We also found the hourly rates sought by the Attorney General for legal services, and by the Enforcement Bureau for investigative costs, to be reasonable. We nonetheless have concluded that Dr. Rao should not be required to bear the entirety of costs in this matter, given that summary decision was not granted on all of the allegations made in the Administrative Complaint, and thus pared the cost award to \$20,000 (approximately 80% of all costs sought).

be stayed and served as a period of probation, contingent upon respondent's compliance with all of the terms and conditions of this Order set forth below. The period of active suspension shall be tolled for any time that respondent practices in any jurisdiction, domestic or foreign.

2. Respondent is assessed an aggregate civil penalty in the amount of \$30,000.

3. Respondent is assessed costs and fees in the aggregate amount of \$20,000. Payment of the civil penalty assessed in paragraph 2 above and of all costs and fees assessed herein shall be due and owing within fifteen days of the date of filing of this Order, unless respondent submits an application, subject to Board approval, to allow payment of the aggregate assessment of \$50,000 in installments. Payment shall be made by certified check, bank check or money order (or any other form of payment acceptable to the Board). In the event payment is not timely made, a certificate of debt shall be filed in accordance with N.J.S.A. 45:1-24, and respondent may be subject to such other actions as may be authorized by law.

4. During the period of active suspension, respondent shall be required to attend and successfully complete courses acceptable to the Board in medical ethics and in medical record keeping.

5. Prior to resuming any practice in the State of New Jersey, respondent shall be required to appear before a Committee of the Board and demonstrate: 1) that she has complied with all terms of this Order, to include the requirement that she refrain from engaging in any practice of medicine and surgery in or outside of New Jersey for a period of two years and the course requirements set forth in paragraph 4 above, and 2) to demonstrate that she is fit and competent to resume the practice of medicine and surgery. The Board expressly reserves the right, in its sole discretion, to then require respondent to complete a practice assessment, by an assessment entity acceptable to the Board, to then determine the scope and breadth of any such assessment, and to impose any additional conditions or restrictions on respondent's practice consistent with any findings or recommendations that may be made following the practice assessment.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By:


Stewart A. Berkowitz, M.D.
Board President

**DIRECTIVES APPLICABLE TO ANY MEDICAL BOARD LICENSEE
WHO IS DISCIPLINED OR WHOSE SURRENDER OF LICENSURE
OR CESSATION OF PRACTICE HAS BEEN ORDERED OR AGREED UPON**

APPROVED BY THE BOARD ON AUGUST 12, 2015

All licensees who are the subject of a disciplinary order or surrender or cessation order (herein after, "Order") of the Board shall provide the information required on the addendum to these directives. Failure to provide the information required may result in further disciplinary action for failing to cooperate with the Board, as required by N.J.A.C. 13:45C-1 et seq: Paragraphs 1 through 4 below shall apply when a licensee is suspended, revoked, has surrendered his or her license, or entered into an agreement to cease practice, with or without prejudice, whether on an interim or final basis. Paragraph 5 applies to licensees who are the subject of an order which, while permitting continued practice, contains probationary terms or monitoring requirement.

1. Document Return and Agency Notification

The licensee shall promptly forward to the Board office at Post Office Box 183, 140 East Front Street, 2nd floor, Trenton, New Jersey 08625-0183, the original license, current biennial registration and, if applicable, the original CDS registration. In addition, if the licensee holds a Drug Enforcement Agency (DEA) registration, he or she shall promptly advise the DEA of the licensure action. (With respect to suspensions of a finite term, at the conclusion of the term, the licensee may contact the Board office for the return of the documents previously surrendered to the Board. Prior to the resumption of any prescribing of controlled dangerous substances, the licensee shall petition the Director of Consumer Affairs for a return of the CDS registration if the basis for discipline involved CDS misconduct. In addition, at the conclusion of the term, the licensee should contact the DEA to advise of the resumption of practice and to ascertain the impact of that change upon his/her DEA registration.)

2. Practice Cessation

The licensee shall cease and desist from engaging in the practice of medicine in this State. This prohibition not only bars a licensee from rendering professional services, but also from providing an opinion as to professional practice or its application, or representing him/herself as being eligible to practice. (Although the licensee need not affirmatively advise patients or others of the revocation, suspension, surrender or cessation, the licensee must truthfully disclose his/her licensure status in response to inquiry.) The licensee subject to the order

is also prohibited from occupying, sharing or using office space in which another licensee provides health care services. The licensee subject to the order may contract for, accept payment from another licensee for rent at fair market value for office premises and/or equipment. In no case may the licensee subject to the order authorize, allow or condone the use of his/her provider number by any health care practice or any other licensee or health care provider. In situations where the licensee has been subject to the order for less than one year, the licensee may accept payment from another professional who is using his/her office during the period that the licensee is (suspended), subject to the order for the payment of salaries for office staff employed at the time of the Board action.

A licensee whose license has been revoked, suspended or subject to a surrender or cessation order for one (1) year or more must immediately take steps to remove signs and take affirmative action to stop advertisements by which his/her eligibility to practice is represented. The licensee must also take steps to remove his/her name from professional listings, telephone directories, professional stationery, or billings. If the licensee's name is utilized in a group practice title, it shall be deleted. Prescription pads bearing the licensee's name shall be destroyed. A destruction report form obtained from the Office of Drug Control (973-504-6558) must be filed. If no other licensee is providing services at the location, all medications must be removed and returned to the manufacturer, if possible, destroyed or safeguarded. (In situations where a license has been suspended for less than one year, prescription pads and medications need not be destroyed but must be secured in a locked place for safekeeping.)

3. Practice Income Prohibitions/Divestiture of Equity Interest in Professional Service Corporations and Limited Liability Companies

A licensee subject to the order shall not charge, receive or share in any fee for professional services rendered by him/herself or others while barred from engaging in the professional practice.¹ The licensee may be compensated for the reasonable value of services lawfully rendered and disbursements incurred on a patient's behalf prior to the effective date of the Board order.

¹This bar on the receipt of any fee for professional services is not applicable to cease and desist orders where there are no findings that would be a basis for Board action, such as those entered adjourning a hearing.

A licensee who is a shareholder in a professional service corporation organized to engage in the professional practice, whose license is revoked, surrendered or suspended or who is ordered to cease practice for a term of one (1) year or more shall be deemed to be disqualified from the practice within the meaning of the Professional Service Corporation Act. (N.J.S.A. 14A:17-11). A disqualified licensee shall divest him/herself of all financial interest in the professional service corporation pursuant to N.J.S.A. 14A:17-13(c). A disqualified licensee who is a member of a limited liability company organized pursuant to N.J.S.A. 42:1-44, shall also divest him/herself of all financial interest. Such divestiture of the licensee's interest in the limited liability company or professional service corporation shall occur within 90 days following the entry of the order rendering the licensee disqualified to participate in the applicable form of ownership. Upon divestiture, a licensee shall forward to the Board a copy of documentation forwarded to the Division of Revenue and Enterprise Services demonstrating that the interest has been terminated. If the licensee is the sole shareholder in a professional service corporation or sole member of the limited liability company, the corporation must be dissolved within 90 days of the licensee's disqualification unless it is lawfully transferred to another licensee and documentation of the valuation process and consideration paid is also provided to the Board.

4. Medical Records

If, as a result of the Board's action, a practice is closed or transferred to another location, the licensee shall ensure that (during the three (3) month period) immediately following the effective date of the disciplinary order, a message will be delivered to patients calling the former office premises, advising where records may be obtained. The message should inform patients of the names and telephone numbers of the licensee (or his/her attorney) assuming custody of the records. The same information shall also be disseminated by means of a notice to be published at least once per month for three (3) months in a newspaper of general circulation in the geographic vicinity in which the practice was conducted. If the licensee has a website, a notice shall be posted on the website as well.

At the end of the three month period, the licensee shall file with the Board the name and telephone number of the contact person who will have access to medical records of former patients. Any change in that individual or his/her telephone number shall be promptly reported to the Board. When a patient or his/her representative requests a copy of his/her medical record or asks that record be forwarded to another health care provider, the licensee shall promptly provide the record without charge to the patient.

5. Probation/Monitoring Conditions

With respect to any licensee who is the subject of any order imposing a probation or monitoring requirement or a stay of an active suspension, in whole or in part, which is conditioned upon compliance with a probation or monitoring requirement, the licensee shall fully cooperate with the Board and its designated representatives, including the Enforcement Bureau of the Division of Consumer Affairs, in ongoing monitoring of the licensee's status and practice. Such monitoring shall be at the expense of the disciplined practitioner.

(a) Monitoring of practice conditions may include, but is not limited to, inspection of the professional premises and equipment, and inspection and copying of patient records (confidentiality of patient identity shall be protected by the Board) to verify compliance with the Board Order and accepted standards of practice.

(b) Monitoring of status conditions for an impaired practitioner may include, but is not limited to, practitioner cooperation in providing releases permitting unrestricted access to records and other information to the extent permitted by law from any treatment facility, other treating practitioner, support group or other individual/facility involved in the education, treatment, monitoring or oversight of the practitioner, or maintained by a rehabilitation program for impaired practitioners. If bodily substance monitoring has been ordered, the practitioner shall fully cooperate by responding to a demand for breath, blood, urine or other sample in a timely manner and providing the designated sample.

6. Payment of Civil and Criminal Penalties and Costs.

With respect to any licensee who is the subject of any order imposing a civil penalty and/or costs, the licensee shall satisfy the payment obligations within the time period ordered by the Board or be subject to collection efforts or the filing of a certificate of debt. The Board shall not consider any application for reinstatement nor shall any appearance before a committee of the Board seeking reinstatement be scheduled until such time as the Board ordered payments are satisfied in full. (The Board at its discretion may grant installment payments for not more than a 24 months period.)

As to the satisfaction of criminal penalties and civil forfeitures, the Board will consider a reinstatement application so long as the licensee is current in his or her payment plans.

NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ORDERS/ACTIONS

All Orders filed by the New Jersey State Board of Medical Examiners are "government records" as defined under the Open Public Records Act and are available for public inspection, copying or examination. See N.J.S.A. 47:1A-1, et seq., N.J.S.A. 52:14B-3(3). Should any inquiry be made to the Board concerning the status of a licensee who has been the subject of a Board Order, the inquirer will be informed of the existence of the Order and a copy will be provided on request. Unless sealed or otherwise confidential, all documents filed in public actions taken against licensees, to include documents filed or introduced into evidence in evidentiary hearings, proceedings on motions or other applications conducted as public hearings, and the transcripts of any such proceedings, are "government records" available for public inspection, copying or examination.

Pursuant to N.J.S.A. 45:9-22, a description of any final board disciplinary action taken within the most recent ten years is included on the New Jersey Health Care Profile maintained by the Division of Consumer Affairs for all licensed physicians. Links to copies of Orders described thereon are also available on the Profile website. See <http://www.njdoctorlist.com>.

Copies of disciplinary Orders entered by the Board are additionally posted and available for inspection or download on the Board of Medical Examiners' website.

See <http://www.njconsumeraffairs.gov/bme>.

Pursuant to federal law, the Board is required to report to the National Practitioner Data Bank (the "NPDB") certain adverse licensure actions taken against licensees related to professional competence or conduct, generally including the revocation or suspension of a license; reprimand; censure; and/or probation. Additionally, any negative action or finding by the Board that, under New Jersey law, is publicly available information is reportable to the NPDB, to include, without limitation, limitations on scope of practice and final adverse actions that occur in conjunction with settlements in which no finding of liability has been made. Additional information regarding the specific actions which the Board is required to report to the National Practitioner Data Bank can be found in the NPDB Guidebook issued by the U.S. Department of Health and Human Services in April 2015. See <http://www.npdb.hrsa.gov/resources/npdbguidebook.pdf>.

Pursuant to N.J.S.A.45:9-19.13, in any case in which the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, the Board is required 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 entered by the Board is provided to the Federation on a monthly basis.

From time to time, the Press Office of the Division of Consumer Affairs may issue press releases including information regarding public actions taken by the Board.

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