STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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

January 7, 1997

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

Paky Huang, M.D.
151 Hudson Terrace
Yonkers, New York 10701

RE: In the Matter of Paky Huang, M.D.

Dear Mr. Smith and Dr. Huang:

Enclosed please find the Determination and Order (No.96-222) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm

Enclosure

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

COPY

IN THE MATTER

OF

PAKY HUANG, M.D.

Administrative Review from a Determination by a Hearing Committee on Professional Medical Conduct

ADMINISTRATIVE REVIEW BOARD DETERMINATION ARB NO. 96-222

In this proceeding pursuant to New York Public Health Law (PHL) §230-c(4)(a) (McKinney's Supp 1996), **DR. PAKY HUANG** (Respondent) asks the Administrative Review Board for Professional Medical Conduct (Board) to review and overturn a Determination by a Hearing Committee on Professional Medical Conduct (Committee), which found that the Respondent committed repeated and serious professional misconduct and which revoked the Respondent's license to practice medicine in New York State. After reviewing the record in this case and conducting Deliberations on November 22 and December 13, 1996, Board Members **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] vote to sustain the Committee's Determination that the Respondent committed professional misconduct in violation of N.Y. Education Law (E L) §6530 and to sustain the Committee's Determination revoking the Respondent's medical license. The Board discusses our Determination in greater detail after we summarize the Committee's Determination on the charges, the issues for review and the Board's review authority.

Administrative Law Judge **JAMES F. HORAN** served as the Board's Administrative Officer and drafted this Determination.

The Respondent represented himself in this proceeding.

David Smith, ESQ. (Associate Counsel, NYS Department of Health) represented the New

[1] Dr. Price did not participate in the Deliberations on November 22nd. Dr. Stewart and Dr. Sinnott participated in the November 22nd Deliberations by telephone conference. Dr. Stewart and Mr. Shapiro participated in the December 13th Deliberations by telephone Conference.

York State Department of Health (Petitioner).

COMMITTEE DETERMINATION ON THE CHARGES

In proceedings under PHL §230(7), three member panels from the State Board for Professional Medical Conduct (BPMC) conduct disciplinary hearings to determine whether physicians have committed professional misconduct in violation of EL §6530. The Petitioner filed charges with BPMC alleging that the Respondent committed misconduct in providing treatment to four patients at the Creedmoor Psychiatric Institute (Creedmoor) in Queens, New York. The record refers to the patients by the initials A through D to protect the Patients' privacy. The Petitioner's Statement of Charges (Pet 1)[2] alleges that the Respondent violated:

- EL §6530(3) by practicing with negligence on more than one occasion in treating Patients A - D;

- EL §6530(5) by practicing with incompetence on more than one occasion in treating Patients A-D;

- EL §6530(4) by practicing with gross negligence in treating Patient A; and,

- EL §6530(32) by failing to maintain accurate records for Patients A - D.

Three BPMC Members, **KENNETH KOWALD (Chair), RALPH LUCARIELLO, M.D. and ADRIAN EDWARDS, M.D.** comprised the Committee who conducted the hearing in the matter and who rendered the Determination which the Board now reviews. Administrative Law Judge **MARY NOE** served as the Committee's Administrative Officer. The Committee found that the Respondent:

- failed to take immediate action and consult a surgeon when Patient A swallowed a metal utensil and failed to note any evaluation on the Patient's medical record;

- failed to order necessary tests for Patient B or monitor Patient B;

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[2] Pet 1 indicates Petitioner's Exhibit 1

- failed to perform an adequate medical examination and note such examination for Patient C;

- failed to treat Patient C for stiffness in the neck;

- ordered an abdominal X-ray for Patient D, who was pregnant;

- failed to follow-up a pregnancy test on Patient D;

- failed to diagnose Patient D as pregnant; and,

- failed to order proper tests on Patient D, such as a sonogram, when suspicions pointed to an ovarian cyst.

In reaching their findings, the Committee relied on testimony by the Petitioner's expert witness, Dr. Tamarin, and on medical records from Creedmoor, although the Committee found the records incomplete. The Committee found, however, that the Respondent had the opportunity throughout the Hearing to obtain complete records from Creedmoor, but failed to do so. The Committee expressed concern over the care standard and record keeping at Creedmoor.

The Committee concluded that the Respondent:

- treated Patient A in a grossly negligent manner;

- treated Patient C in a manner below minimum medical care standards; and,

- practiced outside accepted medical standards in taking an abdominal x-ray on Patient D.

The Committee voted to revoke the Respondent's license to practice in New York State.

REVIEW HISTORY AND ISSUES

The Respondent filed a Notice requesting this review, which the Board received on October 7, 1996. The Record for review contained the Committee's Determination, the hearing transcripts and exhibits, the Respondent's brief and the Petitioner's reply brief. The Board received the Respondent's brief on November 4, 1996. The Respondent failed to provide copies of his brief to the Petitioner. After receiving a copy of the Respondent's brief from the Board's Administrative Officer, the Petitioner's attorney filed a reply brief which the Board received on November 18, 1996.

The Respondent also sought to submit additional material (a letter from the Respondent's wife and a letter from a Brooklyn physician) to the Board in addition to his brief. The Board reviewed only the record from the Hearing and the parties' briefs.

The Respondent's brief argues that Creedmoor is a psychiatric rather than a general hospital and that the Respondent cared for patients by group rather than on an individual service. The Respondent challenges several findings by the Hearing Committee and argues that the Committee found the Respondent guilty for conduct for which others bore responsibility. The Respondent also argues that Creedmoor failed to provide the Respondent with records that the Respondent needed for his case.

The Petitioner requests that the Board dismiss the Respondent's appeal because the Respondent has failed to perfect his appeal. In the alternative, the Petitioner requests that the Board sustain the Committee's Determination because the Respondent fails to argue that the Committee made inconsistent Findings and Determinations and because the Respondent failed to show any error in the Committee's Penalty.

THE BOARD'S REVIEW AUTHORITY

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration. Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

The Review Board may substitute our judgement for that of the Hearing 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. Comm. of Health** 222 AD 2d 750, 634 NYS 2d 856 (Third Dept. 1995).

THE BOARD'S DETERMINATION

The Board has considered the record below and the parties' briefs. First the Board will address the procedural issues that both parties raised. We reject the Petitioner's request that we dismiss the Respondent's case for failure to perfect his appeal. Although the Respondent's failure to provide a copy of his brief to the Petitioner may constitute grounds for the Board to dismiss this review under recent PHL amendments (Chapter 627, Laws of New York 1996), the Board notes that the Respondent had no assistance by an attorney in preparing for this case and we find no prejudice to the Petitioner, because the Petitioner received a copy of the Respondent's brief in time to file a reply brief with the Board. The Board concludes that the Respondent's challenges to certain procedures at his hearing, such as the failure to obtain full records from Creedmoor, constitute legal issues which the Respondent should raise with the Courts. Although the Board may remand a case to the Committee for further proceedings [PHL §230-c(4)(c)], we find no reason to remand the Respondent's case. The Board agrees with the Hearing Committee that the Respondent had ample opportunity to obtain records from Creedmoor to assist in the Respondent's case preparation.

The Board sustains the Committee's Determination finding the Respondent guilty for professional misconduct. We modify that Determination, however, and amend the Committee's conclusions, which we find to be incomplete. We sustain the Committee's Conclusion 1 that the Respondent practiced with gross negligence in treating Patient A. We amend the Committee's Conclusion 2 concerning Patient C. The Committee concluded that the Respondent failed to treat Patient C within minimum medical care standards. The Committee, however, cited to Fact Findings (Findings)11 to 23 to support that conclusion. Although Findings 18 to 23 support the Committee's Conclusion on Patient C, Findings 11 to 17 relate to treatment for Patient B. The Board, therefore, amends the Committee's Conclusion 2 to delete reference to Findings 11 to 17. The Committee's Conclusion 3 cites directly to Transcript Page 171 to support their Conclusion that the Respondent

failed to provide acceptable care to Patient D. The Board adopts that Conclusion as an additional Finding as to Patient D. We also note that the Committee's Findings 27 to 29 support a determination that the Respondent failed to provide acceptable care to Patient D, by failing to follow up a pregnancy test, diagnose the Patient as pregnant and order proper tests when suspicions pointed to an ovarian cyst.

The Board notes that the Committee made no conclusions concerning the care for Patient B and no conclusions relating to charges that the Respondent practiced with incompetence on more than one occasion and failed to maintain accurate records. The Board concludes that the Committee's Findings 10, 17 and 20 - 22 support a conclusion that the Respondent failed to prepare accurate medical records for Patients A, B and C. The Board concludes that the Committee's Findings 8, 10, 28 and 29 demonstrate that the Respondent practiced with incompetence on more than one occasion in treating Patients A and D, because these Findings demonstrate that the Respondent failed to treat or follow up Patient A's condition in a timely fashion and that the Respondent failed to diagnose or order proper tests for Patient D. The Board concludes further that the Committee's Findings 13 and 16 demonstrate that the Respondent failed to provide acceptable medical treatment to Patient B, because the Respondent failed to test or properly monitor that Patient. The Board's conclusions on Patients B and D together with the Committee's Conclusions on Patients A, C and D demonstrate that the Respondent practiced with negligence on more than one occasion in treating Patients A to D.

In making our conclusions and in sustaining and modifying the Committee's, the Board rejects the Respondent's challenges to the Committee's Findings. The testimony by the Petitioner's expert Dr. Tamarin and the records in evidence provided the Committee with the proof to make their Findings. Any conflicting evidence which the Respondent introduced raised a factual question for the Committee, as fact finder, to resolve. We also reject the Respondent's contention that a different care standard existed at Creedmoor. Certain basic medical standards exist in this State which physicians must meet in providing patient care. The Respondent failed to meet those standards in providing care to Patients A to D.

The Board sustains the Committee's Determination revoking the Respondent's license to practice medicine in New York State. The Board concludes that the Respondent demonstrated

repeated and serious deficiencies in his medical practice, he placed patients at risk and he demonstrated an indifference to his patients. The Board concludes further that the Respondent constitutes a danger to the public health in general and specifically to those patients least able to speak for themselves, such as the Patients whom the Respondent treated at Creedmoor. Nothing in this record indicates that the Respondent possesses any insight into his deficiencies or any motivation or ability to change his practice or correct his deficiencies. For that reason the Board finds no grounds on which to consider a retraining program for the Respondent.

We join with the Committee in expressing concern for the patients at Creedmoor, after reviewing the record concerning the practice standards at Creedmoor. The Board finds that those standards constitute no excuse for the Respondent's failure to fulfill his own professional responsibilities. The Board directs the Petitioner, however, to provide copies of this Determination and the Committee's Determination to the Office of Mental Health to assure that the Office will continue to work toward improving care for patients at Creedmoor.

ORDER

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

1. The Board **SUSTAINS** the Hearing Committee's September 24, 1996 Determination finding the Respondent guilty for professional misconduct, except that the Board modifies the Committee's findings on misconduct, as we discuss in the attached Determination.

2. The Board **SUSTAINS** the Hearing Committee's Penalty revoking the Respondent's license to practice medicine in New York State.

3. The Board **DIRECTS** the Office of Professional Medical Conduct to provides copies of this Determination and the Hearing Committee's Determination to the New York State Office of Mental Health for the reasons that we discuss in the attached Determination.

ROBERT M. BRIBER

SUMNER SHAPIRO

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF PAKY HUANG, 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. Huang.

DATED: Schenectady, New York

1/2, 1997

ROBERT M. BRIBER

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

DATED: Delmar, New York

Dec. 31, 1996

SUMNER SHAPIRO

IN THE MATTER OF PAKY HUANG, 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 Huang

DATED: Roslyn, New York
Dec 31, 1996

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF PAKY HUANG, 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. Huang.

DATED: Syracuse, New York
31 Dec, **1996**

William A Stewart

WILLIAM A. STEWART, M.D.