

**DOH 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*

December 15, 1997

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Yang E. Lee, M.D.  
82 Dartmouth Street  
Forest Hills, New York 11375

David W. Smith, Esq.  
NYS Department of Health  
5 Penn Plaza - Sixth Floor  
New York, New York 10001

Arnold J. Goldstein, Esq.  
Goldstein & Goldstein  
26 Court Street-20th Floor  
Brooklyn, New York 11242

**RE: In the Matter of Yang E. Lee, M.D.**

Dear Dr. Lee, Mr. Smith and Mr. Goldstein:

Enclosed please find the Determination and Order (No.94-139R) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

A handwritten signature in black ink that reads "Tyrone T. Butler/nm". The signature is written in a cursive style with a vertical line at the end.

Tyrone T. Butler, Director  
Bureau of Adjudication

TTB:nm

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH  
ADMINISTRATIVE REVIEW BOARD FOR  
PROFESSIONAL MEDICAL CONDUCT (BOARD)

COF 7

IN THE MATTER

OF

YANG E. LEE, M.D. (Respondent)

Proceeding to review a Determination by a Hearing Committee  
(Committee) from Board for Professional Medical Conduct  
(BPMC)

ADMINISTRATIVE  
REVIEW BOARD  
DECISION AND  
ORDER NUMBER  
ARB NO. 94-139R

**BEFORE: ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D.,  
EDWARD C. SINNOTT, M.D. and WILLIAM A. STEWART, M.D.**

After a 1994 hearing into charges that the Respondent committed professional misconduct, a BPMC Committee sustained charges that the Respondent practiced with negligence on more than one occasion and ordered unwarranted tests, in treating eight patients. The Committee voted to censure and reprimand the Respondent and to place him on probation for two years, with a practice monitor. The New York State Department of Health (Petitioner) then began this proceeding, pursuant to N.Y. Pub. Health Law § 230-c(4)(a)(McKinney's Supp. 1997), and asked the Board to modify the Committee's Determination and refer the Respondent for an Evaluation and possible retraining through the Physician Prescribed Education Program (PPEP). After the Board remanded this case twice, for a PPEP Evaluation and a clarification in the Committee's findings, the Committee rendered a Supplemental Determination in July, 1997, that reaffirmed their initial Penalty Determination. The Respondent now requests that the Board modify such Penalty, because the PPEP Evaluation and the passage in time from the Respondent's misconduct demonstrate that the Respondent can practice safely and effectively and demonstrate the need for no further practice restraints on the Respondent. After reviewing the entire record, the Board votes 5-0 to sustain the Hearing Committee's Penalty, because the probation with monitoring will provide the supervision to the Respondent, that will assure that he has corrected the mistakes he displayed in treating the eight patients at issue in this case.

Administrative Law Judge **JAMES F. HORAN** served as the Board's Administrative Officer and drafted this Determination. **ARNOLD J. GOLDSTEIN, ESQ.** represented the Respondent. **DAVID W. SMITH, ESQ.** represented the Petitioner.

## CASE HISTORY TO THIS POINT

Three BPMC Members, **CONRAD ROSENBERG, M.D., Chair, RUFUS A. NICHOLS, M.D. and MORTON M. KLEINMAN** comprised the Committee who conducted the hearing in this matter and who rendered the Determinations which the Board now reviews. Administrative Law Judge **EUGENE A. GAER** served as the Board's Administrative Officer and drafted the initial Determination. Administrative Law Judge **MARC P. ZYLBERBERG** drafted the Committee's Supplemental Determination. The Committee sustained charges that the Respondent practiced below acceptable medical standards and/or ordered unwarranted treatments for eight patients, A through H. The Committee found that the Respondent acted inappropriately in ordering blood work for Patient A and in prescribing Valium and Elavil concurrently for Patients A, B and D. The Committee also found that the Respondent had no basis to order:

- sonographies for Patients B, D and F;
- pulmonary function tests for Patients F and G; or,
- the antibiotics Ceclor or Keflex for Patients E, F, G and H.

The Committee voted to censure and reprimand the Respondent and placed him on probation for two years. The probation terms required that the Respondent practice with a monitor, whom the Respondent would nominate and whom the Office for Professional Medical Conduct (OPMC) would approve.

Following the Committee's Determination, the Petitioner filed a Notice of Review and requested that the Review Board modify the Committee's Determination to require a PPEP Evaluation, and if necessary, retraining followed by two years with a practice monitor. The Respondent opposed any modification in the Committee's penalty. In our January 13, 1995 Determination in this case, the Board ordered that the Respondent undergo the PPEP Phase I Evaluation to determine whether the Respondent possessed basic medical knowledge to practice safely and effectively. We stated at that time, that because the Respondent had not testified at the hearing, we were unable to ascertain whether the Respondent's misconduct resulted from the demands associated with a busy inner-city

practice or whether the Respondent's mistakes resulted from an underlying lack of knowledge or skill. The Board found that the reason underlying the misconduct makes a difference as to whether the Respondent's deficiencies can be corrected by working with a practice monitor or whether the Respondent would need to undergo a course of retraining.

In December, 1995 the Board reviewed a November 16, 1995 PPEP Evaluation, concerning the Respondent, and determined that the Evaluation failed to answer the question which the Board posed in referring the Respondent for the Evaluation. The Board asked PPEP whether the Respondent could practice medicine safely and effectively. The PPEP Evaluation failed to discuss whether the Respondent could practice safely and effectively, but rather concluded that the Respondent is capable of benefiting from an educational program. Absent a PPEP Evaluation that indicated whether the Respondent possessed sufficient knowledge and skill to practice medicine safely and effectively, the Board remanded this case to the Committee to clarify their initial penalty. The Board asked the Committee to conduct additional deliberations and issue a Supplemental Determination, discussing whether they determined that the Respondent's pattern of substandard practice resulted from a lack of skill or knowledge or rather from the demands of an inner-city practice. The Board also asked the Committee to discuss whether a monitor would be sufficient to correct the Respondent's deficiencies or whether the more formalized retraining outlined in the PPEP Evaluation would be necessary. The Remand Order provided that the Committee could request additional information from the parties. Prior to conducting additional deliberations, the Committee asked for and received information concerning the Respondent's employment since the conduct at issue in this proceeding.

In their Supplemental Determination, the Committee again concluded that a practice monitor will provide a sanction sufficient to correct or deal with the Respondent's deficiencies and the Committee reaffirmed their earlier penalty. The Committee noted that the Respondent's refusal to testify at the original hearing left the Committee unable to determine from the record whether the Respondent's misconduct resulted from insufficient knowledge or from demands from a busy inner-city practice. The Committee found that the Respondent has worked as the House Physician in an AIDS Unit Ward at Goldwater Memorial Hospital (Goldwater) for the past seven years, delivering satisfactory and effective care. The Committee concluded that the successful employment

demonstrated that the Respondent had addressed any deficiency in skill or knowledge, if such deficiency ever existed.

### **SUPPLEMENTAL DETERMINATION REVIEW ISSUES**

The Board's 1995 Remand Order provided that either party could submit an additional brief to the Board following the Committee's Supplemental Determination. The Respondent submitted an additional brief on September 2, 1997 and the Petitioner submitted a reply on September 10, 1997. The Respondent brief argued that the information from the Staff Supervising Physicians at Goldwater demonstrated that the Respondent can practice safely and effectively and that any further restraint on the Respondent's practice would stigmatize the Respondent unreasonably and unjustly. In reply, the Petitioner asked that the Board leave the Committee's sanctions in tact, because the Goldwater information proved only that no need exists for retraining. The Petitioner contended that the Committee's sanctions remain necessary to protect the public.

### **REVIEW BOARD AUTHORITY**

In reviewing a Committee's Determination, the Board determines: whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law, and whether the Penalty is appropriate and within the scope of penalties which the law permits [N.Y. Pub. Health Law § 230(10)(i), § 230-c(4)(b)(McKinney's Supp. 1997)]. The Board may remand a case to the Committee for further consideration [N.Y. Pub. Health Law § 230-c(4)(b)(McKinney's Supp. 1997)]. The Board's Determinations result from a majority concurrence among the Board's Members [N.Y. Pub. Health Law § 230-c(4)(c)(McKinney's Supp. 1997)].

The Review Board may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 Ad 2d 86, 606 NYS 2d 381 (Third Dept. 1993), in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 AD 2d 940, 613 NYS 2d 759 (Third Dept. 1994), and in determining credibility Matter of Minielly v.

**REVIEW BOARD DETERMINATION**

The Board has considered the entire record and the parties' additional briefs. We conducted deliberations in this case on October 17, 1997. The Board sustains the Committee's Determination that the Respondent practiced with negligence on more than one occasion and/or ordered unwarranted tests in treating Patients A through H. Neither party challenged the Committee's Determination on the charges. The Board sustains the Committee's Determination to censure and reprimand the Respondent and to place him on probation, with a practice monitor, for two years.

The Board remanded this matter solely to determine whether the Respondent's practice deficiencies warranted a sanction, retraining, in addition to the Committee's Penalty. The additional information in the record demonstrates no need for retraining. We noted in our original Remand Order, that if the Respondent's misconduct resulted solely from problems arising from a busy practice, then practicing on probation, under a monitor's supervision, would provide a sufficient sanction for the Respondent's conduct [see 1994 ARB Order page 5]. The Respondent's additional brief concedes that the care at issue in this proceeding occurred at a high volume inner-city clinic [Response to Supplemental Order page 6].

The Respondent argued during the initial review in this case for the Board to sustain the Committee's Penalty. The Respondent argues now that no necessity exists for further restraints on the Respondent's practice, following his satisfactory performance in the closely controlled community at Goldwater. The Board notes that no legal restrictions limit the Respondent to practice at Goldwater and that he could leave that facility at any time.

The Board concludes that a formal probationary period, with supervision from a monitor the Respondent will nominate, will provide the necessary protection to the public and provide a sufficient sanction against the Respondent for substandard practice that exposed eight patients to unwarranted procedures and prescribed medications to some patients in inappropriate combinations.

In our 1994 Remand Order, we stated that if there were no need for retraining, the Respondent would serve on probation for three years. After reconsidering this matter, when reviewing the Committee's Supplemental Determination, we now agree with the Committee that two years probation will provide a sufficient period for the monitoring.

**ORDER**

**NOW**, based upon this Determination, the Review Board renders the following **ORDER**:

1. The Board **SUSTAINS** the Committee's Determination that the Respondent practiced with negligence on more than one occasion and ordered unwarranted tests, in treating eight patients.
2. The Board **SUSTAINS** the Committee's Determination to censure and reprimand the Respondent and to place him on probation for two years, with the Probation Terms to include the requirement that the Respondent practice with a monitor.

**ROBERT M. BRIBER**

**SUMNER SHAPIRO**

**WINSTON S. PRICE, M.D.**

**EDWARD SINNOTT, M.D.**

**WILLIAM A. STEWART, M.D.**



**IN THE MATTER OF YANG E. LEE, M.D.**

**WILLIAM A. STEWART, M.D.**, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Lee.

**DATED: Syracuse, New York**

9 Dec, 1997



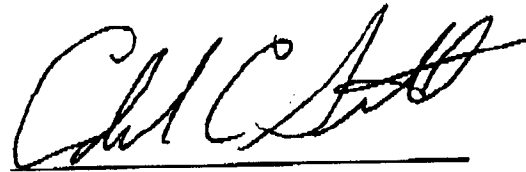
**WILLIAM A. STEWART, M.D.**

**IN THE MATTER OF YANG E. LEE, M.D.**

**EDWARD C. SINNOTT, M.D.**, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Lee.

**DATED: Roslyn, New York**

Dec 9, 1997

A handwritten signature in black ink, appearing to read "Ed C. Sinnott", written over a horizontal line.

**EDWARD C. SINNOTT, M.D.**

**IN THE MATTER OF YANG E. LEE, M.D.**

**SUMNER SHAPIRO**, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Lee.

**DATED: Delmar, New York**  
December 9, 1997

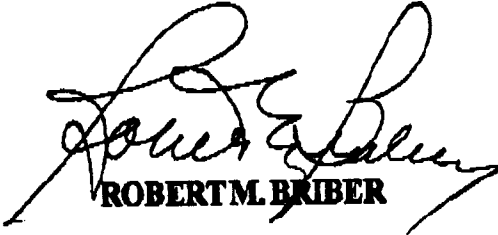
  
SUMNER SHAPIRO

**IN THE MATTER OF YANG E. LEE, M.D.**

**ROBERT M. BRIBER**, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Lee.

**DATED: Schenectady, New York**

**12/10/97**

  
**ROBERT M. BRIBER**