STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Dennis P. Whalen
Executive Deputy Commissioner

November 19, 1998

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Francis Chen Hsuing Chuang, M.D.
10 Lane 491 Dounhua Road
Tai Chung City
Taiwan, R.O.C.

Francis Chen Hsuing Chuang, M.D.
132-1 Chung Sing Road, 1F
Changhua
Taiwan, R.O.C.

Ann Gayle, Esq.
NYS Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th floor
New York, NY 10001

RE: In the Matter of Francis Chen Hsuing Chuang, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 98-276) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties **other than suspension or revocation** until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be

sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mla
Enclosure

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

COPY

IN THE MATTER

OF

FRANCIS CHEN HSIUNG CHUANG, M.D.

DETERMINATION

AND

ORDER

BPMC - 98 - 276

JAMES P. MILSTEIN, ESQ. (Chair), **RICHARD S. KOPLIN, M.D.** and **BRUMMITTE D. WILSON, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law of the State of New York ("**P.H.L.**").

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE ("ALJ"), served as the Administrative Officer.

The Department of Health ("**Department**") appeared by **HENRY M. GREENBERG, ESQ.**, General Counsel, by **ANN GAYLE, ESQ.**, Associate Counsel.

FRANCIS CHEN HSIUNG CHUANG, M.D. ("**Respondent**"), did not appear personally and was not represented by counsel.

A Hearing was held on October 28, 1998. Evidence was received and examined. A transcript of the proceeding was made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq. of the P.H.L.).

This case, brought pursuant to P.H.L. §230(10)(p), is also referred to as an "expedited hearing". The scope of an expedited hearing is strictly limited to evidence or sworn testimony relating to the nature and severity of the penalty (if any) to be imposed on the licensee[1] (Respondent).

Respondent, FRANCIS CHEN HSIUNG CHUANG, M.D., is charged with professional misconduct within the meaning of §6530(9)(b) of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with professional misconduct within the meaning of §6530(9)(b) of the Education Law, to wit: "professional misconduct ... by reason of having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state ..." (Department's Exhibit # 1 and §6530[9][b] of the Education Law).

In order to find that Respondent committed professional misconduct, under §6530(9)(b) of the Education Law, the Hearing Committee must determine: (1) whether Respondent was found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state and (2) whether Respondent's conduct on which the findings were based would, if committed in New York State, constitute professional misconduct under the laws of New York State.

A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. All Findings and Conclusions herein were unanimous. The Department, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

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[1] P.H.L. §230(10)(p), fifth sentence.

1. Respondent was authorized to practice medicine in New York State on August 17, 1971 by the issuance of license number 109844 by the New York State Education Department (Department's Exhibits # 1 & 2)[2].

2. Respondent is not currently registered to practice medicine in New York State (Department's Exhibit # 2).

3. Chih Ming Yu attempted to personally serve on Respondent a Notice of Referral Proceeding and a Statement of Charges on at least 2 separate occasions in September 1998 (see sworn affidavit of due diligence - Department's Exhibit # 1).

4. On October 7, 1998, Johnette Hamer mailed, by registered mail, a copy of a Notice of Referral Proceeding and a Statement of Charges to Respondent (Department's Exhibit # 1).

5. The State Board For Professional Medical Conduct has obtained personal jurisdiction over Respondent (legal decision made by the Administrative Officer [Respondent was timely served, filed no objection to the service effected upon him and pursuant to §6502(5) of the Education Law, is under a duty to notify the Department of Education of any change of mailing address within thirty (30) days of such change]); (P.H.L. § 230[10][d]); (Department's Exhibit # 1); [T-5, 10-12][3].

6. The Maryland Board of Physician Quality Assurance of the State of Maryland ("**Maryland Board**"), is a state agency charged with regulating the practice of medicine pursuant to the laws of the State of Maryland (Department's Exhibit # 3).

7. On December 31, 1996, the Maryland Board issued a Final Order and Opinion ("**Final Order**") which revoked Respondent's license to practice medicine in Maryland (Department's Exhibit # 3).

8. The Final Order also indicated that Respondent could not apply for reinstatement for a period of at least 15 years (Department's Exhibit # 3).

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[2] refers to exhibits in evidence submitted by the New York State Department of Health (Department's Exhibit). Dr. Chuang did not submit any exhibits.

[3] Numbers in brackets refer to transcript page numbers [T-].

9. The Maryland Board found, by clear and convincing evidence, that Respondent violated Maryland Practice Act §14-404(a)(22)[4] when he provided anesthesia services to a patient during and after a surgical hip repair procedure (Department's Exhibit # 3).

10. The Hearing Committee accepts the Final Order as well as the Findings of Fact, conclusion and discussion made by the Maryland ALJ, as part of its own Findings of Fact and incorporates same as Appendix II (Department's Exhibit # 3).

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that Factual Allegation A from the August 17, 1998 Statement of Charges is SUSTAINED.

The Hearing Committee further concludes that the SPECIFICATION OF CHARGES in the Statement of Charges is SUSTAINED[5].

The Hearing Committee concludes that the Department of Health has shown by a preponderance of the evidence that Respondent was found to have committed improper professional practice and of professional misconduct by the State of Maryland and that Respondent's conduct in Maryland would constitute professional misconduct under the laws of New York State. The Department of Health has met its burden of proof.

I Professional Misconduct under § 6530(9)(b) of the Education Law.

The Maryland Board is a duly authorized professional disciplinary agency. In 1996, the State of Maryland, through the Maryland Board instituted disciplinary action against Respondent. In September of 1996, the ALJ found that Respondent had significantly violated the Maryland Medical Practice Act.

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[4] (a) ... the [Maryland] Board ... may ... revoke a licensee if the licensee: (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care ...

[5] It is also noted that Respondent has not submitted a written answer to the charges and allegations in the Statement of Charges, as required by P.H.L. §230(10)(c). Therefore, in addition to the Hearing Committee's independent determination, the charges and allegations are deemed admitted.

The record establishes that Respondent committed professional misconduct pursuant to, at least, the New York equivalent of §6530(4)[6] of the Education Law.

In the September 18, 1996 Decision of the Maryland ALJ, adopted by the Maryland Board, the facts and conclusions establish that Respondent: failed to sufficiently hydrate the patient prior to administration of anesthesia; inappropriately administered an additional dose of Propofol during resuscitation efforts; failed to assess and manage the patient's neurologic status; failed to provide appropriate postoperative care; and failed to properly document the care and treatment that he provided to the patient. Based on those findings, the Maryland Board found that Respondent had violated the Maryland Medical Practices Act and that Respondent's license should be revoked.

Taking the findings of the Maryland Board as true, the Hearing Committee finds that the record establishes that Respondent's total disregard for the particular patient's care would constitute gross negligence in the State of New York.

The Hearing Committee finds that Respondent's conduct, if committed in New York State, would constitute professional misconduct under, at least, §6530(4) of the Education Law. Therefore, Respondent has committed professional misconduct pursuant to § 6530(9)(b) of the Education Law.

DETERMINATION

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service; and (10) probation.

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[6] Each of the following is professional misconduct... Practicing the profession with gross negligence on a particular occasion;

Respondent did not respond to the charges filed against him here in New York. Nor did Respondent respond to the charges filed in Maryland. Since Respondent did not appear at this proceeding, he was not subject to direct or cross-examination nor to questions from the Hearing Committee in this proceeding. Therefore the Committee is bound by the documentary evidence presented. Respondent has not provided any mitigation to his conduct and acts regarding the care and treatment of the patient or any explanations.

The record clearly establishes that Respondent committed a significant violation of the Maryland Medical Practices Act. Respondent's behavior clearly demonstrates that he should not be allowed to continue to practice as a physician.

The Hearing Committee concludes that if this case had been held in New York, on the facts presented it would have resulted in a unanimous vote for revocation of Respondent's license.

In determining an appropriate sanction the Hearing Committee has considered, among other things, the nature and circumstances of Respondent's misconduct, the protection of the public, and the standards of practice for physicians.

The Hearing Committee considers Respondent's gross negligence to be very serious. With a concern for the health, safety and welfare of patients in New York State, the Hearing Committee determines that revocation of Respondent's license is the appropriate sanction to impose under the circumstances. The sanction imposed is designed not to punish Respondent, but to protect the people at large. The Hearing Committee notes that the sanction imposed by Maryland, to wit revocation, is an appropriate sanction to impose in New York as well.

It is the unanimous determination of the Hearing Committee that Respondent's license to practice medicine be revoked.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The Specification of professional misconduct contained within the Statement of Charges (Department's Exhibit # 1) is **SUSTAINED,** and

2. Respondent's license to practice medicine in the State of New York is hereby **REVOKED.**

3. This Determination and Order shall be effective on personal service on the Respondent or 7 days after the date of mailing of a copy to Respondent by certified mail or as provided by P.H.L. §230(10)(h).

DATED: **New York, New York**
~~October~~ November 4, ~~1998~~ 1998

JAMES P. MILSTEIN, ESQ. (Chair)
RICHARD S. KOPLIN, M.D.
BRUMMITTE D. WILSON, M.D.

FRANCIS CHEN HSIUNG CHUANG, M.D.
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FRANCIS CHEN HSIUNG CHUANG, M.D.
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Changhua
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Ann Gayle, Esq.
Associate Counsel,
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

APPENDIX I

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

IN THE MATTER OF FRANCIS CHEN HSIUNG CHUANG, M.D.	STATEMENT OF CHARGES

Francis Chen Hsiung Chuang, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 17, 1971, by the issuance of license number 109844 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about December 31, 1996, the Maryland Board of Physician Quality Assurance ("Board") revoked Respondent's license to practice medicine in that State and ordered that Respondent may not apply for reinstatement of said license for a period of at least fifteen years, based on findings by the Board that Respondent failed to meet the appropriate standard of care in the evaluation and treatment that he provided to Patient A, in violation of Md. Health Occ. Code Ann. Section ~~14-405(d) (1994)~~ 14-404(a)(22)(1991), as follows: On September 26, 1993, Respondent, an anesthesiologist, *inter alia*, failed to hydrate Patient A sufficiently prior to administration of anesthesia, inappropriately administered an additional dose of Propofol during resuscitation efforts, failed to assess and manage Patient A's neurologic status, failed to provide appropriate postoperative care, and failed to properly document his care and treatment of Patient A; as a result of Respondent's failure to meet the appropriate standard of care in his evaluation and treatment of Patient A, she suffered metabolic anoxic encephalopathy due to lack of oxygen to the brain.

10/28/93 MP2

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

HAVING BEEN FOUND GUILTY OF

PROFESSIONAL MISCONDUCT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(b)(McKinney Supp. 1998) by having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state (namely N.Y. Educ. Law §6530(4) as alleged in the facts of the following:

10/28/98
MP2

1. Paragraph A.

DATED: August 17, 1998
New York, New York

Marcia E. Kaplan for Roy Nemerson

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

IN THE MATTER OF	*	BEFORE THE BOARD
FRANCIS C. CHUANG, M.D.	*	OF PHYSICIAN
Respondent	*	QUALITY ASSURANCE
License Number: D43982	*	Case Number: 94-0961
	*	OAH#:96-DHMH-BPQA-71-290

* *

FINAL ORDER AND OPINION

PROCEDURAL BACKGROUND

On May 28, 1996, the Board of Physician Quality Assurance (the"BPQA") issued charges against Francis C. Chuang, M.D. (the "Respondent") for violating the Maryland Medical Practice Act, Md. Code Ann., Health Occ. (HO) §14-404(a)(22), "[f]ails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State." The charges were based on an adverse action report received by the Board in 1993 in which Liberty Medical Center reported that Respondent's hospital privileges were revoked as a result of the Respondent's "administration of anesthesia inconsistent with the accepted protocol which led to hypoxia and metabolic encephalopathy." The charges were also based on a claim filed with Health Claims Arbitration ("HCA") in April, 1995 against the Respondent. Based on these reports, the BPQA sent the matter to the Medical and Chirurgical Faculty of Maryland's ("Med Chi") Peer Review Management Committee (the "PRMC"). The PRMC reviewed Respondent's medical and hospital records of the patient who filed the HCA claim and determined that the Respondent failed to meet the standard of care.

On July 10, 1996, a CRC was held in which the Respondent did not attend. Because the Respondent did not attend the CRC and no settlement could be reached, the CRC directed the Administrative Prosecutor to go to a hearing.

A hearing on the merits was held on August 24, 1996. Suzanne S. Fox, Administrative Law Judge (the "ALJ") presided over the hearing. On September 18, 1996, the ALJ issued a Recommended Decision wherein she concluded that Respondent had violated Md. Code Ann., Health Occ. §14-404(a)(22) by failing to meet the standard of care as determined by an appropriate peer review. The ALJ recommended that the Respondent's license be revoked, and that the Respondent may not apply for reinstatement for a period of fifteen (15) years and not until Respondent can demonstrate to the BPQA that he has obtained sufficient education, retraining and experience which will enable him to practice medicine in the State of Maryland within the standards recognized as appropriate by the BPQA.

By letter dated September 18, 1996, the parties were notified of their right to file exceptions to the Recommended Decision. No exceptions were filed by either party. On November 20, 1996, the BPQA considered the ALJ's Recommended Decision. On that date, the BPQA convened for a final decision.

FINDINGS OF FACT

After consideration of the record, BPQA adopts and incorporates by reference the Findings of Fact made by the ALJ in her Recommended Decision issued on September 18, 1996. The Recommended Decision is attached and incorporated into this Final Order as Appendix A.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, there is clear and convincing evidence to support the conclusion of a majority of the full authorized membership of the BPQA considering this case that Respondent violated the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §14-404(a)(22) which states as follows:

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 31st day of December, 1996, by a majority of the full authorized membership of the BPQA considering this case

ORDERED that the license of Respondent, Francis C. Chuang, M.D., to practice medicine in the State of Maryland is hereby REVOKED; and it is further

ORDERED that the Respondent may not apply for reinstatement for a period of at least fifteen (15) years and not until Respondent can demonstrate to the Board that he has obtained sufficient education, retraining and experience which will enable him to practice medicine in the State of Maryland within the standards recognized as appropriate by the Board.

ORDERED that this is a Final Order of the Board of Physician Quality Assurance, and, as such, is a PUBLIC DOCUMENT pursuant to Maryland State Gov't Code Ann. §§ 10-610 et seq. and is reportable to both the Federation of State Medical Boards and the National Practitioner's Data Bank.

NOTICE OF RIGHT TO APPEAL

Pursuant to Maryland Health Occupations Code Ann. §14-408, you have the right to take a direct judicial appeal. Any appeal shall be made as provided for judicial review of a final decision in the Administrative Procedure Act, State Government Article and Title 7, Chapter 200 of the Maryland Rules of Procedure.

12-31-96
Date

Suresh C. Gupta
Chair

I HEREBY ATTEST AND CERTIFY UNDER PENALTY OF PERJURY ON 1/27/97 THAT THE FORGOING DOCUMENT IS A FULL, TRUE AND CORRECT COPY OF THE ORIGINAL ON FILE IN MY OFFICE AND IN MY LEGAL CUSTODY.

EXECUTIVE DIRECTOR
MARYLAND STATE BOARD OF
PHYSICIAN QUALITY ASSURANCE

EXHIBIT A

STATE BOARD OF PHYSICIAN	*	BEFORE SUZANNE S. FOX,
QUALITY ASSURANCE	*	AN ADMINISTRATIVE LAW JUDGE
V.	*	OF THE MARYLAND OFFICE
FRANCIS C. CHUANG, M.D.	*	OF ADMINISTRATIVE HEARINGS
License No.: D43982	*	OAH No.: 96-DHMH-BPQA-71-290

* * * * * * * * * * * *

PROPOSED DECISION

STATEMENT OF THE CASE
ISSUE
SUMMARY OF THE EVIDENCE
FINDINGS OF FACT
DISCUSSION
CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On June 3, 1996, the Maryland State Board of Physician Quality Assurance ("Board") issued charges against Francis C. Chuang, M.D. ("Respondent") for failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State, in violation of the Medical Practice Act, Md. Health Occ. Code Ann. § 14-404(a)(22) (1991).

A prehearing conference was conducted by Administrative Law Judge Ann C. Kehinde on August 5, 1996. She issued a Pre-Hearing Report and Order on August 15, 1996, which is attached hereto as Attachment A. As noted in the Pre-Hearing Report and Order prepared by Judge Kehinde, neither the Respondent nor his representative appeared at the Pre-Hearing Conference. At the hearing, Mr. Gilbert established that the Board met its requirement to notify Respondent of the investigation and

subsequent charges against him.[1]

An evidentiary hearing was held on August 26, 1996, at the Office of Administrative Hearings, 10753 Falls Road, Lutherville, Maryland 21093, before Suzanne S. Fox, Administrative Law Judge ("ALJ"), pursuant to Md. Health Occ. Code Ann. § 14-405(a) (1991)[2]. The Respondent was neither present nor represented by counsel at the hearing. Robert Gilbert, Assistant Attorney General and administrative prosecutor for the Board, represented the Board.

Procedure for the service of notice is governed by Md. State Gov't Code Ann. §§ 10-208 and 209 (1995), and continuing jurisdiction over licensees under investigation and requirements for advising the Board of any change of address is governed by Md. Health Occ. Code Ann. § 14-316 (1991). Md. Health Occ. Code Ann. § 14-405 (d) (1991) sets the requirements for an ex parte hearing where a licensee fails to be present for a disciplinary hearing.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, Md. State Gov't Code Ann. §§ 10-201 through 10-227 (1995), Code of Maryland Regulations ("COMAR") 10.32.02 and the Rules of Procedure of the Office of Administrative Hearings, COMAR 28.02.01.

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1 See Board Ex. #10.

2 The actions which are the basis for the charges against the Respondent occurred in 1992, and, therefore, the 1991 Medical Practice Act, rather than the current 1994 Code volume, is applicable to these proceedings.

ISSUE

The issue in this case is whether the Respondent failed to meet appropriate standards as determined by appropriate peer review when he provided anesthesia services to a patient for a surgical hip repair on or about September 27, 1993, in violation of Md. Health Occ. Code Ann. § 14-404(a)(22) (1991).

SUMMARY OF THE EVIDENCE

Exhibits.

The Board submitted the following exhibits which were admitted into evidence:

Bd. Ex. # 1 -	Maryland licensure application
Bd. Ex. #2 -	Curriculum Vitae of Michael J. Reynolds, M.D., expert witness for the Board.
Bd. Ex. #3 -	November 3, 1995 Report of Michael J. Reynolds, M.D.
Bd. Ex. #4 -	November 14, 1995, Peer Review Committee Report.
Bd. Ex. #5 -	Charges Under the Maryland Medical Practice Act.
Bd. Ex. #7 -	Medical Records for Patient A.
Bd. Ex. #8 -	Anesthesia Record, dated September 27, 1993 (excepted from Board Ex. #7)
Bd. Ex. #9 -	Poster enlargement of Board Ex. #8, page 25 of Medical Records of Patient A. Marked for identification, but not admitted into the record
Bd. Ex. #10 -	Index of Mailings to and From the Respondent
Bd. Ex. #11 -	Mask used for purposes of assisting in ventilation of patient during surgical procedures. Marked for identification, but NOT ADMITTED into the record.
Bd. Ex. #12 -	Endotracheal tube marked for identification, but NOT ADMITTED into the record.

The Respondent, who did not appear at the hearing, did not submit any exhibits into the record.

Testimony.

The following witnesses testified on behalf of the Board: Pamela J. Cromer, Compliance Specialist for the Board; and

Michael J. Reynolds, M.D., who testified as an expert in the area of Anesthesiology.

FINDINGS OF FACT

Having considered all of the evidence presented, I find the following facts by clear and convincing evidence:

1. At all times relevant to this proceeding, the Respondent was a licensed physician in the State of Maryland.
   a. Originally, the Respondent was issued a license to practice medicine in Maryland on or about December 3, 1992.
   b. Respondent did not apply to renew his medical license during the 1994 renewal period.
2. Respondent failed to notify the Board of his correct mailing address during the course of the investigation into the matters entailed in this proceeding.
3. In 1993, Respondent was a practicing anesthesiologist at Liberty Medical Center ("LMC").
4. On September 26, 1993, Patient A[1] was admitted to LMC after sustaining a hip fracture.
   a. Patient A is female was 69 years old, five feet, five inches tall and weighed 165 pounds at the time of her admission.
   b. On September 27, 1993, Patient A underwent a surgical repair of the hip fracture.
5. Respondent provided anesthesia to the patient during the

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[1] For purposes of confidentiality, the patient is identified in this Proposed Decision as Patient A. The Respondent is aware of the identity of this individual.

surgical repair of the fractured hip on September 27, 1993. (See Board Ex. #7 pp. 22 through 29)

a. The anesthesia started at 8:40 p.m.

b. Respondent administered 90 mg. of Propofol, a sedative hypnotic agent (70 mg. Followed by an additional 20 mg.) prior to the patient's lateral positioning for spinal anesthesia and surgery.

c. At approximately 9:07 p.m., Respondent administered 10 mg. Of Tetracaine (also known as Pontocaine), a spinal anesthetia and noted "no reflux of CSF seen." (See Board Ex. #7 p. 25)

d. Respondent then administered an additional 4 mg. of Tetracaine.

e. At about 9:10 p.m., the patient began to experience hypotension and bradycardia.

f. Respondent administered 0.4 mg. of Atropine and 30 mg. of Ephedrine.

g. Between 9:10 p.m. and 9:30 p.m., the Respondent administered another 30 mg. of Propofol, 0.4 mg. of Atropine, and initiated an epinephrine infusion. At this time, the patient was mechanically ventilated, but she was not intubated.

h. Surgery began at 9:28 p.m., and concluded at 10:25 p.m., and the anesthesia was terminated at 10:38 p.m.

i. At the conclusion of the surgery, the patient was "not awake." (See Board Ex. #7 p. 23)

6. Patient A was admitted to the post anesthesia care unit ("PACU") at approximately 10:30 p.m.

a. Between 10:30 p.m. and 11:00 p.m., the Patient was hypoxic.

b. The patient remained in the PACU for one hour and 45 minutes, during which she remained unresponsive to all stimuli.

7. At 12:30 a.m. on September 28, 1993, Patient A was transferred to the Intensive Care Unit ("ICU"). (See Board Ex. #7 p. 49)

a. At the time of the transfer, the patient was unconscious, and hypotensive.

b. At 12:50 a.m., the patient had a P_aO_2 of 74 and O_2 saturation of 94%, while receiving 100% oxygen by mask.

c. At about 5:00 a.m., the patient went into respiratory distress and experienced seizure activity. (See Board Ex. #7 p. 53)

i. A physician (not Respondent) intubated Patient A with an endotracheal tube and placed her on a ventilator.

ii. At 6:15 a.m., a chest x-ray was taken which revealed that the patient had bilateral central pulmonary infiltrates compatible with possible aspiration pneumonia. (See Board Ex. #7 p. 134)

8. In the afternoon of September 28, 1993, as electroencephalogram ("EEG") showed a moderate degree of metabolic encephalopathy. (See Board Ex. #7 p. 135)

9. A consultant, requested by the orthopedic surgeon, found the patient to have probable anoxic hypoxia encephalopathy. (See Board Ex. #7 p. 97)

10. The standard of care for the treatment of an otherwise healthy patient, age 69, who is undergoing a surgical hip repair, requires the anesthesiologist to:

a. Ensure that the patient is properly hydrated prior to administration of spinal anesthesia. The anesthesiologist should administer 500 - 1000 CCS off fluid to a patient prior to the administration of a spinal anesthesia. Spinal anesthesia causes the blood vessels in the lower part of the body to dilate and can result in a lowering of blood pressure.

b. Administer only enough Propofol, a sedative-hypnotic medication to sedate the patient. For a spinal procedure, the standard of care does not provide for administration of Propofol in an amount sufficient to induce unconsciousness.

c. Administer spinal anesthesia in a dosage based on the patient's height and the procedure to be performed. Before administering a second dose of spinal anesthesia, the standard of care requires that the anesthesiologist perform some tests to determine the level of anesthesia already administered, for example, ask the patient if he or she feels an alcohol swab being rubbed on his or her skin, or if the patient feels pin pricks.

d. Document any asystole in the anesthesia chart and employ life support measures as required, including external heart massage and assisted ventilation by means of an endotracheal tube. The endotracheal tube

is required to prevent the patient from aspirating gastric fluid which can occur during unconsciousness.

e. Assess and monitor the patient's neurological status during surgery.

f. Provide an Anesthesia Narrative Note in the medical record which accurately records any asystole, circumstances of hypotension, bradycardia and lack of responsiveness during a surgical procedure; any complications which occur during the surgical procedures and the anesthesiologist's responses; and the reason Propofol was administered after the complications occurred.

g. Ensure that the patient is properly ventilated in the PACU and take steps to diagnose the reason for a patient's hypoxia or comatose status.

h. In the event of hypoxia, take arterial blood gas, an electrocardiogram, blood glucose levels and electrolytes immediately.

i. Take affirmative steps to notify the surgeon and obtain additional consultations or arrange to meet with other physicians in order to properly assess and manage a patient who has experienced complications of asystole, hypotension, bradycardia o and hypoxia.

j. Intubate and place a hypoxic patient on a respirator with 100% O_2.

k. Take affirmative steps by means of x-ray, serum electrolytes and blood glucose to assess and manage a patient who remains comatose after surgery.

1. Document the assessment and management of the patient's ventilation and oxygenation, neurologic status and consultations post-operatively.

11. Respondent administered only 1000 CCS of fluid during the entire surgical procedure which is insufficient hydration for a patient undergoing an open hip reduction with spinal anesthesia. (See Board Ex. #8)

12. Propofol is a sedative hypnotic medication used to reduce the patient's anxiety and pain, and if administered appropriately, allows the physicians to position the patient properly with a minimum of discomfort. (Testimony of Dr. Reynolds)

13. Propofol is administered 1 mg per kilo for patients up to 55 years of age.

14. Respondent gave Patient A, who weighed 165 lbs., 70 mg of Propofol, and 10 minutes later he gave the patient an additional 20 mg of Propofol.

15. When the patient was positioned, Respondent administered 10 mg Pontocaine (Tetracaine), a spinal anesthesia, and he then administered another 4 mg of Pontocaine.

16. Pontocaine is a medication which should be administered by calculation according to the patient's height and the surgical procedure. To achieve an acceptable level of anesthesia in an operation such as an open hip reduction for a patient such as Patient A, the appropriate dosage of Pontocaine would be 6 to 8 mg. (Testimony of Dr. Reynolds).

17. Within minutes of receiving the spinal anesthesia, the patient experienced a precipitous drop in her blood pressure

and heart rate. Her blood pressure dropped to 100 systolic, and her heart rate dropped to 60. (See Board Ex. #8)

18. Respondent failed to document asystole in the medical records.

19. Respondent administered Atropine 0.4 mg. Atropine is a medication which increases the heart rate.

20. Respondent administered 30 mg of epinephrine, a medication which increases the blood pressure.

21. Patient A's vital signs remained depressed, blood pressure 100/40, and heart rate from 60 to 48, for about 15-20 minutes after the medications were administered. (See Bd. Ex. #8)

22. Respondent then administered additional Propofol to the patient. (See Bd. Ex. #8) Propofol, the sedative-hypnotic medication, depresses the heart rate and counteracts the epinephrine and Atropine. (Testimony of Dr. Reynolds)

23. Respondent's recordation of administration of O_2 during the surgery was inaccurate. (See Bd. Ex. #8)

    a. Respondent stated that he used a mask, but he did not record why the mask was used.

    b. Respondent recorded a tidal volume of 600, and tidal volume can be administered only through an endotracheal tube.

    c. Respondent did not record use of an endotracheal tube as part of the airway management.

    d. It is not possible to know from reading the anesthesia chart how the patient was being ventilated.

24. The surgery continued, uninterrupted, and ended at about

10:25 p.m. At that time, the patient was not awake, and she was taken to the post anesthesia care unit (PACU) where she remained for about 1 hour and 45 minutes. (See Board Ex. #7 p. 23)

25. Patient A remained unresponsive and hypoxic (O_2 level of 75) in the PACU.

26. Respondent did not take arterial blood gas, electrocardiogram, blood glucose or electrolytes immediately when the hypoxia was noted.

27. While the patient was in the PACU, Respondent performed a chin lift and head extension to assist the patient with her ventilation, and, 15 minutes later, he placed a mask on her to increase her oxygenation. As a result of his interventions, the patient's O_2 increased only to 92-93.

28. Adequate infusion of O_2 should raise the oxygenation level to 98-99. (Testimony of Dr. Reynolds)

29. Respondent failed to document his assessment and management of the patient's ventilation and oxygenation, consultations and neurological status.

30. Patient A suffered metabolic anoxic encephalopathy due to lack of O_2 to the brain. (Testimony of Dr. Reynolds)

31. The last address provided by Respondent to the Board was 1144 York Road, Lutherville, Maryland 21093. (See Board Ex. #10)

32. The Board attempted to correspond with Respondent at any and all addresses known to them to advise him of the investigation and proceeding against him. (See Board Ex. #10)

a. 5/12/94 - The Board, by certified mail, requested a response from Respondent. The request was mailed to 1144 York Road, Lutherville, Maryland 21093, an address provided by Liberty Medical Center. Grace Wu signed the certificate of receipt on May 18, 1994.

b. 6/10/94 - The Board received a response from the Respondent dated June 4, 1994. Respondent listed his return address as 132-1 Chung Sing Road, 1F, Changhua, Taiwan R.O.C.

c. 6/29/94 - The Board again attempted to correspond with Respondent at 1256 Peacock Hill, Santa Ana, California 92705, the address which Respondent listed as his correct address with the Board at the time of his licensure in Maryland, December 3, 1992.

d. 5/3/95 - The Board attempted to correspond with Respondent at the address provided on his June 4, 1994 letter to the Board, 132-1 Chung Sing Road, 1F, Changua, Taiwan R.O.C.

e. 8/4/95 - The Board attempted to correspond with Respondent by certified and regular mail at the following addresses: 18452 Hillcrest Avenue, Villa Park, CA 92667; 1256 Peacock Hill, Santa Ana, CA 92705, and 132-1 Chung Sing Road, 1F, Changua, Taiwan, R.O.C. A person named "Tean" signed for the letter to Hillcrest Avenue, the letter addressed to

1256 Peacock Hill was returned marked "Order Expired", and there was no response from the Taiwan address.

f. 6/29/96 - The Charging Documents were mailed certified and regular mail to the three addresses recited above. The documents sent to the Peacock Hill address were returned on 6/10/96 marked "Undeliverable as addressed forwarding order expired", the documents sent to 18452 Hillcrest Avenue were returned "Unclaimed" with notices sent on 6/3/96, 6/10/96 and 6/18/96, and there was no response from the Taiwan address.

g. 6/3/96 - The Board again attempted to correspond with Respondent by regular mail to the three addresses cited above. The documents which were sent to 1252 Peacock Hill were returned "Forwarding Order Expired". This document was resent to the correct address by Federal Express on 7/3/96.

h. 6/20/96 - The Board again attempted to correspond with Respondent by regular mail to the three addresses cited above. The document sent to 1257 Peacock Hill was returned "Return to sender FWDG order expired". This document was resent to eh correct address by Federal Express on 7/3/96.

DISCUSSION

Although the Respondent did not appear for any of the pre-hearing proceedings or the hearing, presentation by the administrative prosecutor proceeded in accordance with Md. Health Occ. Code Ann. § 14-405(d) (1994), which provides:

> Ex parte hearings. If after due notice the individual against whom action is contemplated fails or refuses to appear, nevertheless the hearing officer may hear and refer the matter to the Board for Disposition.

Additionally, the hearing regulations governing administrative hearings before the Office of Administrative Hearings under the Administrative Procedure Act empower administrative law judges to proceed ex parte or issue proposed/final default orders when a party fails to participate in a hearing after receiving proper notice. COMAR 28.02.01.20A.

In this case, the Charges against Respondent were served in accordance with Code of Maryland Regulations (COMAR) 10.32.02.03C(5). The testimony of Pamela Cromer, a Board of Physician Quality Assurance Compliant Specialist, established that service was effectuated by regular and certified mail, and the Respondent had actual notice of the investigation against him as demonstrated by his response to the Board which was sent from Taiwan on June 4, 1994. Multiple efforts were made to encourage Respondent's participation in the adjudicatory hearing. The evidence presented clearly establishes that Respondent had actual notice of the investigation of this matter, and regular and certified mail was sent to his address of record and two additional addresses which appeared on the mail he directed to the Board. Md. Health Occ. Code Ann. § 14-316(f) requires that

the licensee notify the secretary of the Board in writing of any change in his name or address within 60 days after the change.

Md. Health Occ. Code Ann. § 14-403(a) (1994) provides:

> Unless the Board agrees to accept the surrender of a license, certification, or registration of an individual the Board regulates, the individual may not surrender the license, certification, or registration nor may the license, certification, or registration lapse by operation of law while the individual is under investigation or while charges are pending.

Although the Respondent did not apply for renewal of his medical license by September 30, 1994, he was aware at that time that he was under investigation, and, in accordance with the above cited section, the license does not lapse while charges are pending.

In a case which arose in California, *Baughman v. Medical Board of California*, 40 Cal. App. 4th, 400 (Cal. App. 2 Dist. 1995), the Medical Board of California revoked the medical license of Dr. Baughman following the filing and serving of an accusation of misconduct which the physician failed to answer. The doctor challenged the decision to revoke his license on the ground that he was not properly serviced with the accusation, and thereby he was deprived of due process notice and opportunity to be heard. The court in that case decided that the physician was not denied due process by revocation of his license after he failed to appear for the hearing since he was required to keep his address on file with the agency and process was delivered by certified mail to that address. The court determined that an allegation that a physician did not personally receive notice did not establish lack of due process. The facts of the instant case mimic *Baughman* in that the Board effectuated service by regular

and certified mail to the Respondent's last address provided to the Board. Respondent cannot be heard to suffer a lack of due process on the basis that he did not receive personal service of the charges in this case.

With regard to the issue of merit in this case, Md. Health Occ. Code Ann. § 14-404(a) (1994) provides, in pertinent part:

> (a) *In general.*--Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state.

Michael J. Reynolds, M.D., the Board's expert in Anesthesiology, established the standard of care required of an anesthesiologist in the treatment of an otherwise healthy 69 year old female patient who requires spinal anesthesia for the surgical repair of a fractured hip. An anesthesiologist is charged with insuring the general well being of the patient, rendering anesthesia, and monitoring vital signs to make sure the patient is stable.

In this case, the Respondent failed to meet the standard of care in the evaluation and treatment that he provided. He failed to hydrate the patient sufficiently prior to administration of the anesthesia. He inappropriately administered an additional dose of Propofol during resuscitation efforts. He also failed to note the patient's asystole or the method of ventilation provided to the patient on the anesthesia record.

Respondent failed to assess and manage the patient's

neurologic status appropriately by obtaining x-rays, serum electrolytes, blood glucose, brain scan or consultations with other medical professionals. He failed to document appropriately what occurred during the intraoperative phase of treatment provided to the patient: he did not create an anesthesia narrative/note in the medical record; he did not document why he administered Propofol during resuscitation efforts; he failed to document that the patient became asystolic during surgery; and he failed to document appropriately the circumstances involving the patient's hypotension, bradycardia, hypoxia and asystole, and what treatments he provided for the patient in response to these conditions.

Respondent failed to provide appropriate postoperative care for Patient A. He failed to ensure that the patient was ventilated adequately after her discharge from surgery and upon her arrival and stay in the PACU. Additionally, Respondent did not undertake appropriate therapeutic measures to address the patient's hypoxic status in a timely manner. He failed to assess and manage the patient's neurologic status during the post-operative period, and he failed to seek appropriate consultation or to engage in communications with the other physicians responsible for the care of the patient.

Additionally, Respondent failed to document appropriately what occurred during the postoperative phase of treatment provided to Patient A. He did not adequately document his assessment and management of the patient's ventilation and oxygenation in the PACU. He did not adequately document his assessment and management of the patient's neurologic status in

the PACU, and he failed to document any consultation or communication with other physicians responsible for the care of the patient.

As a result of his failure to practice anesthesiology within the accepted standard of care, the patient suffered dire consequences. Respondent has not appeared to provide any further explanation of his actions. Thus, I recommend that the Board REVOKE the medical license of the Respondent and I further recommend that the Board not consider any request for reinstatement of his license for a period of at least fifteen (15) years. The deviation from the standard of care is so pervasive and so serious that it is inconceivable that Respondent, absent a showing of satisfactory completion of comprehensive medical education and training, could satisfy the requirements necessary to maintain a license to practice medicine in the State of Maryland.

CONCLUSIONS OF LAW

Based upon the foregoing findings of fact and discussion, I conclude, as a matter of law, that the Respondent did violate Md. Health Occ. Code Ann. § 14-404(a)(22) (1994). I further conclude that, as a result, the Board may discipline the Respondent pursuant to Md. Health Occ. Code Ann. § 14-404(a) by REVOKING his

medical license in the State of Maryland without consideration of a request for reinstatement for a period of at least fifteen (15) years.

PROPOSED DISPOSITION

I PROPOSE that the charges filed by the Board on June 3, 1996, against Francis C. Chuang, M.D. be UPHELD.

I PROPOSE that the Board REVOKE the medical license of Francis C. Chuang, M.D., effective as of the issuance of the final decision in this case. I further propose that the Board not consider any request for reinstatement for a period of at least fifteen (15) years and not until Respondent can demonstrate to the Board that he has obtained sufficient education, retraining and experience which will enable him to practice medicine in the State of Maryland within the standards recognized as appropriate by the Board.

September 18, 1996
Date

Suzanne S. Fox
Administrative Law Judge

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions to this proposed decision with the Board of Physician Quality Assurance within fifteen (15) days of receipt of the decision, in accordance with Md. State Gov't Code Ann. § 10-216 (1995) and COMAR 10.32.02.03F.