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

September 24, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David Smith, Esq.
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza - 6th Floor
New York, New York 10001

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

Effective Date: 10/01/96

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

Dear Mr. Smith and Dr. Huang:

Enclosed please find the Determination and Order (No. BPMC-96-222) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

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 all action 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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

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

COPY

IN THE MATTER

OF

PAKY HUANG, M.D.

DETERMINATION

AND

ORDER

No. BPMC-96-222

The undersigned Hearing Committee consisting of **KENNETH KOWALD**, Chairperson, **RALPH LUCARIELLO M.D.**, and **ADRIAN EDWARDS M.D.**, were duly designated and appointed by the State Board for Professional Medical Conduct. **MARY NOE, ESQ.** (Administrative Law Judge) served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 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 **PAKY HUANG 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.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	March 11, 1996
Pre-Hearing Conferences:	April 15, 1996
Hearing dates:	April 30, 1996 June 4, 1996
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Date of Deliberation:	August 21, 1996
Petitioner appeared by:	Henry M. Greenberg, General Counsel NYS Department of Health By: David Smith, Esq. Assistant Counsel

Respondent appeared pro se with his wife, Mrs. Huang

WITNESSES

For the Petitioner:
Steven Tamarin

For the Respondent:
Paky Huang, M.D., the Respondent

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with acceptable standards of medical practice in this State. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious means a conspicuously bad act or severe deviation from standards.

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.

Inaccurate record keeping was defined as a failure to keep records which accurately reflect the evaluation and treatment of a patient. The standard applied would be whether a substitute or future physician or reviewing entity could review a given chart and be able to understand Respondent's course of treatment and basis for same.

FINDINGS OF FACT

The following findings of fact were made after review of the entire record. Numbers in parenthesis (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at 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. The Petitioner was required to meet the burden of proof by a preponderance of the evidence. All findings of fact made by the Hearing Committee were established by at least a preponderance of the evidence. All findings and conclusions herein were unanimous unless otherwise noted.

GENERAL FINDINGS

1. Paky Huang, M.D., Respondent, was authorized to engage in the practice of medicine in the State of New York, on by the issuance of license number by the New York State Education Department (Pet. Ex. 2)

FINDINGS OF FACT WITH REGARD TO PATIENT "A"

2. Between January 6, 1987 and January 9, 1987 Patient A was a patient of Dr. Huang at Creedmore Psychiatric Institute, Queens, N.Y. (Ex. 3, Resp. A)

3. Patient A had a history for swallowing metal and for self-abusing behavior (Ex. 3 p. 27, T. 32)

4. The Respondent failed to note as to whether he performed a physical exam on Patient A. (T 30)

5. According to Patient's A medical record, on January 6, 1986, the Nurse's note states that Patient A complained of pain in the right side and was seen by the Respondent (Ex. 3 p 36, Resp. A)

6. According to Patient A's medical record, on January 6, 1986 the Respondent ordered an abdominal x-ray (T. 27; Ex. 3, p. 37)

7. On January 7, 1986,Patient A's medical record states that Patient A had swallowed a metal utensil such as a knife tip. (Ex. 3 p. 39-40)

8. The Respondent failed to take immediate action and consult with a surgeon. (T 61)

9. Although results of the x-ray were available on January 7, 1986, no action was taken by the Respondent till January 9, 1986. (Ex. 3, p. 30, 31)

10. The Respondent did not adequately evaluate. treat or follow up Patient A's condition in a timely fashion and failed to note any evaluation on the Patient's medical record. (T 32, 36, 40, 42, 48, 51, 60, 61)

FINDINGS OF FACT WITH REGARD TO PATIENT "B"

11. On or about June 1992 and January 1993, Patient B was a patient of the Respondent (Ex. 4).

12. Patient B was a 52 year old male who was HIV positive with a low T cell count. (T 81)

13. The Respondent failed to take a CBC test on Patient B between June 11, 1992 and January 20, 1993 (T 82).

14. Blood count monitoring including T cells count is essential in treating HIV positive patients who will be treated with a toxic drug such as AZT (T 83).

15. On March 24, 1993 Alan Diner, MD, Interim Directive Medicine at Creedmore wrote to the Respondent and found the Respondent's "... care of the above patient [Patient B] to be less than standard." (T 83, 84; Ex. 4a)

16. The Respondent knew Patient B was on AZT but failed to monitor Patient B or note such monitoring (T 87, 92, 124).

17. The Respondent failed to maintain medical records on Patient B between December 1992 and January 1993. (Ex. 4)

FINDINGS OF FACT WITH REGARD TO PATIENT "C"

18. Between July 6, 1984 and July 9, 1984, Patient C was a patient of the Respondent. (Ex. 5)

19. Respondent failed to perform an adequate physical examination or note such examination in the Patient's chart (Ex. 5, T 138, 139)

20. Patient C's Physical Examination chart is blank except for one sentence regarding Patient C's dementia and one sentence as to heart and lungs. (Ex. 5)

21. The Respondent failed to note vital signs, patient's history, summary and all other required information on the Physical Examination chart. (Ex. 5 p. 1)

22. On July 8, 1984, the Respondent notes that Patient C had stiffness of neck on July 6, 1984 but failed to note same in the Patient's Physical Examination chart of July 6, 1984. (T. 139, T. 140)

23. The Respondent failed to treat the Patient's condition of stiffness of neck after such evaluation. (T 139)

FINDINGS OF FACT WITH REGARD TO PATIENT "D"

24. On April 18, 1989 the Respondent ordered a pregnancy test for Patient D. (Ex. 6)

25. Patient D was seen by the Respondent on May 3, 1989. The Respondent noted on the Patient's chart that the Patient had diarrhea, vomiting and the absence of menstruation along with a 10 to 15 centimeter soft mass in the right lower quadrant of the abdomen (Ex. 6; T 158).

26. The Respondent ordered an abdominal x-ray (T 159).

27. The Respondent failed to follow up the results of the Patient's pregnancy test (T 159).

28. The Respondent failed to diagnose the Patient as pregnant (T 159).

29. The Respondent failed to order proper tests, such as a sonogram in light of a suspicion of an ovarian cyst. (T 159).

DETERMINATION OF THE HEARING COMMITTEE

Paragraph A.1. is **SUSTAINED**

Paragraph A.2. is **SUSTAINED**

Paragraph B.1. is **SUSTAINED**

Paragraph B.2. is **SUSTAINED**

Paragraph B.3. is **NOT SUSTAINED**

Paragraph C.1. is **SUSTAINED**

Paragraph C.2. is **SUSTAINED**

Paragraph C.3. is **NOT SUSTAINED**

Paragraph C.4. is **SUSTAINED**

Paragraph D.1. is **SUSTAINED**

Paragraph D.2. is **NOT SUSTAINED**

Paragraph D.3. is **SUSTAINED**

Paragraph D.4. is **SUSTAINED**

DISCUSSION

The Panel members found Dr. Tamarin's testimony to be credible as to the medical records he reviewed. However, the Panel notes that the medical records on each Patient were not the complete medical records for the Patients despite the first page declaration from Creedmore State Hospital stating that the records were complete. The Respondent raised the issue of

incomplete records at several times during the hearing. However, the Respondent had every opportunity to obtain these records and failed to do so.

During the course of the hearing, the Hearing Committee became increasingly concerned about the standard of care of patients and the record-keeping of the Creedmore Psychiatric Institute. While the matters before the panel ranged from those more than 10 years ago, the most recent case was in January, 1993. The Panel would like to be assured that its concerns regarding Creemoor are allayed, not only by current practice, but by future practice which will assure that patient care and record keeping are at, the very least up to acceptable standards. The patients in this institution are among those least able to speak for themselves and we feel it incumbent upon us to make this statement for them.

The Panel also notes that the Respondent had a problem communicating in English and we permitted Mrs. Huang to assist at every opportunity.

Finally, the Respondent chose to represent himself without counsel at these hearings. Both the Administrative Law Judge and the Panel provided information regarding the procedure of the hearings and gave the Respondent great latitude as to cross-examination and in representing himself.

CONCLUSIONS

1. The Respondent's treatment of Patient A was grossly negligent. (Findings of Fact 1-10)

2. The Respondent's failure to evaluate and treat Patient C was below the minimum standard of medical care. (Findings of Fact 11-23)

3. An abdominal x-ray of Patient D's abdomen when she was 18 months pregnant is not accepted medical practice (T 171).

The Hearing Committee unanimously determines that the Respondent's license to practice medicine in the state of New York should be **REVOKED**.

ORDER

Based upon the foregoing, **IT IS ORDERED THAT:**

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

DATED: Albany, New York
September 23, **1996**

KENNETH KOWALD, CHAIRPERSON

RALPH LUCARIELLO, M.D.
ADRIAN EDWARDS, M.D.

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

IN THE MATTER OF PAKY HUANG, M.D.	STATEMENT OF CHARGES

PAKY HUANG, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 30, 1981, by the issuance of license number 148249 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Between on or about January 6, 1987 and on or about January 9, 1987, Respondent treated Patient A for abdominal pain and other medical conditions at Creedmoor Psychiatric Institute, Queens, New York. (All patients are identified in the Appendix attached hereto)

1. Respondent failed to perform an adequate physical examination on Patient A or note such examination, if any.

2. Respondent knew Patient A had swallowed a knife. Nevertheless, Respondent failed to adequately evaluate, treat or follow-up such condition in a timely fashion or note such evaluation, follow-up or treatment, if any.

B. Between in or about June, 1992 and in or about January, 1993, Respondent treated Patient B for AIDS and other medical conditions at Creedmoor Psychiatric Institute, Queens, New York.

1. Respondent knew Patient B was on AZT but nevertheless failed to perform adequate clinical monitoring of him or note such monitoring, if any.

2. Although Respondent was treating Patient B between December, 1992 and January, 1993, Respondent failed to maintain a record for such treatment.

3. In January, 1993, Patient B contracted pneumonia but Respondent failed to adequately evaluate, follow-up or treat such condition or note such evaluation, follow-up or treatment, if any.

C. Between on or about July 6, 1984 and on or about July 9, 1984, Respondent treated Patient C for dementia and other medical conditions at Creedmoor Psychiatric Institute, Queens, New York.

1. Respondent failed to perform an adequate physical examination or note such examination, if any.

2. Respondent failed to obtain an adequate medical history or note such history, if any.

3. Patient C had a prior medical record at Creedmoor but Respondent failed to review it or note such review, if any.

4. Upon admission to the facility Respondent noted that Patient C presented with rigidity and the beginning of a slow rhythm of deep mandibular breathing. Nevertheless, Respondent failed to adequately evaluate, follow-up or treat such condition or note such evaluation, follow-up or treatment, if any.

D. In or about April, 1989 and May, 1989, Respondent treated Patient D for diarrhea and other medical conditions at Creedmoor Psychiatric Institute, Queens, New York.

1. On or about April 8, 1989 Respondent ordered a urine pregnancy test but failed to adequately evaluate or follow-up the results of such test or note such evaluation or follow-up, if any.

2. On or about May 17, 1989, Respondent order a pregnancy test but failed to adequately evaluate or follow-up the results of such test or note such evaluation or follow-up, if any.

3. Patient D was, in fact, pregnant but throughout the period Respondent failed to make this diagnosis.

4. Respondent inappropriately diagnosed Patient D with an intestinal obstruction or ovarian cyst but, nevertheless, failed to adequately evaluate or follow-up such diagnosis or note such

evaluation or follow-up, if any.

SPECIFICATION OF CHARGES

FIRST 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.) 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:

1. Paragraphs A and A1-2; B and B1-3; C and C1-3; and/or D and D1-4.

SECOND 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. 1995) 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:

between on or about January 6, 1987 and on or about January 9, 1987

2. Paragraphs A and A1-2; B and B1-3; C and C1-3; and/or D and D1-4.

THIRD SPECIFICATION

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1995) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. Paragraphs A and A1-2.

FOURTH THROUGH SEVENTH SPECIFICATIONS

FAILING TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1995) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patients as alleged in the facts of the following:

4. Paragraphs A and A1-2.
5. Paragraphs B and B1-3.
6. Paragraphs C and C1-3
7. Paragraphs D and D1, 2, and 4.

DATED: March 11, 1996
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct