STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

March 25, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Paul Stein, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Robert H. Harris, Esq.
Schneider, Harris & Harris
1015 Broadway
Woodmere, New York 11598

Moon Ho Huh, M.D.
8708 Justice Avenue
Elmhurst, New York 11373

RE: In the Matter of Moon Ho Huh, M.D.

Dear Mr. Stein, Mr. Harris and Dr. Huh:

Enclosed please find the Determination and Order (No. BPMC-97-75) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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 T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

COPY

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

IN THE MATTER

- OF -

MOON HO HUH, M.D.

DECISION
AND
ORDER
OF THE
HEARING COMMITTEE

ORDER NO. BPMC 97-75

The undersigned Hearing Committee consisting of **KENNETH KOWALD, Chairperson, KENNETH J. FREESE, M.D., RALPH LEVY, D.O.,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, ESQ.,** Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Section 230(10) of the New York State Public Health Law and Sections 301-307 and 401 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law by **MOON HO HUH, M.D.** (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

RECORD OF PROCEEDING

Original Notice of Hearing and Statement of Charges	Dated: July 31, 1996 / Served: August 6, 1996
Notice of Hearing returnable:	August 28, 1996
Location of Hearing:	5 Penn Plaza, New York
Respondent's answer dated / served:	N/A
The State Board for Professional Medical Conduct (hereinafter referred to as "Petitioner" or "The State") appeared by:	**HENRY M. GREENBERG, ESQ.** General Counsel by **PAUL STEIN, ESQ.** Associate Counsel Bureau of Professional Medical Conduct 5 Penn Plaza Room 601 New York, New York 10001
Respondent appeared in person and was represented by:	**JAMES C. EBERZ, ESQ.** Meiselman, Farber, Packman & Eberz 118 North Bedford Road Mount Kisko, New York
	and subsequently by: **ROBERT H. HARRIS, ESQ.** Schneider, Harris & Harris 1015 Broadway Woodmere, New York 11598
Respondent's present address:	8708 Justice Ave., Elmhurst, N.Y. 11373
Respondent's License	Number: 117526 / Registration Date: September 6, 1973
Pre-Hearing Conference Held:	August 20 (phone) and August 28, 1996
Hearings held on:	August 28, October 3, and November 19, 1996
Conferences held on:	August 20 (phone), August 28, October 3, and November 19, 1996
Closing briefs received:	December 6, 1996
Record closed:	December 10, 1996
Deliberations held:	December 10, 1996

SUMMARY OF PROCEEDINGS

The Statement of Charges in this proceeding alleges eight grounds of misconduct:

1. Respondent has committed **fraud** as set forth in N.Y. Education Law Section 6530 (2)

2. Respondent has committed **gross negligence** as set forth in N.Y. Education Law Section 6530 (4)

3. Respondent has committed **gross incompetence** as set forth in N.Y. Education Law Section 6530 (6)

4. Respondent has committed **negligence on more than one occasion** as forth in N.Y. Education Law Section 6530 (3)

5. Respondent has committed **incompetence on more than one occasion** as set forth in N.Y. Education Law Section 6530 (5)

6. Respondent has committed misconduct **by permitting, aiding or abetting an unlicensed person to perform acts requiring a license** as set forth in N.Y. Education Law Section 6530 (11)

7. Respondent has committed misconduct by **delegating professional responsibilities** as set forth in N.Y. Education Law Section 6530 (25)

8. Respondent has committed misconduct by **failing to maintain patient records** as set forth in N.Y. Education Law Section 6530 (32)

The allegations arise from thirteen patients seen by Respondent in 1992 and from a document filed in 1993. The allegations are more particularly set forth in the Statement of Charges which is attached hereto as Appendix One.

Respondent entered a verbal denial of each of the charges.

Petitioner called these witnesses:

Mildred Howell	Fact Witness
Isaac Azar, M.D.	Expert Witness

Respondent testified and called this witness:

Leo Arthur Green, M.D.	Expert Witness
Maryann Podraza, M.D.	Expert Witness

SIGNIFICANT LEGAL RULINGS
INSTRUCTIONS TO THE TRIER OF FACT

1. The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. Fraud was defined for the Committee as the intentional misrepresentation or concealment of a known fact, made in connection with the practice of medicine. The Committee was instructed that there are three elements to a finding of fraud in the practice of medicine. To sustain its burden, Petitioner must show that within the practice of medicine:

   a. A false representation was made by Respondent, whether by words, conduct or concealment of that which should have been disclosed, and
   b. Respondent knew the representation was false, and
   c. Respondent intended to mislead through the false representation.

2. The Committee was further instructed that knowledge and intent may properly be inferred from facts found by the hearing committee. However, the committee must specifically state the inferences it is drawing regarding knowledge and intent.

3. The Administrative Law Judge instructed the panel that negligence as used herein, is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with accepted standards of medical practice in this state. Incompetence was defined as a failure to exhibit that level of knowledge and expertise expected of a licensed physician in this state and thus consistent with accepted standards of medical practice. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct.

Likewise, Gross incompetence was defined as a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct. The panel was told that the term egregious meant a conspicuously bad act or severe deviation from standards.

4. In reference to the Twenty Seventh Specification (permitting, aiding or abetting an unlicensed person to perform acts requiring a license) and the Twenty-Eighth Specification (delegating professional responsibilities), the Committee was instructed that the ordinary usage of the terms made the charges self-explanatory.

5. With regard to the keeping of medical records, the Committee was instructed that state regulations require a physician to maintain an accurate record of the evaluation and treatment of each patient. The standard to be applied in assessing the quality of a given record is whether a substitute or future physician or reviewing body could read a given chart or record and be able to understand a practitioner's course of treatment and the basis for same.

6. The standard of proof in this proceeding is a preponderance of the evidence. In assessing whether the proof adduced meets that standard, it was explained to the Committee that the State does not meet its burden of proof, and the charges cannot be sustained against Respondent merely by adducing testimony as to what some other physician would have done in circumstances similar to those found to have existed, at the time of treatment. In order to find that Respondent committed one or more of the Specifications of Charges, the State must demonstrate that Respondent's action, or failure to act, was a departure from accepted standards of medical care as they existed at that time.

7. With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training,

experience, credentials, demeanor and credibility. The Committee was further instructed that it is not bound to the testimony offered by an expert witness. Notwithstanding the presentation and qualification of a witness as an expert, the Committee was told it is free to reject some or all of the testimony as irrelevant, not probative, not credible or unpersuasive.

8. The Committee was further under instructions that with regard to a finding of medical misconduct, The Committee must first assess Respondent's medical care without regard to outcome but rather as a step-by-step assessment of patient situation followed by medical response. However, where medical misconduct has been established, outcome may be, but need not be, relevant to penalty, if any.

9. The Committee was instructed that patient harm need never be shown to establish negligence or incompetence in a proceeding before the State Board For Professional Medical Conduct.

FINDINGS OF FACT

The findings of fact which follow, were made after review of the entire record. Reference to transcript pages (Tr.__) and/or exhibits (Ex.__) denotes evidence that was found persuasive in determining a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. Unless otherwise stated, all findings and conclusions herein were unanimous.

GENERAL
FINDINGS OF FACT

1. Respondent was authorized to practice medicine in New York State on September 6, 1973 by the issuance of license number 117526 by the New York State Education Department. (Ex. 2)

2. Respondent is not board certified in anesthesiology due to his inability to pass the oral portion of the examination. (Tr. 21, Eh. 4)

3. Respondent has no current or recent hospital affiliation. (Eh. 4)

FINDINGS OF FACT
WITH REGARD TO
ALL PATIENTS

4. Respondent employed unlicensed assistants who took the patient's medical history, measured the patient's blood pressure, completed the patient's medical record, and monitored the patient in the recovery room. (Tr. 22-24, 47-55, 189-90, 249, 359, 452), (Eh. 3), (Eh. 7B, C, D, E, F, G, H, I, J, K, L, M, and N)

5. Respondent did not obtain or record the prior anesthesia history and family anesthesia history of each patient. (Tr. 56-58), (Eh. 7B, C, D, E, F, G, H, I, J, K, L, M, and N)

6. Respondent did not obtain or record the weight of each patient. (Tr. 58-59, 83, 217), (Eh. 7B, C, D, E, F, G, H, I, J, K, L, M, and N)

7. Respondent made minimally acceptable preoperative evaluations of the breath and heart sounds of each patient. (Tr. 64-66), (Eh. 7C, E, F, G, H, I, J, L, M, and N)

8. The patients referred to in this proceeding had had nothing to eat (were NPO) for a significant period of time prior to surgery. Respondent did not make a specific notation of this in each of the charts. (Tr. 279) (Ex. 7C, E, F, G, H, I, J, L, M, and N)

9. Respondent examined the airways of each of the patients in this proceeding. Respondent made no notation of these examinations. (Tr. 276, 283, 285) (Ex. 7C, E, F, G, H, I, J, L, M, and N)

10. Respondent administered anesthesia to each of the patients. Respondent did not have qualified licensed personnel available at all times to monitor the patient's condition or assist with anesthesia complications that could reasonably be anticipated in the recovery room. (Tr. 22-23, 66-67), (Ex. 7B, C, D, E, F, G, H, I, J, K, L, M, and N)

11. Respondent did not adequately monitor the vital signs of the patients in the recovery room. (Tr. 67-69), (Ex. 7B, C, D, E, F, G, H, I, J, K, L, M, and N)

12. Respondent did not accurately document the discharge time of each patient from the recovery room. (Tr. 70-71, 83-84, 95-96, 187, 223-24, 464-65, 471-72), (Ex. 7B, C, D, E, F, G, H, I, J, K, L, M, and N)

13. The values entered on each of the patient charts for temperature, pulse, and respiration are identical. The blood pressure values for each of the patients are virtually identical. Furthermore, the vital signs do not change throughout the procedure in almost every instance. (Tr. 60-2, 70-71, 83-84, 95-96), (Ex. 7B, C, D, E, F, G, H, I, J, K, L, M, and N)

14. Respondent wrote his charts at the end of the day rather than during or at the end of each procedure. In some instances the values recorded are estimates. (Tr. 187, 223--24)

15. As a matter purely of form, Respondent made minimally acceptable charts reflecting the care rendered to each patient. While only positive findings were noted, all necessary subjects were discussed or examined. (Tr. 397, 399, 427), (Ex. 7C, E, F, G, H, I, J, L, M, and N)

16. Respondent submitted bills for care given by others in the recovery room. He also submitted bills for care in excess of what was rendered. (Tr. 358-59, 385, 368-75 & 379-80,449-50)

FINDINGS OF FACT WITH REGARD TO PATIENT B[1]

17. On September 26, 1992, Patient B, a 44 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat menometrorrhagia. Respondent administered anesthesia to Patient B for the procedure. Patient B's chart included a notation indicating that Patient B had reported chest pain preoperatively. (Tr. 101), (Ex. 7B)

18. Respondent performed surgery in the absence of a cardiac workup and medical clearance. (Tr. 101-103), (Ex. 7B)

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[1]There was no Patient A in this proceeding

FINDINGS OF FACT WITH REGARD TO PATIENT C

19. On November 14, 1992, Patient C, a 35 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat dysfunctional uterine bleeding. Respondent administered anesthesia to Patient C for the procedure. Patient C's chart included a notation indicating that Patient C was obese. (Tr. 110), (Ex. 7C)

20. Respondent did not document a preoperative evaluation of Patient C's airway. (Tr. 110-12), (Ex. 7C)

21. Respondent did not premedicate Patient C with antacids. (Tr. 110-112), (Ex. 7C)

22. Respondent did not employ rapid induction of anesthesia with endotracheal intubation for Patient C. (Tr. 110-112), (Ex. 7C)

FINDINGS OF FACT WITH REGARD TO PATIENT D

23. On October 31, 1992, Patient D, a 27 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat an incomplete abortion. Respondent administered anesthesia to Patient D for the procedure. Patient D's chart included a notation indicating that Patient D had been bleeding heavily prior to the surgical procedure. (Tr. 120), (Ex. 7D)

24. Respondent did not determine the time of onset of Patient D's bleeding. (Tr. 120-21), (Ex. 7D)

25. Respondent did not determine the time of Patient D's last meal in relation to the time of the bleeding. (Tr. 120-121), (Ex. 7D)

26. Respondent did not specifically establish whether or not Patient D's stomach was empty before induction of general anesthesia. (Tr. 120-121), (Ex. 7D)

FINDINGS OF FACT WITH REGARD TO PATIENT E

27. On October 24, 1992, Patient E, a 27 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat dysfunctional uterine bleeding. Respondent administered anesthesia to Patient E for the procedure. Patient E's chart included notations indicating that Patient E had been bleeding heavily prior to the surgical procedure and that Patient E had a history of chronic bronchitis. (Tr. 120, 128-29), (Ex. 7E)

28. Respondent did not determine the time of onset of Patient E's bleeding. (Tr. 120-21), (Ex. 7E)

29. Respondent did not determine the time of Patient E's last meal in relation to the time of the bleeding. (Tr. 120-21), (Ex. 7E)

30. Respondent did not establish whether or not Patient E's stomach was empty before induction of general anesthesia. (Tr. 120-21), (Ex. 7E)

31. Respondent did not order a preoperative chest X ray of Patient E. (Tr. 129-30), (Ex. 7E)

32. Respondent did not order a preoperative white blood cell count for Patient E. (Tr. 129-30), (Ex. 7E)

FINDINGS OF FACT WITH REGARD TO PATIENT F

33. On October 3, 1992, Patient F, a 47 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat menometrorrhagia. Respondent administered anesthesia to Patient F for the procedure. Patient F's chart included a notation indicating that Patient F had a history of chronic bronchitis. (Tr. 128-29), (Ex. 7F)

34. Respondent did not order a preoperative chest X ray of Patient F. (Tr. 129-30), (Ex. 7F)

35. Respondent did not order a preoperative white blood cell count for Patient F. (Tr. 129-30), (Ex. 7F)

FINDINGS OF FACT WITH REGARD TO PATIENT G

36. On October 24, 1992, Patient G, a 34 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat vaginal bleeding and an abnormal pap smear. Respondent administered anesthesia to Patient G for the procedure. Patient G's chart included a notation indicating that Patient G had a history of chronic bronchitis. (Tr. 128-29), (Ex. 7G)

37. Respondent did not order a preoperative chest X ray of Patient G. (Tr. 129-30), (Ex. 7G)

38. Respondent did not order a preoperative white blood cell count for Patient G. (Tr. 129-30), (Ex. 7G)

FINDINGS OF FACT WITH REGARD TO PATIENT H

39. On September 26, 1992, Patient H, a 40 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to terminate her pregnancy. Respondent administered anesthesia to Patient H for the procedure. Patient H's chart included a notation indicating that Patient H had a history of chronic bronchitis. (Tr. 128-29), (Ex. 7H)

40. Respondent did not order a preoperative chest X ray of Patient H. (Tr. 129-30), (Ex. 7H)

41. Respondent did not order a preoperative white blood cell count for Patient H. (Tr. 129-30), (Ex. 7H)

FINDINGS OF FACT WITH REGARD TO PATIENT I

42. On September 18, 1992, Patient I, a 23 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat a missed abortion. Respondent administered anesthesia to Patient I for the procedure. Patient I's chart included a notation indicating that Patient I had a history of bronchial asthma. (Tr. 138), (Ex. 7I)

FINDINGS OF FACT WITH REGARD TO PATIENT J

43. On November 3, 1992, Patient J, a 21 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat an incomplete abortion. Respondent administered anesthesia to Patient J for the procedure. Patient J's chart included a notation indicating that Patient J had a history of bronchial asthma. (Tr. 138), (Ex. 7J)

FINDINGS OF FACT WITH REGARD TO PATIENT K

44. On October 24, 1992, Patient K, a 30 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat an incomplete abortion. Respondent administered anesthesia to Patient K for the procedure. Patient K's chart included a notation indicating that Patient K had a history of asthma. (Tr. 138), (Ex. 7K)

FINDINGS OF FACT WITH REGARD TO PATIENT L

45. On September 26, 1992, Patient L, a 29 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to terminate her pregnancy. Respondent administered anesthesia to Patient L for the procedure. Patient L's chart included a notation indicating that Patient L had a history of asthma. (Tr. 138), (Ex. 7L)

FINDINGS OF FACT WITH REGARD TO PATIENT M

46. On October 24, 1992, Patient M, a 46 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat dysfunctional uterine bleeding. Respondent administered anesthesia to Patient M for the procedure. (Ex. 7M)

47. Respondent billed for providing anesthesia care to Patient M during a period of time during which he billed for providing anesthesia care to Patient N. (Tr. 143-45, 298-99), (Ex. 3), (Ex. 7M), (Ex. 7N)

FINDINGS OF FACT WITH REGARD TO PATIENT N

48. On October 24, 1992, Patient N, a 29 year old female, was treated at the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat dysfunctional uterine bleeding. Respondent administered anesthesia to Patient N for the procedure. Patient N's chart included a notation indicating that Patient N had a history of heavy smoking. (Ex. 7N)

49. Respondent billed for providing anesthesia care to Patient N during a period of time during which he billed for providing anesthesia care to Patient M. (Tr. 143-45, 298-99), (Ex. 3), (Ex. 7M), (Ex. 7N)

FINDINGS OF FACT WITH REGARD TO GROUP HEALTH INCORPORATED APPLICATION

50. On February 20, 1993, Respondent executed an Individual Application for Participation and submitted it to Group Health Incorporated, 330 West 42nd Street, New York, NY 10036. (Ex. 5)

51. In this application, Respondent wrote that he had an application for a hospital affiliation pending at Jackson Heights Hospital, Queens, New York and that he was affiliated with St. John's Hospital, Queens, New York (Tr. 17-21, 195-97), (Ex. 5)

52. At the time of the application, Respondent knew these statements to be false. (Tr. 17-21, 195-97), (Ex. 5)

CONCLUSIONS WITH REGARD TO GROUP A FACTUAL ALLEGATIONS

This case involves thirteen patients (Patient B through N). The State made eleven allegations which address the over-all care provided by Respondent and apply equally to each of the thirteen patients. Each allegation will be addressed separately.

FACTUAL ALLEGATION A. 1.

In this charge, Respondent is alleged to have employed "unqualified and unlicensed" assistants to:

a. take patient medical histories;
b. measure patient blood pressures;
c. complete patient medical records;
d. monitor the patients in the recovery room.

It is uncontroverted that Respondent had unlicensed staff members performing tasks a, b and d. The Committee finds that Respondent completed the patient medical forms. Furthermore, the Committee finds it credible and acceptable that Respondent trained his staff to take patient medical histories (upon which he followed up) and measure patient blood pressures. It is the opinion of the Committee that one need not be a licensed professional to begin a patient history for the physician's review. Likewise, one need not be licensed to accurately measure blood pressure.

However, the Committee finds Respondent also relied upon unlicensed individuals to monitor patients in the recovery room. The Committee finds this dangerous and unacceptable. In so finding, the Committee adopts the opinion of both the State's expert Dr. Azar as well as Respondent's expert witness, Dr. Podraza. It was Dr. Podroza who stated,

> An anesthesiologist can only care for one patient at a time until that patient is discharged, unless they have given that patient's care over to somebody who is qualified or trained by them, a licensed professional. (Tr. 423)

Dr. Podraza also stated that leaving a patient in the care of an unlicensed person would not have met medical standards at the time of these events. (Tr. 438-9, 455-7 and 467) When a patient is recovering from anesthesia, there are grave risks which can arise extremely quickly. Respondent had no one present who was qualified by virtue of licensure to recognize symptoms early enough and react quickly enough, should a patient have an untoward result. Moreover, assuming that Respondent was attending to one patient while another was in recovery, he had no one present to substitute for him either in providing anesthesia or treating the patient in recovery in the event of an emergency. It is important to note that the key in this discussion is not so much a license, *per se*, as what the license represents. In this discussion, the Committee finds that only by earning a license can one be assured to have the level of training warranted for the task of monitoring patients in the recovery room. While an unlicensed person can be trained to perform the tasks numerated earlier, attending to the potential needs of a patient in recovery from anesthesia is so high a responsibility that only a licensed person would have sufficient training to be qualified to perform the function.

To sustain the First Allegation, the State must show the employees utilized by Respondent were both unqualified and unlicensed. The State has met this burden as to one of the elements of this charge: While none of the employees were licensed, they were qualified to perform each of the tasks enumerated except for (d.) monitoring the patients in the recovery room. In the opinion of the Committee, element (d.) is the most significant element in Allegation A.1.

Therefore,

Allegation A. 1 is SUSTAINED in part.

FACTUAL ALLEGATION A. 2.

The Committee finds that as alleged, Respondent did not review or record family anesthesia histories. It is the opinion of the Committee that while this is not an insignificant part of a routine pre-anesthesia review, given the very limited scope of the care rendered, the failure to obtain or record this information in and of itself does not rise to the level of professional misconduct. It is therefore sustained as factually correct but not as the basis of misconduct.

Therefore,

Allegation A. 2 is SUSTAINED.

FACTUAL ALLEGATION A. 3

The Committee also finds that as alleged, Respondent did not measure or record the weight of each patient. It is the opinion of the Committee that while this is not an insignificant part of a routine pre-anesthesia review, given the very limited scope of the care rendered, the failure to obtain or record this information in and of itself does not rise to the level of professional misconduct. It is therefore sustained as factually correct but not as the basis of misconduct.

Therefore,

Allegation A. 3 is SUSTAINED.

FACTUAL ALLEGATION A. 4

In Allegation A.4, Respondent is alleged to have failed to measure the patient's vital signs pre-operatively. The Committee finds that Respondent did in fact do so, at least to a minimal extent..

Therefore,

Allegation A. 4 is NOT SUSTAINED.

FACTUAL ALLEGATION A. 5

In Allegation A.5, Respondent is alleged to have failed to measure and document the breath and heart sounds of the patients pre-operatively. The Committee finds that Respondent did in fact do so to a minimal extent. In so finding the Committee believes that Respondent could make a minimally sufficient assessment merely by interviewing the patient. The Committee acknowledges that no record of any findings were kept. Nevertheless, the Committee is satisfied that this requirement of minimally acceptable care was met.

Therefore,

Allegation A. 5 is NOT SUSTAINED.

FACTUAL ALLEGATION A. 6

In Allegation A.6, the issue of unqualified personnel is again visited. In Allegation A.1, only the post-operative monitoring was cited. Here, Respondent is charged with the administration of anesthesia in the absence of another licensed person. The Committee finds that minimum accepted standards of medicine require Respondent to have had another licensed person available both to monitor the patient and to assist in the event that reasonably anticipated complications of anesthesia occurred.

The Committee sustains this charge. In so finding, the Committee again refers to the position of both the State's expert as well as Respondent's own expert. An anesthesiologist can care for one patient at a time. In this case, prior to discharge of one patient, Respondent would begin to care for another patient. As both experts stated, another professional needed to be present in order to meet minimum accepted standards of medicine.

Moreover, notwithstanding that there may not have been a patient in the recovery room, accepted standards of medicine warrant the presence of another person, trained to at least the level of a licensed practical nurse. This is because when complications of anesthesia occur, they happen very quickly and there is little time to accomplish resolution without permanent injury to the patient. A physician practicing within accepted standards of medical care must have an assistant available, other than the operating surgeon, who can intubate the patient and perform other highly technical functions on a moment's notice. Respondent had no such person available to him at the time in question.

Therefore,

Allegation A. 6 is SUSTAINED.

FACTUAL ALLEGATION A. 7

In A.7, Respondent is charged with inadequate monitoring of patient vital signs in the recovery room. This charge is sustained upon grounds similar to those set forth under Allegation A.1. As stated by both experts, a licensed professional was required in the recovery room, among other reasons, to monitor patient vital signs for subtle symptoms of post-anesthesia complications. Dr. Azar pointed out that complications of anesthesia can arise quickly. The sooner care is rendered, the more likely a dangerous event will be avoided or mitigated. Absent a trained professional, the subtle signs that could lead to early intervention are likely to go unnoticed. This creates unwarranted risk for the patient.

Therefore,

Allegation A. 7 is SUSTAINED.

FACTUAL ALLEGATION A. 8

The question here is whether the records kept by Respondent met minimum accepted standards. While even Respondent's expert considered the records "sub-optimal," the fact is that the Committee believes that while Respondent only noted positive findings, he did in fact address all pertinent issues. His intra-operative records were entirely complete as to form. Given the very limited nature of the care being rendered, and limiting review

solely to form, the Committee finds Respondent's records were adequate.

Therefore,

Allegation A. 8 is NOT SUSTAINED.

FACTUAL ALLEGATION A. 9

The Committee finds that while Respondent's records were minimally complete as to form, they were far from accurate. Respondent testified that he would leave his record keeping to the end of the day and rely upon limited notes taken during each procedure. Respondent admitted that some of the values recorded in his charts were "estimates" (Tr. 223-24).

The facts are, however, that as a group, the charts shows little or no variability for temperature, heart rate, pulse, respiratory rate, blood pressure and other vital signs. For instance, in eight of the thirteen patients, the blood pressure recorded is 110 over 70. Given the physical differences between the thirteen patients, it is beyond the realm of medical possibility that the actual values exhibited by the patients would be precisely the same 80% of the time. Moreover, Respondent shows no changes in blood pressure through out most of the procedures. This also is virtually impossible. Indeed, the Committee believes that at the end of each day, Respondent merely filled in the charts to reflect values within normal limits. The Committee does not believe that Respondent made any effort to accurately record the values exhibited by the patients.

Moreover, the Committee finds Respondent was not accurate in his billing records. On one occasion, October 24, 1992, he billed for eighteen hours of service. According to his own expert, Dr. Podraza, it is not possible for Respondent to have performed eighteen hours of anesthesia on that date (Tr. 449-50). The Committee finds that this is only one example of routine submissions for patient care that were inaccurate and, in fact falsified.

Therefore,

Allegation A. 9 is SUSTAINED.

FACTUAL ALLEGATION A. 10

Having sustained Factual Allegation A.9 on the bases explained, Factual Allegation A.10 must logically follow.

Therefore,

Allegation A. 10 is SUSTAINED.

FACTUAL ALLEGATION A. 11

In this allegation Respondent is charged with billing for anesthesia services during routine post-operative care. As has been previously established, Respondent would leave patients in the care of an unlicensed person during the final stages of recovery and begin treatment of a new patient. Nevertheless, Respondent would bill for his time in the treatment of both patients. As has been previously established, an anesthesiologist can only care for one patient at a time. Therefore, Respondent was not entitled to charge for his services during the care of more than one patient.

Therefore,

Allegation A. 11 is SUSTAINED.

CONCLUSIONS WITH REGARD TO PATIENT B

There are two allegations arising from the care and treatment of Patient B. Respondent performed anesthesia on this patient notwithstanding her report of pre-operative chest pain. The State alleges Respondent should have postponed the surgery until a cardiac workup had been performed and until a medical clearance had been obtained (Allegation B.1). The State charges in the alternative, that Respondent should have ordered a pre-operative cardiac work-up and a medical examination (Allegation B.2). Respondent admits that neither did he postpone anesthesia nor did he order a pre-operative evaluation or examination. The Committee finds this dangerous and unacceptable.

The Committee bases its finding on this reasoning: While it is entirely likely that the chest pain in issue was not serious, there was no way for Respondent to have assured himself of this, at the time, absent the pre-operative care cited by the State. In retrospect all went well but the point is that Respondent took an unnecessary and unwarranted risk in performing anesthesia on a patient who may have been suffering from some sort of cardiac disorder. Furthermore, the record discloses no mitigation such as a contemporaneous physical examination by Respondent. There are no remarks about history of previous similar events. Based upon this record there is no way for the Committee to know whether the chest pain was a manifestation of anxiety, indigestion or a serious event. There is no evidence in this record that Respondent considered the potential seriousness of the complaint at all. The issue is not entirely that Respondent did not perform the pre-anesthesia work-up cited. The issue is that he neither did the examinations to assure himself the event was benign nor did he note any observations or thinking upon which he concluded that the event was sufficiently lacking in seriousness to allow him to proceed. The two failures combined constitute a grave deviation from accepted standards.

Therefore,

Allegation B. 1 is SUSTAINED.

and

Allegation B. 2 is SUSTAINED.

CONCLUSIONS WITH REGARD TO PATIENT C

The patient record for Patient C indicates she is obese. This is not disputed. Nor is it disputed that obese patients present somewhat greater risks in anesthesia than patients with normal body weights. The State takes issue with Respondent because there is no notation that he evaluated the patient's airway (Allegation C.1); That he failed to premedicate the patient with antacids (Allegation C.2) and that he failed to use rapid induction of anesthesia with endotracheal intubation (Allegation C.3).

The Committee agrees that there is no record that documents an evaluation of this patient's airway. However, based upon Respondent's testimony, the Committee believes it was done but not recorded. Furthermore, the Committee believes that it is the evaluation which is of primary importance. The recording of the evaluation is of secondary importance and while it would be advisable to include remarks in the patient record which document the evaluation, the failure to document same is not, in and of itself, a deviation from accepted standards.

Therefore,

Allegation C. 1 is NOT SUSTAINED.

In Allegations C.2 and C.3, Respondent is alleged to have violated accepted standards of medicine because he failed to premedicate the patient with antacids (Allegation C.2) and he failed to use rapid induction of anesthesia with endotracheal intubation (Allegation C.3). Both these precautions arise because this patient was noted to be obese and patients who are obese present greater risks of esophageal reflux and aspiration.

The Committee agrees with the State's contention that obese patients present higher risks than patients at their normal body weights. The Committee also finds that Respondent did not perform either of the tasks listed by the State. Hence, the Committee will sustain these factual allegations. However, the Committee does not find that the lapses cited in C.2 and C.3 rise to the level of medical misconduct. In so finding, the Committee asserts that reasonable minds could disagree as to the necessity of the use of antacids and rapid induction, given the very limited procedure to be undertaken. Of even greater importance, the Committee notes that each of the patients had had nothing to eat (NPO) for a significant period of time prior to surgery. Therefore, while the risks alluded to did in fact exist, they were minimal. Accordingly, while these factual allegations are sustained, they will not form the basis of a finding of misconduct.

Therefore,

Allegation C. 2 is SUSTAINED.

and

Allegation C. 3 is SUSTAINED.

CONCLUSIONS WITH REGARD TO PATIENT D

With regard to Patient D, the patient record indicates that the patient had been bleeding heavily prior to the procedure. The State cites Respondent for a failure to determine the time of the onset of the bleeding (Allegation D.1), failure to determine the time of this patient's last meal (Allegation D.2) and a failure to determine if the patient's stomach was empty (Allegation D.3).

In reference to the first allegation, the Committee agrees that Respondent did not determine the time that the bleeding began. However, Respondent had sufficient history to surmise the time within a reasonable degree. Furthermore, and of greater importance, the cure for this patient's problem was the performance of a dilation and curettage. The length of time of the bleeding would be of little assistance in treating and presumably curing this patient. Therefore, while the Committee sustains this allegation as factually accurate, it will not form the basis for a finding of misconduct.

Therefore,

Allegation D. 1 is SUSTAINED.

In Allegations D.2 and D.3, the State cites Respondent for failing to determine the patient's last meal in relation to the onset of the bleeding. Respondent is also cited for a failure to establish that the patient's stomach was empty. While both assertions are accurate and will be sustained, they will not form the basis of a finding of misconduct. As was indicated in the discussion of Patient C, the Committee finds that each of these patients were NPO (nothing by mouth) prior to the procedure. While Respondent did not record either the NPO status nor the time the fast began in relation to the onset of bleeding, the Committee finds that this information would have been of little practical help to the practitioner. Respondent was aware of the patient's complaint, the probable cause and cure. The time relationship, while not irrelevant, was of little moment under the circumstances.

Therefore,

Allegation D. 2 is SUSTAINED.

and,

Allegation D. 3 is SUSTAINED.

CONCLUSIONS WITH REGARD TO PATIENT E

The issues raised concerning Patient E were similar to the issues raised concerning Patient D. The patient record for Patient D and Patient E show that each had been bleeding heavily prior to the surgery. As with Patient D, in the allegations concerning Patient E, the State cites Respondent for a failure to determine the time of the onset of the bleeding (Allegation E.1), failure to determine the time of this patient's last meal (Allegation E.2) and a failure to determine if the patient's stomach was empty (Allegation E.3).

Since the issues in these allegations are the same as those presented by Patient D, the conclusions by the Committee are the same and are based upon the same reasoning: In reference to the first allegation, the Committee agrees that Respondent did not determine the time that the bleeding began. However, Respondent had a sufficient history to estimate the time within a reasonable degree of certainty. Furthermore, and of greater importance, the cure for this patient's problem was the performance of a dilation and curettage. The length of time of the bleeding would be of little assistance in treating and presumably curing this patient. Therefore, while the Committee sustains this allegation as factually accurate, it will not form the basis for a finding of misconduct.

In Allegations E.2 and E.3, the State cites Respondent for failing to determine the patient's last meal in relation to the onset of the bleeding. Respondent is also cited for a failure to establish that the patient's stomach was empty. While both assertions are accurate and will be sustained, they will not form the basis of a finding of misconduct. As was indicated in the discussion of Patient C, the Committee finds that each of these patients were NPO (nothing by mouth) prior to the procedure. While Respondent did not record either the NPO status nor the

time the fast began in relation to the onset of bleeding, the Committee finds that this information would have been of little practical help to the practitioner. Respondent was aware of the patient's complaint, the probable cause and cure. The time relationship, while not irrelevant, was of little moment under the circumstances.

Therefore,

Allegation E. 1 is SUSTAINED.
Allegation E. 2 is SUSTAINED.

and

Allegation E. 3 is SUSTAINED.

Allegation E. 4 brings another issue before this body. Patient E had a history of chronic bronchitis. The State cites Respondent for failing to order a preoperative X ray (Allegation E.4) and for his failure to order a preoperative white blood count (Allegation E.5). The State asserts that these procedures were required to tell Respondent whether the patient had chronic or acute pulmonary difficulties which might lead to differing forms of management. Respondent stated that he examined each of the patient's airways, found them patent and therefore did not need the additional information to safely perform anesthesia. The Committee agrees with Respondent. While the chest x-ray and blood count would not be irrelevant, they would provide little if any useful information for Respondent, given the nature of the anesthesia he was about to provide. Given the limited nature of the anesthesia to be rendered and with the proviso that Respondent assessed the airway of each patient, the Committee finds that although the State's assertions are factually correct, they do not display a departure from accepted standards and hence, will not form the basis of a finding of medical misconduct.

Therefore

Allegation E. 4 is SUSTAINED.

and,

Allegation E. 5 is SUSTAINED.

CONCLUSIONS WITH REGARD TO PATIENTS F THROUGH H

Patients F, G and H present the same issues as those raised by the last two allegations asserted under Patient E. These patients each presented a history of chronic bronchitis. Therefore, the State Cites Respondent for failing to order a preoperative x ray (Allegations F. 1, G. 1 and H. 1) and for his failure to order a preoperative white blood count (Allegations F. 2, G. 2 and H. 2).

Based upon the reasoning set forth with regard to Patient E in Allegations E. 4 and E. 5, the Committee sustains these allegations as accurate but not representative of deviations from accepted medical standards. The State cites Respondent for failing to order a preoperative X ray (Allegation F. 1, G. 1 and H. 1) and for his failure to order a preoperative white blood count (Allegation F. 2, G. 2 and H. 2). Upon questioning by the Committee, Dr. Azar, the State's expert admitted that in the absence of acute symptoms, it is unlikely that neither an x ray nor a white blood count would have provided the practitioner with any significant information. (Tr. 133-5) Respondent stated that he examined each of the patient's airways, found them patent and therefore did not need the additional information to safely perform anesthesia. The Committee agrees with Respondent. While the chest x-ray and blood count would not be irrelevant, they would provide little if any useful information for Respondent, given the nature of the anesthesia he was about to provide. Given the limited nature of the anesthesia to be rendered and with the proviso that Respondent assessed the airway of each patient, the Committee finds that although the State's assertions are factually correct, they do not display a departure from accepted standards and hence, will not form the basis of a finding of medical misconduct.

Therefore,

Allegation F. 1 is SUSTAINED.
Allegation F. 2 is SUSTAINED.

Allegation G. 1 is SUSTAINED.
Allegation G. 2 is SUSTAINED.

Allegation H. 1 is SUSTAINED.

Allegation H. 2 is SUSTAINED.

CONCLUSIONS WITH REGARD TO PATIENTS I THROUGH L

Patients I, J, K, and L present the same issues. Respondent is cited for providing anesthesia to patients he knew suffered from bronchial asthma. The theory of this charge is that patients with asthma present a great enough risk of serious complications that Respondent should have had additional licensed personnel that he could call upon in the event of an emergency. (Tr. 138) In the alternative, Respondent should not have provided anesthesia to patients with asthma in the absence of qualified help.

The Committee agrees with this contention. Both the State's expert, Dr. Azar and Respondent's expert, Dr. Podraza, agreed that it was a violation of accepted standards for Respondent to have unlicensed personnel in the recovery room. The same opinions apply to the issues raised by these patients in that patients with asthma require closer monitoring both in the operating room and the recovery room because the possibility of breathing problems is significant in these patients.

Therefore,

Allegation I is SUSTAINED.
Allegation J is SUSTAINED.
Allegation K is SUSTAINED.
Allegation L is SUSTAINED.

CONCLUSIONS WITH REGARD TO PATIENTS M AND N

These allegations are self explanatory. Respondent is charged with billing for anesthesia services rendered to Patient M at the same time he billed for services provided to Patient N, and that he did so knowingly and intentionally. As set forth in Finding of Fact 47, the records affirm the fact that Respondent billed for

overlapping time periods.. The Committee finds that Respondent submitted the bills knowing that they were false with the intention of being paid twice for the same period of time. This Committee does not believe this was a clerical error or an act of negligence. In so finding, the Committee refers to Respondent's testimony. While allowing for the fact that English did not appear to be Respondent's native language, the Committee found Respondent evasive and deceitful. There was the sense that in certain instances Respondent was making up the testimony as he testified. In other instances, Respondent admitted that entries in the patient charts for some of the vital signs were "estimates." These charts were presented to various authorities, including this Committee as accurate records of events as they occurred or could be remembered from notes. To testify that the entries included "estimates" is to admit fraudulent record keeping and is consistent with the charge of double billing.

Therefore,

Allegation M. 1 is SUSTAINED.
Allegation N. 1 is SUSTAINED.

CONCLUSIONS WITH REGARD TO Application to GHI by Respondent

Factual Allegation O asserts that Respondent submitted a false application to Group Health Incorporated (GHI). As stated in Findings of Fact fifty through fifty-one, and as admitted by Respondent, on February 20, 1993, Respondent executed an Individual Application for Participation and submitted it to Group Health Incorporated. Respondent wrote that he had an application for a hospital affiliation pending at Jackson Heights Hospital, Queens, New York and that he was affiliated with St. John's Hospital, Queens, New York. At the time of the application, Respondent knew these statements to be false.

Respondent suggested in his testimony that there may have been a misunderstanding based upon language. The Committee does not accept even the suggestion of a mis-understanding to be credible. Having listened to and observed Respondent during his testimony, this Committee stands convinced that Respondent

submitted the application, that he knew it contained false information, and intended to deceive GHI.

Therefore,
Allegation O is SUSTAINED.

CONCLUSIONS WITH REGARD TO THE FIRST THROUGH THE FOURTEENTH SPECIFICATIONS (FRAUDULENT PRACTICE)

The Committee applied the definition of fraud in the practice of medicine as set forth above and as applied to Allegation A. 9, A.10, A.11, M.1, N.1 and O. The Committee finds that through out the records submitted as well as the application to GHI, the State has shown Respondent engaged in the intentional misrepresentation or concealment of a known facts. He did so in connection with patient records, bills for medical services and an application for hospital privileges. Therefore the misrepresentations and concealment were made in connection with the practice of medicine. In their analysis of the records and exhibits herein, and as previously discussed, the Committee found that Respondent affirmatively acted to commit fraud in that he fabricated records, billed more than once for services rendered and filed a deceptive application to participate in GHI. Furthermore, this Committee has no doubt these misrepresentations were done with the knowledge that the information was false and that Respondent did what he did to obtain a benefit. That is, he submitted false patient records to obtain payment and submitted the false application in the hope of gaining participant status.

Each of the elements of fraud are fulfilled.

Therefore:
The First through Fourteenth Specification are SUSTAINED

CONCLUSIONS
WITH REGARD TO
THE FIFTEENTH THROUGH THE NINETEENTH SPECIFICATIONS
(GROSS NEGLIGENCE)

While the Committee has been critical of Respondent's level of care and diligence, the Committee does not find that his conduct rises to the level of an extreme deviation from standards. Accordingly, the standards warranting a finding of gross negligence have not been met.

Therefore:
The Fifteenth through Nineteenth Specification are NOT SUSTAINED

CONCLUSIONS
WITH REGARD TO
TWENTIETH THROUGH TWENTY FOURTH SPECIFICATIONS
(GROSS INCOMPETENCE)

As stated in reference to the previous specifications, while the Committee has been critical of Respondent's practices, it does not find an extreme deviation from standards. Accordingly, the standards warranting a finding of gross incompetence have not been met.

Therefore:
The Twentieth through The Twenty Fourth Specifications are NOT SUSTAINED.

CONCLUSIONS
WITH REGARD TO
TWENTY-FIFTH SPECIFICATION
(NEGLIGENCE ON MORE THAN ONE OCCASION)

This Committee has found eight deviations from accepted standards in each of the thirteen patients

presented in this proceeding. That is, as to patients B through N Respondent:

1. Employed unlicensed persons to attend patients in his recovery room;
2. failed to obtain and record the anesthesia history of each patient and patient family;
3. failed to obtain and record the patient's weight;
4. administered anesthesia in the absence of additional qualified personnel;
5. did not appropriately monitor patient vital signs in the recovery room;
6. knowingly and intentionally created records which do not accurately reflect the condition and anesthesia care rendered to patients;
7. knowingly and intentionally created records with false vital signs;
8. knowingly and intentionally rendered false bills.

Having so found, the Committee concludes that Respondent has displayed a pattern of (among other things) inappropriate levels of care and diligence. The Committee finds that Respondent knew that the actions found were in deviation of accepted standards, yet chose to act without conformity. On a number of occasions Respondent admitted that his records were substandard and inaccurate. Respondent's expert noted that it was a violation of accepted standards to leave patients in the care of unlicensed persons. The Committee accepts the findings of the State's expert that the other listed activities did not comport with accepted standards of care and diligence.

The Committee finds that each patient record presented demonstrated the same or very similar lapses in care and diligence. Therefore, each patient presented represents a separate occasion of negligence.

Therefore:
The Twenty-Fifth Specification is SUSTAINED

CONCLUSIONS
WITH REGARD TO
TWENTY SIXTH SPECIFICATION
(INCOMPETENCE ON MORE THAN ONE OCCASION)

The Committee finds that Respondent had the requisite training and knowledge to qualify him for the work he did. In many respects this makes his lapses all the more serious since he obviously knew how to act within appropriate standards. Nevertheless, the fact that Respondent appeared to have the requisite knowledge and experience necessary, the definition of incompetence is not met.

Therefore:
The Twenty Sixth Specification is NOT SUSTAINED

CONCLUSIONS
WITH REGARD TO
TWENTY SEVENTH SPECIFICATION
(PERMITTING UNLICENSED PERSONS)

Earlier in this decision, the Committee has discussed their conclusion that it was a violation of accepted standards for Respondent to employ unlicensed persons to attend patients in the recovery room. As stated by both experts, a licensed professional was required in the recovery room, among other reasons, to monitor the vital signs of each patient for subtle symptoms of post-anesthesia complications. Dr. Azar pointed out that complications of anesthesia can arise quickly. The sooner care is rendered, the more likely a dangerous event will be avoided or mitigated. Absent a trained professional, the subtle signs that could lead to early intervention are likely to go unnoticed. This creates unwarranted risk for the patient. It follows that Respondent has violated the Education Law, as charged.

Therefore:
The Twenty Seventh Specification is SUSTAINED

CONCLUSIONS
WITH REGARD TO
TWENTY EIGHTH SPECIFICATION
(DELEGATING PROFESSIONAL RESPONSIBILITY)

Once again, the Committee refers to their conclusion that it was a violation of accepted standards for Respondent to employ unlicensed persons to attend patients in the recovery room. It is noteworthy that professional responsibilities can be delegated, but only to qualified persons. This Committee has found that the delegation in this case was to unqualified personnel and hence constitutes a violation of the Education Law, as charged.

Therefore:
The Twenty-Eighth Specification is SUSTAINED

CONCLUSIONS
WITH REGARD TO
TWENTY NINTH AND THIRTIETH SPECIFICATIONS
(FAILURE TO MAINTAIN RECORDS)

It is the conclusion of this body that the records received herein were minimally acceptable in that they reflected the very limited care rendered by Respondent in each instance. In so finding, the Committee is limiting itself strictly to the objective contents of the records as opposed to their specific accuracy. Obviously, the Committee does not wish to endorse the falsification of the records. Rather, the Committee simply believes that the necessary elements of a record were present.

Therefore:
The Twenty Ninth and Thirtieth Specifications are NOT SUSTAINED

CONCLUSIONS WITH REGARD TO PENALTY

The citations found by this Committee primarily involve inadequate staff and falsification of documents. That the Committee has found Respondent marginally competent by no means mitigates Respondent's practice of placing patients at higher risk than necessary. Even Respondent's own expert stated that it was a violation of standards for Respondent to leave patients in the care of unlicensed individuals during the final stages of recovery. Certainly, marginal competence does not mitigate outright fabrication of records.

If there is a pattern in Respondent's violations, it is one of greed. Respondent was willing to allow patient risk to be elevated by providing less expensive, non-professional care. Respondent submitted bills for services he did not render. Respondent fabricated records rather than take the time necessary to produce accurate ones.

While Respondent admitted his record keeping was sloppy, he has demonstrated no true understanding of his violations of standards. The Committee is left with the impression that any improvements to Respondent's practice as a result of this proceeding are because he was caught, not because he recognizes the need to provide better medical care. Respondent has exhibited no remorse It is the conclusion of this body that if given the opportunity to go back to his former patterns of personnel, office record keeping and billing, Respondent would have no hesitation to do so.

This brings the Committee to a discussion of professional ethics. Respondent does not seem to have any. One of the primary arguments presented in his closing arguments to the trier of fact is that he over-billed because the insurance industry does not pay what Respondent believes his services are worth. Respondent has placed his income over the responsible practice of medicine. In so doing, he has betrayed the trust bestowed upon him by the public, and even the insurance industry. The public has a right to rely upon physicians to accurately record

patient data and honestly submit for payment. If the amounts offered by a carrier are less than a practitioner feels is warranted, there are avenues open to the practitioner besides theft.

Respondent shows no understanding that he has committed wrongdoing. He defends his unlawful practices as justified. These facts make rehabilitation hopeless. The utter failure of Respondent to confront his deeds combined with the egregious nature of the ethical violations make the only appropriate penalty revocation.

ORDER

WHEREFORE, Based upon the foregoing facts and conclusions,

It is hereby **ORDERED** that:

53. The Factual allegations in the Statement of Charges are **SUSTAINED**

Furthermore, it is hereby **ORDERED** that;

54. The Specifications of Misconduct contained within the Statement of Charges (Appendix One) are **SUSTAINED**;

Furthermore, it is hereby **ORDERED** that;

55. The license of Respondent to practice medicine in the State of New York is **REVOKED**;

Furthermore, it is hereby **ORDERED** that;

56. This order shall take effect **UPON RECEIPT** or **SEVEN (7) DAYS** after mailing of this order by Certified Mail.

Dated:
Richmond Hill, New York

March 21 **1997**

KENNETH KOWALD, Chairperson,
KENNETH J. FREESE, M.D.
RALPH LEVY, D.O.

TO:

PAUL STEIN, ESQ.
Associate Counsel
Bureau of Professional Medical Conduct
New York State Department of Health
5 Penn Plaza
New York, New York 10001

ROBERT H. HARRIS, ESQ.
Schneider, Harris & Harris
1015 Broadway
Woodmere, New York 11598

MOON HO HUH, M.D.
8708 Justice Ave.
Elmhurst, N.Y. 11373

APPENDIX ONE

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

IN THE MATTER

OF

MOON HO HUH, M.D.

NOTICE

OF

HEARING

TO: MOON HO HUH, M.D.
Econo-Surgical Center
87-08 Justice Avenue
Elmhurst, NY 11373

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1996) and N.Y. State Admin. Proc. Act §§301-307 and 401 (McKinney 1984 and Supp. 1996). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on August 28, 1996, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the

hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1996), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, §51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a (McKinney Supp. 1996). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
July 31, 1996

/S/

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to:

Paul Stein
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2617

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

IN THE MATTER

OF

MOON HO HUH, M.D.

STATEMENT
OF
CHARGES

MOON HO HUH, M.D., the Respondent, was authorized to practice medicine in New York State on September 6, 1973 by the issuance of license number 117526 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided care and treatment to Patients B, C, D, E, F, G, H, I, J, K, L, M, and N (all patients are identified in Appendix A), as specified below in paragraphs B through N. The below allegations (A-1 through A-11) each apply individually to patients B through N.

1. Respondent employed unqualified and unlicensed assistants who took the patient's medical history, measured the patient's blood pressure, completed the patient's medical record, and monitored the patient in the recovery room.
2. Respondent failed to take and document the patient's prior anesthesia history and family anesthesia history.
3. Respondent failed to take and document the patient's weight.
4. Respondent failed to take the patient's vital signs preoperatively.
5. Respondent failed to adequately make and document a preoperative evaluation of the patient's breath and heart

sounds.

6. Respondent inappropriately administered anesthesia to the patient without the availability of qualified licensed personnel to monitor the patient's condition and handle anesthesia complications that were at risk of arising in the recovery room.

7. Respondent failed to adequately monitor the patient's vital signs in the recovery room.

8. Respondent failed to keep an adequate record for the patient, including, but not limited to, the failure to document the patient's discharge time from the recovery room.

9. Respondent knowingly and intentionally created a record for the patient that does not accurately document the patient's condition and anesthesia care.

10. Respondent knowingly and intentionally created a record for the patient that documents fictitious vital signs.

11. Respondent knowingly and intentionally falsely billed as anesthesia services the routine postoperative nursing care for the patient.

B. On or about September 26, 1992, Patient B, a 44 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat menometrorrhagia. Respondent administered anesthesia to Patient B for the procedure. Patient B's chart included a notation indicating that Patient B had reported chest pain preoperatively.

1. Respondent failed to postpone Patient B's surgery until an appropriate cardiac workup and medical clearance had been obtained.
2. Respondent failed to order an appropriate preoperative work-up for Patient B, including, but not limited to, a 12 lead ECG and a medical consultation to clear Patient B for surgery.

C. On or about November 14, 1992, Patient C, a 35 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat dysfunctional uterine bleeding. Respondent administered anesthesia to Patient C for the procedure. Patient C's chart included a notation indicating that Patient C was obese.

1. Respondent failed to make and document a preoperative evaluation of Patient C's airway.
2. Respondent failed to premedicate Patient C with antacids.
3. Respondent failed to utilize rapid induction of anesthesia with endotracheal intubation for Patient C.

D. On or about October 31, 1992, Patient D, a 27 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat an incomplete abortion. Respondent administered anesthesia to Patient D for the procedure. Patient D's chart included a notation indicating that Patient D had been bleeding heavily prior to the surgical procedure.

1. Respondent failed to determine the time of onset of Patient D's bleeding.
2. Respondent failed to determine the time of Patient D's last meal in relation to the time of the bleeding.
3. Respondent failed to establish whether or not Patient D's stomach was empty before induction of general anesthesia.

E. On or about October 24, 1992, Patient E, a 27 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat dysfunctional uterine bleeding. Respondent administered anesthesia to Patient E for the procedure. Patient E's chart included notations indicating that Patient E had been bleeding heavily prior to the surgical procedure and that Patient E had a history of chronic bronchitis.

1. Respondent failed to determine the time of onset of Patient E's bleeding.
2. Respondent failed to determine the time of Patient E's last meal in relation to the time of the bleeding.
3. Respondent failed to establish whether or not Patient E's stomach was empty before induction of general anesthesia.
4. Respondent failed to order a preoperative chest X ray of Patient E.
5. Respondent failed to order a preoperative white blood cell count for Patient E.

F. On or about October 3, 1992, Patient F, a 47 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat menometrorrhagia. Respondent administered anesthesia to Patient F for the procedure. Patient F's chart included a notation indicating that Patient F had a history of chronic bronchitis.

1. Respondent failed to order a preoperative chest X ray of Patient F.
2. Respondent failed to order a preoperative white blood cell count for Patient F.

G. On or about October 24, 1992, Patient G, a 34 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat vaginal bleeding and an abnormal pap smear. Respondent administered anesthesia to Patient G for the procedure. Patient G's chart included a notation indicating that Patient G had a history of chronic bronchitis.

1. Respondent failed to order a preoperative chest X ray of Patient G.
2. Respondent failed to order a preoperative white blood cell count for Patient G.

H. On or about September 26, 1992, Patient H, a 40 year old female, visited the Econo-Surgical Center, 87-08 Justice

Avenue, Elmhurst, New York, for a dilatation and curettage to terminate her pregnancy. Respondent administered anesthesia to Patient H for the procedure. Patient H's chart included a notation indicating that Patient H had a history of chronic bronchitis.

1. Respondent failed to order a preoperative chest X ray of Patient H.
2. Respondent failed to order a preoperative white blood cell count for Patient H.

I. On or about September 18, 1992, Patient I, a 23 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat a missed abortion. Respondent administered anesthesia to Patient I for the procedure. Patient I's chart included a notation indicating that Patient I had a history of bronchial asthma.

J. On or about November 3, 1992, Patient J, a 21 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat an incomplete abortion. Respondent administered anesthesia to Patient J for the procedure. Patient J's chart included a notation indicating that Patient J had a history of bronchial asthma.

K. On or about October 24, 1992, Patient K, a 30 year old female,

visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat an incomplete abortion. Respondent administered anesthesia to Patient K for the procedure. Patient K's chart included a notation indicating that Patient K had a history of asthma.

L. On or about September 26, 1992, Patient L, a 29 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to terminate her pregnancy. Respondent administered anesthesia to Patient L for the procedure. Patient L's chart included a notation indicating that Patient L had a history of asthma.

M. On or about October 24, 1992, Patient M, a 46 year old female, visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat dysfunctional uterine bleeding. Respondent administered anesthesia to Patient M for the procedure.

1. Respondent knowingly and intentionally falsely billed for providing anesthesia care to Patient M for part of the same time period for which he billed for providing anesthesia care to Patient N.

N. On or about October 24, 1992, Patient N, a 29 year old female visited the Econo-Surgical Center, 87-08 Justice Avenue, Elmhurst, New York, for a dilatation and curettage to treat dysfunctional uterine bleeding. Respondent administered

anesthesia to Patient N for the procedure. Patient N's chart included a notation indicating that Patient N had a history of heavy smoking.

1. Respondent knowingly and intentionally falsely billed for providing anesthesia care to Patient N for part of the same time period for which he billed for providing anesthesia care to Patient M.

O. On or about February 20, 1993, Respondent executed an Individual Application for Participation and submitted it to Group Health Incorporated, 330 West 42nd Street, New York, NY 10036. In this application, Respondent, with intent to defraud, wrote that he had an application for a hospital affiliation pending at Jackson Heights Hospital, Queens, New York and that he was affiliated with St. John's Hospital, Queens, New York, when Respondent knew these statements to be false.

SPECIFICATIONS

FIRST THROUGH FOURTEENTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2)(McKinney Supp. 1996) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

1. Paragraphs A and A9-11 in so far as they apply to Patient B.
2. Paragraphs A and A9-11 in so far as they apply to Patient C.
3. Paragraphs A and A9-11 in so far as they apply to Patient D.
4. Paragraphs A and A9-11 in so far as they apply to Patient E.
5. Paragraphs A and A9-11 in so far as they apply to Patient F.
6. Paragraphs A and A9-11 in so far as they apply to Patient G.
7. Paragraphs A and A9-11 in so far as they apply to Patient H.
8. Paragraphs A and A9-11 in so far as they apply to Patient I.
9. Paragraphs A and A9-11 in so far as they apply to Patient J.
10. Paragraphs A and A9-11 in so far as they apply to Patient K.
11. Paragraphs A and A9-11 in so far as they apply to Patient L.
12. Paragraphs A and A9-11 in so far as they apply to Patient M and paragraphs M and M-1.
13. Paragraphs A and A9-11 in so far as they apply to Patient N and paragraphs N and N-1.
14. Paragraph O.

FIFTEENTH THROUGH NINETEENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1996) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

15. Paragraphs B and B1-2, and A and A1-8 in so far as they apply to Patient B.
16. Paragraphs E and E1-5, and A and A1-8 in so far as they apply to Patient E.
17. Paragraphs F and F1-2, and A and A1-8 in so far as they apply to Patient F.
18. Paragraphs G and G1-2, and A and A1-8 in so far as they apply to Patient G.
19. Paragraphs H and H1-2, and A and A1-8 in so far as they apply to Patient H.

TWENTIETH THROUGH TWENTY-FOURTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1996) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

20. Paragraphs B and B1-2, and A and A1-8 in so far as they apply to Patient B

21. Paragraphs E and E1-5, and A and A1-8 in so far as they apply to Patient E.

22. Paragraphs F and F1-2, and A and A1-8 in so far as they apply to Patient F.

23. Paragraphs G and G1-2,, and A and A1-8 in so far as they apply to Patient G.

24. Paragraphs H and H1-2, and A and A1-8 in so far as they apply to Patient H.

TWENTY-FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1996) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

25. Paragraphs A and A1-8, B and B1-2, C and C1-3, D and D1-3, E and E1-5, F and F1-2, G and G1-2, H and H 1-2, I, J, K, L, M and N.

TWENTY-SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1996) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

26. Paragraphs A and A1-8, B and B1-2, C and C1-3, D and D1-3, E and E1-5, F and F1-2, G and G1-2, H and H 1-2, I, J, K, L, M and N.

TWENTY-SEVENTH SPECIFICATION

PERMITTING, AIDING OR ABETTING AN UNLICENSED PERSON

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(11)(McKinney Supp. 1996) by permitting, aiding or abetting an unlicensed person to perform activities requiring a license, as alleged in the facts of the following:

27. Paragraphs A and A1.

TWENTY-EIGHTH SPECIFICATION

DELEGATING PROFESSIONAL RESPONSIBILITIES

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(25)(McKinney Supp. 1996) by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them, as alleged in the facts of the following:

28. Paragraphs A and A1.

TWENTY-NINTH AND THIRTIETH SPECIFICATIONS

FAILING TO MAINTAIN A RECORD

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1996) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient as alleged in the facts of the following:

29. Paragraphs A and A2, 3, 5, and 8-11.

30. Paragraphs C and C1.

DATED: New York, New York
July 31, 1996

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct