STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

February 24, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building
Scarsdale, New York 10583

Jung & Sang, Han, M.D.
75 Briarcliff Road
Staten Island, NY 10305

David W. Smith, Esq.
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001-1810

RE: In the Matter of Jung and Sang Han, M.D.

Dear Mr. Scher, Mr. Smith and Drs. Han and Han:

Enclosed please find the Determination and Order (No. BPMC-93-29) of the Hearing Committee 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
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 than 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), "(t)he 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
Corning Tower - Room 2503
Empire State Plaza
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.

Very truly yours,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTERS	:	DETERMINATION AND
OF	:	ORDER OF THE
JUNG HAN, M.D.	:	HEARING COMMITTEE
AND	:	ORDER NOS.
SANG HAN, M.D.	:	BPMC-93-29 BPMC-93-31

The undersigned Hearing Committee consisting of **ROBERT J. O'CONNOR, M.D., Chairperson, ALBERT B. ACCETTOLA, Jr., M.D.,** and **MORTON M. KLEINMAN,** was duly designated and appointed by the State Board for Professional Medical Conduct. **JONATHAN M. BRANDES, Administrative Law Judge,** served as Administrative Officer.

The hearing was conducted pursuant to the provisions of section 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 **JUNG HAN, M.D., and SANG HAN, M.D.** 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 PROCEEDINGS

Original Notice of Hearing and Statement of Charges dated:	May 14, 1992
Location of Hearing:	5 Penn Plaza New York, NY 10001
Respondents' Answer Served:	None
The State Board for Professional Medical Conduct appeared by:	David W. Smith, Esq. Assistant Counsel Bureau of Professional Medical Conduct 5 Penn Plaza New York, N.Y. 10001
Respondents appeared in person and were represented by:	Wood and Scher The Harwood Building Scarsdale, New York 10583 Anthony Z. Scher, Esq., of Counsel
Respondents' Present Mailing Address:	75 Briarcliff Road Staten Island, New York 10305
Hearings Held on:	July 13, 1992 August 4, 27 and 28, 1992 September 30, 1992 October 5 and 6, 1992 November 10, 1992
Conferences Held On:	June 29, 1992 October 5, 1992 November 10, 1992
Closing Briefs Received:	December 30, 1992
Record Closed:	December 30, 1992
Deliberations Held:	January 5, 1993

NOTE: Respondents waived the 60 day time limit set forth in §230(10)(h) of the Public Health Law.

SUMMARY OF PROCEEDINGS

This Determination and order refers to two separate proceedings against two separate physicians. The proceedings were joined because the charges involve three patients, two of whom were seen and treated by both Respondents. As it so happens, the Respondents happen to be husband and wife, which is peripherally relevant, as will be seen.

There is one identical factual basis for the charges against each of the two physicians. Hence, there will be only one recitation of the facts for each of the three patients. However, since each Respondent is charged separately, there will be a separate analysis of the charges against each Respondent.

The two Statements of Charges allege Respondents have committed gross negligence, negligence on more than one occasion and incompetence on more than one occasion. Respondents are also charged with fraud and the failure to keep patient records in a manner required by law. The allegations arise from treatment of three patients between 1987 and 1990. The allegations are more particularly set forth in the Statements of Charges which are attached hereto as appendices I and II.

The State Board for Professional Medical Conduct (hereinafter referred to as "The State") called Stanley Wittenberg, M.D. as its sole witness. Dr. Wittenberg testified as an expert witness.

Respondents testified on their own behalves and called these witnesses:

Marlon Seliger, M.D.	Expert Witness
Iris F. Nostrand, M.D.	Expert Witness
Alexander Mouskop, M.D.	Expert Witness
Richard Blum, M.D.	Expert Witness

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 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. Gross incompetence was similarly 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.

With regard to the expert testimony herein, including

Respondents', 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 instructed that fraudulent practice constituted an intentional misrepresentation or concealment of a known fact. The Committee was further instructed that the intent and knowledge of a Respondent could be inferred from other facts established in the record.

Finally, 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 entity could read a given chart and be able to understand a practitioner's course of treatment and the basis for same.

The findings of fact in this decision were made after review of the entire record. Numbers in parenthesis, refer to transcript pages in the transcript of the proceeding or to exhibits 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 State 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 OF FACT

1. The Respondent, Jung Han, M.D., was authorized to practice medicine in New York State on May 1, 1981 by the issuance of license number 145890 by the New York State Education Department (Exhibit No. 1, Statement of Charges - Jung Han, M.D., Exhibit No. 2B).

2. Dr. Jung Han is currently registered with the New York State Education Department to practice medicine for the period of January 1, 1991 to December 31, 1992 (Exhibit No. 1, Statement of Charges - Jung Han, M.D., Exhibit No. 2B).

3. The Respondent, Sang Han, M.D. was authorized to practice medicine in New York State on August 27, 1982 by the issuance of license number 131423 by the New York State Education Department (Exhibit No. 1, Statement of Charges - Sang Han, M.D., Exhibit No. 2A).

4. Dr. Sang Han is currently registered to practice medicine for the period of January 1, 1991 to December 31, 1992 (Exhibit No. 1, Statement of Charges - Sang Han, M.D., Exhibit No. 2A).

5. Dr. Jung Han specializes in neurology and psychiatry (176 - 178; Exhibit A).

6. Dr. Jung Han has practiced in the hospital setting as a psychiatrist and she has practiced privately in neurology,

neurophysiology and psychiatry (180 - 181; Exhibit A). She is affiliated with Staten Island University Hospital, St. Vincent's Medical Center of Richmond, Doctors' Hospital of Staten Island, Bayley Seton Hospital and Richmond Memorial Hospital (181 - 182; Exhibit A).

7. Dr. Sang Han received his medical education in Korea and performed a one year internship under the auspices of the Korea University Medical School (618-619).

8. After emigrating to the United States, Dr. Sang Han performed a three year residency in radiation oncology at Ellis Fisher Hospital in Columbia, Missouri (619).

9. From July 1979 to June 1980, Dr. Sang Han trained in pathology at Jamaica Hospital in Queens, New York (619).

10. From July 1980 to June 1983, Dr. Sang Han performed a surgical residency at Long Island College Hospital in Brooklyn, New York. The training program was not completed because the residency program was discontinued (619).

11. Dr. Sang Han practices primarily at the International Longshoreman's Association Medical Center as a staff physician. In addition, he sees a few private patients at his home office either at night or on weekends (620-621).

12. Dr. Sang Han had experience in prescribing controlled drugs in Korea, during his training in radiation and oncology and during his surgical residency (621-623).

13. In his current, small private practice, Dr. Sang Han sees patients at the office space used by his wife (624).

FINDINGS OF FACT WITH REGARD TO PATIENT A

14. Patient A was first seen by Dr. Jung Han on August 26, 1986 at St. Vincent's Medical Center of Richmond (the "Hospital") (183 - 184; Exhibit B).

15. Patient A had been hit by a steel beam in a work related accident which took place on September 4, 1984 (185 - 186; Exhibit No. 41, Exhibit B).

16. Subsequent to September 4, 1984, Patient A saw several physicians in different specialties all relating to the disabling injury that he suffered (Exhibit No. 41).

17. Patient A's injuries were broad in scope and quite severe. Among other things, he had exhibited chronic back pain since September 1984. This pain sometimes lasted all day; he had exhibited numbness in his right hand and arm; impaired urination requiring self-catheterization; loss of erection; and fractured vertebrae (187 - 189; Exhibit No. 41; Exhibit B).

18. While Patient A was in the Hospital in August, 1986, Dr. Jung Han took a medical history for Patient A and performed a neurological examination (184; Exhibit B).

19. Subsequent to discharge Patient A began coming to Dr. Jung Han's medical office where he was followed through June, 1989. The precise date of his initial visit could not be ascertained from the exhibits and other testimony (191; Exhibit No. 3; Exhibit C).

20. Dr. Jung Han obtained an adequate general history and performed a neurological examination of Patient at the Hospital.

These were included in her Discharge Summary for Patient A (Exhibit B).

21. A copy of the Discharge Summary was forwarded to Dr. Jung Han's office (192). The Discharge Summary became part of Dr. Jung Han's office record for Patient A (192).

22. The primary treatment rendered by Dr. Jung for Patient A was pharmacological. In addition, various tests were performed, consultations were recommended and physical therapy was prescribed (220 - 224; Exhibit No. 3, Exhibit C).

23. Sometime in 1986, Dr. Jung Han received a medical report on Patient A written by Dr. William Head. Dr. Head's medical report was incorporated into and became part of Dr. Jung Han's office record on Patient A (226; Exhibit No. 41).

24. During 1986, Patient A was receiving Percocet, Percodan, Darvocet, Tylenol #4, Robaxin, Valium, Xanax, Flexeril and Demerol from various treating physicians (230-231; Exhibit No. 41).

25. There came a time when Patient A reported that the various medications prescribed by Dr. Jung Han were insufficient by themselves to relieve his symptoms. The patient requested percocet with which he had success in the past. Dr. Jung Han asked her husband Dr. Sang Han, to evaluate Patient A and prescribe percocet if warranted. Dr. Jung Han made her records available to Dr. Sang Han for this evaluation (231-232).

26. Dr. Sang Han prescribed Percocet for Patient A on numerous occasions including but not limited to March 22, 1987,

April 14, 1987, May 21, 1987 and August 22, 1988 (Exhibit Nos. 5, 8, 9, 10 and 11).

27. Dr. Jung Han prescribed no Percocet for Patient A at any time (231, 269-270).[1]

28. During the period identified in the Statement of Charges (June, 1987 - April, 1989), Dr. Jung Han prescribed chloral hydrate for Patient A on two occasions -- August 18, 1987, and September 15, 1987 (Exhibit No. 3, pp. 17 and 19).

29. During the period identified in the Statement of Charges, Dr. Jung Han prescribed Xanax for Patient A on five occasions -- December , 1987, April 1988, September , 1988, December , 1988 and March 1989 (Exhibit No. 3, pp. 2, 6, 9, 14 and 15).

29. Dr. Jung Han prescribed Valium for Patient A on numerous occasions during the period identified in the Statement of Charges (Exhibit No. 3, Exhibit C).

30. Dr. Sang Han prescribed chloral hydrate (Noctec) for Patient A on one occasion, September 28, 1987 (Exhibit No. 30).

31. Dr. Sang Han prescribed Xanax for Patient A on two occasions, August 24, 1987 and September 28, 1987 (Exhibit Nos. 28 and 31).

32. On or about September 29, 1987, Patient A was admitted to the Hospital due to an overdose of multiple medications (225-

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[1] The one or two references to Percocet in Dr. Jung Han's records refer to Percocet which was still being prescribed by Dr. Post or being prescribed by Dr. Sang Han (Exhibit No. 3, p. 3, 21, and 24).

256; Exhibit No. 33).

33. Patient A was discharged from the Hospital a few days later (Exhibit No. 33, Exhibit B). It was concluded by Dr. Jung Han and by the psychiatrist who saw Patient A in consultation that he was not suicidal (256 - 257; Exhibit B, Exhibit No. 33).

34. Following Patient A's discharge from the Hospital, Dr. Sang Han continued to prescribe Percocet for Patient A (276, 635; Exhibit No. 5).

35. Dr. Jung Han submitted bills to Workers' Compensation seeking payment for medical care for Patient A for September 4, 1986, October 14, 1986, December 1, 2 and 3 1986, April 14, 1987, May 1, and 3, 1987, June 27, 1987 and December 19, 1987 (Exhibit Nos. 13, 14, 15, 16, 17 and 18).

36. Dr. Jung Han submitted a bill to Medicare seeking payment for medical services rendered to Patient A for June 9, 1989 (Exhibit No. 19).

CONCLUSIONS REGARDING JUNG HAN, M.D.

AND

PATIENT A

In allegation A.1 the State charges Dr. Jung Han with a failure to obtain and note an adequate medical history. The Committee finds, that while it is true Respondent did not obtain such a history when she saw Patient A in her office, she did obtain such a history when Patient A was in the hospital. This hospital history became a part of Dr. Jung Han's total office record and thus it was unnecessary for Dr. Jung Han to note a

separate history in her office charts. As for the history itself, the Committee finds it contained a chief complaint, a current complaint, a review of symptoms and a social history. All in all, the history was sufficient for Respondent Jung Han's purposes. Accordingly:

Allegation A.1 is **NOT SUSTAINED**

With regard to allegation A.2, here the State alleges Respondent Dr. Jung Han wrote some 5 prescriptions for controlled substances without evaluating the patient. The committee finds that each of the prescriptions in issue were signed by Dr. Sang Han. Therefore, in reference to Dr. Jung Han:

Allegation A.2 is **NOT SUSTAINED.**

Under allegation A.3, Respondent Dr. Jung Han is charged with inappropriately prescribing "large" quantities of various controlled substances including Percocet. The essence of this allegation is that the number of units and dosage of the substances prescribed was contrary to accepted standards of medicine. The Committee finds, at the outset, that Dr. Jung Han prescribed no Percocet whatsoever. Therefore, that part of the allegation cannot be sustained. Furthermore, in assessing all the testimony and evidence, the Committee cannot say that Dr. Jung Han was not engaged in chronic pain management with Patient A. Therefore the Committee cannot say that the amounts and dosages of the controlled substances that were given, were inappropriate. In so finding, the Committee gives limited weight to the opinion of the State's expert, Dr. Wittenberg. Dr. Wittenberg seemed to

be of the opinion that pain management, that is the repeated, long term prescription of potent analgesics to patients with confirmed chronic conditions which cause chronic, significant pain, was never within the bounds of accepted medical practice. The Committee cannot accept such a global rejection. Moreover, Dr. Wittenberg appeared hesitant and unsure of his answers, suggesting less than extensive knowledge of the subject of pain management. On the other hand, Respondents' experts were eminently qualified and completely sure of their subject and answers. Respondents' experts characterized the care rendered as chronic pain management, and stated that as such, the prescriptions were within accepted standards of medical practice.

In summary then, the amounts and dosages given to this patient were appropriate for chronic pain management. Clearly, patient A was suffering from chronic pain due to a verified and confirmed condition. Based upon the evidence presented, the Committee can find no basis to characterize the prescriptions as "inappropriate." Accordingly:

Allegation A.3 is **NOT SUSTAINED**

Under allegation A.4, Respondent Dr. Jung Han is charged with continuing to prescribe controlled substances to Patient A despite learning that Patient A was a substance abuser. The Committee does not sustain this allegation. The only evidence adduced by the State in support of the proposition that Patient A was a substance abuser was a reference to a telephone call from a member of Patient A's family to Respondent Dr. Jung Han in the latter

part of 1987. The family member expressed concern to Dr. Jung Han that Patient A was taking excessive amounts of controlled substances. When Dr. Jung Han inquired of her patient, he denied any abuse. Dr. Jung Han gave the telephone call little credence and the Committee does likewise. Furthermore, the facts are that despite several hospitalizations during the period of treatment by Dr. Jung Han, the hospital records never showed any reference to a history of, or ongoing substance abuse. Dr. Jung Han was entitled to believe her patient when he denied any abuse. Moreover, there was no objective evidence of abuse, such as requests for additional quantities or larger doses. Absent any objective proof of abuse, the Committee finds Respondent Dr. Jung Han did not act inappropriately in continuing to prescribe controlled substances to Patient A. Therefore:

Allegation A.4 is **NOT SUSTAINED.**

Under Allegation A.5, Respondent Dr. Jung Han is charged with continuing to prescribe controlled substances despite an "attempted suicide by overdosing on Percocet." As a starting point, the Committee again states that there was no evidence that Dr. Jung Han ever prescribed Percocet to Patient A. More substantively, the committee finds that there was an incident on September 29, 1987 during which Patient A was hospitalized due to the ingestion of an excessive amount of medication. However, there was no evidence that the incident was an attempt at suicide. In fact the psychiatrist who examined Patient A at the time of the hospitalization found that the event was not an attempted suicide

nor did Patient A have suicidal ideations or other potentially dangerous mental states. Finally, the credible testimony of Respondent Jung Han's experts shows that an abrupt discontinuation of the medication prescribed to this patient would have had a significant deleterious effect on the patient. Based upon all the above, the Committee finds that:

Allegation A.5 is **NOT SUSTAINED.**

Allegation A.6 is divided into two parts. Under Allegation A.6(a), Dr. Jung Han is charged with submitting bills to Worker's Compensation for payment for office visits which did not occur. The Committee has reviewed the bills and correlated them to Dr. Jung Han's record of office visits. While the correlation does not produce a precise match between dates of visits and dates billed for, the Committee finds that the total number of visits billed for, is at least equal to the number of office visits listed. Furthermore, the Committee finds Respondent Jung Han did not bill for services that could have been billed for. Accordingly, the Committee finds:

Allegation A.6(a) is **NOT SUSTAINED.**

Allegation A.6(b) charges Respondent Jung Han with submitting a bill to Medicare for an office visit on June 9, 1989 when Respondent did not actually treat Patient A. There can be no doubt that Dr. Jung Han submitted a bill for that date. However, Respondent Jung Han's office record shows a visit on that date. While the Committee finds Respondent Jung Han's office records suspicious (this will be addressed further later), it cannot be

said that the State has proven by a preponderance of the evidence that there was, in fact, no office visit on the date in question. Accordingly, the Committee finds:

Allegation A.6(b) is **NOT SUSTAINED.**

CONCLUSIONS REGARDING SANG HAN, M.D.

AND

PATIENT A

In allegation A.1, the State charges Dr. Sang Han with a failure to obtain and note an adequate history. The Committee notes Dr. Sang Han had Dr. Jung Han's office record available to him. Hence, he had the history taken in the hospital by Dr. Jung Han. The Committee has previously found this history to be adequate (see discussion regarding Allegation A.1 above). Having found the history in question to be adequate for Dr. Jung Han to use as a neurologist and primary care physician, the Committee also finds it adequate for Dr. Sang Han to use as a primary care physician. The Committee notes it was not called upon to assess the quality or adequacy of the physical examination in Dr. Sang Han's office record. Accordingly, the Committee finds:

Allegation A.1 is **NOT SUSTAINED.**

Under Allegation A.2 Dr. Sang Han is accused of giving five prescriptions for controlled substances to Patient A without making an evaluation or examination of him. The prescriptions fall into two categories: Those issued before June of 1987 (there are three of these) and those issued after June of 1987 (there are two of these). The Committee divides the prescriptions along

these lines because the evidence is clear, indeed, Respondent Sang Han admitted, that he did not actually see patient A until June of 1987. Based upon the uncontroverted date of Dr. Sang Han's first examination of this patient, the Committee concludes that on three occasions, March 22, 1987 (Allegation A.2(i)), April 14 1987 (Allegation A.2(ii)), and May 21 (Allegation A.2(iii)), 1987, Dr. Sang Han prescribed Schedule II controlled substances for Patient A without making an evaluation of him or making a note in his office record. Therefore, the Committee finds:
Allegations A.2 (i) (ii) and (iii) are **SUSTAINED.**
Allegations A.2 (iv), (v) are **NOT SUSTAINED.**

Allegation A.3 charges Dr. Sang Han with inappropriately prescribing large quantities of controlled substances to Patient A. Notwithstanding the finding under Allegation A.2, the Committee does not sustain this allegation. In A.2, the issue was prescribing without an examination. In this charge, the issue goes to the dose and quantity of drugs given. As previously explained under this charge in reference to Dr. Jung Han, the Committee finds that the type of drugs, the dosage and the quantities given were appropriate for pain management. The State has not proven that the drugs were not given for pain management, therefore the charge cannot be sustained. Accordingly:
Allegation A.3 is **NOT SUSTAINED.**

In Allegation A.4 and A.5 Dr. Sang Han is charged with prescribing controlled substances to patient A despite learning he was a substance abuser (Allegation A.4) and despite an attempted

suicide (Allegation A.5). The Committee makes reference to its discussion of these charges with regard to Dr. Jung Han. The Committee did not sustain these charges in regard to Dr. Jung Han and for the reasons stated under that discussion, will not sustain the charges with regard to Dr. Sang Han. Therefore:

Allegation A.4 is **NOT SUSTAINED**, and

Allegation A.5 is **NOT SUSTAINED.**

Under Allegations A.6(a) and A.6(b), Dr. Sang Han is charged with billing Worker's Compensation (Allegation A.6(a)) and Medicare (Allegation A.6(b)) for office visits that did not occur. A review of the evidence shows each of the bills in question were under the name of Dr. Jung Han. Therefore these charges cannot be sustained with regard to Dr. Sang Han. Accordingly:

Allegation A.6(a) is **NOT SUSTAINED** and,

Allegation A.6(b) is **NOT SUSTAINED.**

FINDINGS OF FACT WITH REGARD TO PATIENT B

37. Patient B was first seen by Dr. Jung Han on June 4, 1988 (717 - 718; Exhibit G). He continued in her care through August 30, 1989 (Exhibit G).

38. Patient B was referred to Dr. Jung Han from a Dr. Garand who was covering for a Dr. Atlas (735 - 736; Exhibit No. 6, Exhibit G). Patient B was referred with a diagnosis of narcolepsy (721 - 722; Exhibit No. 6, Exhibit G).

39. During her initial visit with Patient B, Dr. Jung Han took a history and performed a neurological examination (718, 897; Exhibit G). Her original diagnosis was sleep apnea or narcolepsy

(721-722).

40. Dr. Jung Han prescribed Dexedrine for Patient B's condition on at least two occasions. Subsequently she requested her husband to monitor the patient medically and to continue the prescribing regimen if he deemed it appropriate (722 - 723, 776 - 777).

41. Dr. Sang Han obtained and noted a medical history for Patient B and performed a physical examination on July 2, 1988 (777 - 779; Exhibit No. 6).

42. On several occasions, Dr. Sang Han prescribed Dexedrine for Patient B's condition (Exhibit Nos. 6, 24, 25, 26, and 27).

43. At no time did Patient B report any side effects to the Dexedrine or Ritalin prescribed for him (740, 779, 900).

44. Patient B reported that the medication prescribed helped him to stay awake during the day and this improved his daytime functioning (749 - 750, 794).

45. At no time was it necessary to increase the dosage level (10 mg, 3 times per day) which was prescribed for Patient B (745, 779, 900).

46. The use of stimulants like Dexedrine is an accepted method of treating narcolepsy and hypersomnolence (739, 899 - 900).

47. Dr. Jung Han submitted bills to Medicare for care rendered to Patient B on these dates (Exhibit 20, 22 and 23):

June 4, 1988

July 2 and 9 1988

August 6, 1988

September 4, 1988

October 27, 1988

December 29, 1988

April 1, 1989

June 30 1989

48. Dr. Sang Han submitted bills for care rendered to Patient C on these dates (Exhibit 21):

July 2 and 9 1988

September 4, 1988

December 2, 1988

December 29, 1988

CONCLUSIONS REGARDING JUNG HAN, M.D.

AND

PATIENT B

Under Allegations B.1 and B.2 Dr. Jung Han is charged with the failure to obtain and note an adequate history (Allegation B.1) and an adequate physical examination (Allegation B.2). The Committee finds that both the history and physical examination noted in the records in evidence were adequate within the confines of Dr. Jung Han's specialty as a neurologist. Therefore, the Committee finds:

Allegation B.1 is **NOT SUSTAINED** and,

Allegation B.2 is **NOT SUSTAINED.**

Allegation B.3 charges Dr. Jung Han with prescribing

controlled substances, including Dexedrine and Ritalin without justification. It is unclear to the Committee to what extent Dr. Jung Han prescribed these drugs, if at all. However, insofar as the drugs were prescribed, they were given to treat a sleep disorder of which the patient complained. Dr. Jung Han was entitled to believe her patient and his reports of symptoms. The drugs which were prescribed are the drugs of choice for the complaints reported to Dr. Jung Han by her patient. Accordingly, the Committee finds sufficient justification for the prescriptions. Therefore:

Allegation B.3 is **NOT SUSTAINED.**

In Allegation B.4, Dr. Jung Han is charged with billing Medicare for services which were not actually rendered. A review of the bills received in evidence and Dr. Jung Han's office notes shows a correlation between bills and visits; that is, for each billing listed there is an office note. The exception to this is June 4, 1989 (Allegation B.4(v)). There is in fact no billing for this date by Dr. Jung Han. With regard to the other dates in issue, the Committee finds that the State has failed to meet its burden in proving this charge. In so finding, the Committee notes that there is a dispute between the parties over what actually constitutes Dr. Jung Han's records. It is noted that there were at least two versions of records submitted by Dr. Jung Han. In her testimony, Dr. Jung Han explained that she attempted to submit neat type written notes to the State when her records were subpoenaed. Dr. Jung Han testified that she kept some of her

original handwritten notes and destroyed some of her handwritten notes after they were transcribed. She also testified that the typist often did not transcribe her handwritten notes accurately. The entire explanation makes the panel more than suspicious. The Committee finds it tests their credulity that some of the notes were transcribed and others were not; plus some originals were destroyed, but others were not. This is particularly hard to believe given Dr. Jung Han's testimony that the typing was not done in the ordinary course of business but rather in response to the subpoena from the State. Ultimately, the Committee finds themselves suspicious, but with no conclusive evidence upon which to make a finding of guilt. After weighing all the credible evidence, the Committee cannot find that the State has proven this charge by a preponderance of the evidence. Therefore:

Allegation B.4 is **NOT SUSTAINED.**

Allegation B.5 has 5 subdivisions (i through v). Allegation B.5 (i) was withdrawn by the State. The remaining allegations charge Dr. Jung Han with prescribing controlled substances for Patient B without seeing him, evaluating him or making an appropriate office note. The Committee finds that Allegations B.5 (iii) and (v) refer to prescriptions issued by Dr. Sang Han. Therefore, these charges cannot be sustained as to Dr. Jung Han. With regard to the remaining prescriptions dated August 6, 1988 (Allegation B.5 (ii)) and October 27, 1988 (Allegation B.5 (iv)), the Committee finds an adequate office note for each visit. Again, the Committee is mindful that Dr. Jung Han's office notes

reflect, to say the least, some irregularities. Nevertheless, the Committee cannot find that the State has met its burden of proof with regard to this charge. Therefore:

Allegation B.5 is **NOT SUSTAINED.**

CONCLUSIONS REGARDING SANG HAN, M.D.

AND

PATIENT B

Under Allegations B.1 and B.2, Dr. Sang Han is charged with a failure to obtain an adequate history (Allegation B.1) or perform an adequate physical examination of patient B. Upon review of Dr. Sang Han's office notes, the Committee finds his history and physical were adequate for the limited purposes for which the patient was being seen. In so finding, the Committee notes Dr. Sang Han had access to Dr. Jung Han's office records and this is reflected in their finding of adequacy. Accordingly:

Allegation B.1 is **NOT SUSTAINED** and,

Allegation B.2 is **NOT SUSTAINED.**

In Allegation B.3, Dr. Sang Han is charged with inappropriately prescribing Dexedrine and Ritalin to Patient B. As stated under the analysis of the charges directed at Dr. Jung Han, this patient reported the signs and symptoms of a sleep disorder. There were never any symptoms of adverse effects and, in fact, the patient reported he was doing well. The drugs mentioned are the medications of choice for the condition being treated. Under all the facts and circumstances, the Committee can

find no fault with the prescribing in issue. Therefore:

Allegation B.3 is **NOT SUSTAINED.**

Allegation B.4 is divided into six subdivisions (B.4 (i) through B.4 (vi)). The State alleges Dr. Sang Han billed Medicare for six office visits although he actually rendered no care on the dates in question. With regard to Allegations B.4 (iv), (v) and (vi), the Committee can find no evidence of bills submitted by Dr. Sang Han. On July 2, 1988; July 9, 1988 and December 29, 1988, the Committee finds bills and a record of an office visit by patient B to Dr. Sang Han. Thus the Committee either finds a visit noted or no bill rendered for each of the dates in issue. Accordingly:

Allegation B.4 is **NOT SUSTAINED.**

Allegation B.5 is divided into five subdivisions (B.5 (i) through B.5 (v)). Allegation B.5 (i) was withdrawn by the State. The other four dates correspond to prescriptions issued by Dr. Sang Han to patient B. The charge is that Dr. Sang Han issued these prescriptions without actually seeing and evaluating the patient. The Committee finds that Dr. Sang Han did indeed issue prescriptions for Patient B on the dates in the charges and there is no office note reflecting a visit to or evaluation by Dr. Sang Han. The Committee concludes that in the absence of an office note, Dr. Sang Han did not see or evaluate this patient on the dates in question. Therefore:

Allegation B.5 **IS SUSTAINED.**

FINDINGS OF FACT WITH REGARD TO PATIENT C

47. Patient C was first seen by Dr. Sang Han on June 29, 1987 (799; Exhibit No. 7).

48. Patient C was 67 years old when he first presented to Dr. Sang Han (Exhibit No. 7). He had been followed by his physician at the VA Hospital (800; Exhibit No. 7).

49. Patient C's past medical history included osteoarthritis with low back pain syndrome for which Patient C stated he was receiving Dilaudid (800; Exhibit No. 7).

50. Dr. Sang Han recommended blood work and various tests for Patient C including an X-ray and a CAT scan of the lumbo-sacral spine (Exhibit No. 7). He continued to prescribe Dilaudid to Patient C (800-801; Exhibit No. 7).

51. Patient C agreed to undergo the tests recommended by Dr. Sang Han (805; Exhibit No. 7). Patient C indicated to Dr. Sang Han that he had tried various medications for his chronic back pain and that only Dilaudid provided relief (800; Exhibit No. 7).

52. Dr. Sang Han recommended that Patient A have orthopedic and neurologic consultations. Patient C agreed to have these consultations at the VA Hospital (805; Exhibit No. 7).

53. After several months it became clear that Patient C had not complied with Dr. Sang Han's recommendations to undergo certain tests and to have neurologic and orthopedic consultations (804).

54. Dr. Sang Han continued to prescribe Dilaudid for Patient C through May 29, 1989 (802-803; Exhibit No. 7).

55. Patient C did not exhibit any tolerance to the medication being prescribed such that it was necessary to increase the dosage (803, 1071, 1140).

56. On each occasion that a prescription for Dilaudid is noted on the chart for Patient C, Dr. Sang Han examined the patient for side effects and made a note of the office visit and examination in his office chart (802-803).

SPECIAL NOTE: The State withdrew all charges against Dr. Jung Han in relation to Patient C.

CONCLUSIONS REGARDING SANG HAN, M.D.

AND

PATIENT C

There is only one allegation associated with Patient C. Under Allegation C.1, Dr. Sang Han is charged with inappropriately prescribing Dilaudid for this patient every three to four weeks. It was uncontroverted that Dr. Sang Han prescribed Dilaudid, an extremely potent narcotic analgesic, to patient C on a regular basis, approximately every three weeks for about two years. The question presented then is whether the prescriptions were "appropriate." The State's expert said they were not. But, as previously stated, Dr. Wittenberg, the State's expert, was of the opinion that treating patients for pain management primarily with drugs, was always outside the bounds of accepted standards of medicine. Again, as stated previously, the Committee gives

relatively less weight to such a rigid view. The more commonly accepted view would appear to be that chronic pain management may call for analgesics on a regular basis, depending on the patient and the particular facts of the case. With this in mind, the Committee is of the opinion that the State failed to prove that the giving of Dilaudid to this patient was inappropriate. Respondents' experts testified that the dose and number given were within acceptable limits for the pain management being rendered. Furthermore, the patient records show this was a 65 year old man who had significant pain and who reported that nothing else worked for him. He appeared functional, and exhibited none of the manipulative behavior associated with addicts and substance abusers. Upon analysis of the credible evidence and testimony, the Committee cannot find that the State met its burden of proof with regard to this charge. Therefore:

Allegation C.1 is **NOT SUSTAINED.**

CONCLUSIONS

REGARDING

SPECIFICATIONS

IN REFERENCE TO DR. JUNG HAN

SPECIFICATIONS ONE THROUGH FIVE

The Committee did not sustain any factual allegations under Patients A or B. The charges against Dr. Jung Han regarding Patient C were withdrawn by the State. Therefore, the First through Fifth Specifications cannot be sustained.

SPECIFICATION ONE IS **NOT SUSTAINED.**

SPECIFICATION TWO IS **NOT SUSTAINED.**

SPECIFICATION THREE IS **NOT SUSTAINED.**

SPECIFICATION FOUR IS **NOT SUSTAINED.**

SPECIFICATION FIVE IS **NOT SUSTAINED.**

SPECIFICATIONS SIX, SEVEN AND EIGHT

Under the sixth, seventh and eighth specifications, Dr. Jung Han is accused of keeping sub-standard office records for her patients. The Committee finds that Dr. Jung Han kept seriously deficient records in her office. The records received in evidence were incomplete, indecipherable and there were various versions of the records submitted to the Committee. The various versions were not always consistent with each other or the original handwritten records. Dr. Jung Han explained the various versions by saying that when the State subpoenaed her records, she endeavored to make them more readable by engaging the services of a typist. When typed, some of the original handwritten notes were destroyed. According to Dr. Jung Han, some of the original handwritten notes were not destroyed and made their way into evidence in this proceeding. The Committee finds this explanation dubious. Dr. Jung Han further explained the state of her notes by saying they were written on the back of scrap paper she had on hand. Upon examination of the backs of the various notes submitted, it appears that Dr. Jung Han used consecutive pages of another document. If Dr. Jung Han were indeed using scrap paper for office visits that had several week gaps between them, one would expect to see random pages from the document being used as

scrap. The fact that the pages appear to be in order, without gaps, suggests that Dr. Jung Han wrote these notes in one sitting and was thus less than truthful with the Committee. While these comments do not reflect directly on the charges, they do bear on the credibility of Dr. Jung Han and are also included to demonstrate that the Committee reviewed and considered the evidence carefully.

Disregarding the issue of candor, the notes received in evidence and reviewed by this Committee are very seriously substandard. It is also of great significance that Dr. Jung Han admitted she destroyed original notes and considered this of no moment. The Committee takes notice that appropriate protocol requires that when notes are corrected, the originals be retained with relevant notations of the corrections. This is particularly necessary when, as in this case, the final product is often quite different from the original. Without the original, it is impossible to make a comparison and important information can be lost forever. Of perhaps greatest concern to the Committee, was Dr. Jung Han's attitude about all of the above. She expressed no hint that she understood the seriousness of destroying original notes. Nor did she express the slightest suggestion that she recognized the importance of complete and decipherable notes so that subsequent treating physicians and reviewers could be appraised of her treatment and thought processes.

For all the above reasons the Committee sustains the Sixth and Seventh Specifications. The charges associated with the

Eighth Specification (regarding Patient C) were withdrawn by the State.

The Sixth Specification **IS SUSTAINED**

The Seventh Specification **IS SUSTAINED**

The Eighth Specification **IS NOT SUSTAINED**

IN REFERENCE TO DR. SANG HAN

SPECIFICATION ONE

Under the First Specification, Dr. Sang Han is accused of a single act of gross negligence based upon Allegation A and A.1 through A.5. Utilizing the definitions previously set forth, the Committee finds that providing Patient A with controlled substances on three occasions (Allegations A.2 (i), (ii) and (iii)) constitutes an egregious departure from accepted standards of care and diligence. Hence, the allegations sustained amount to gross negligence. In so finding, the Committee notes that Dr. Sang Han admitted he prescribed controlled substances to this patient three times before he first examined him in June, 1987. That Dr. Sang Han understood the importance of examining a patient prior to prescribing controlled substances is shown by his later activities with this patient and the others. In all cases, Dr. Sang Han gave his patients a reasonable physical review to assure that the prescription was necessary and would not cause more harm than good. His failure to even see patient A, prior to

prescribing is thus a glaring deviation from both objective standards of care and diligence as well as his own his own standards of care and diligence. Furthermore, the prescriptions established in this case, given without even a cursory physical examination by the prescriber, put this patient at risk. It is further damning that Dr. Jung Han thought it unwise to prescribe these drugs herself even though she had examined the patient several times and was quite familiar with the patient. She referred Patient A to Dr. Sang Han for management. If the prescription of controlled substances to this patient was serious enough to warrant Dr. Jung Han to refer him to a different doctor, albeit her husband with whom she shared office space, surely it was incumbent upon the new physician to at least examine the patient. Based upon the above findings:

The First Specification **IS SUSTAINED**

SPECIFICATION TWO

The Second Specification charges Respondent with negligence on more than one occasion. As drafted, Allegation A and its various sub-parts, A.1 through A.5, constitute one occasion. Based upon the discussion above, the Committee finds that simple negligence is a lesser included offense in the more serious finding of gross negligence. Therefore, the findings above support a conclusion of simple negligence on one occasion.

Turning its attention to Allegation B, the Committee finds that while the factual allegations are true, they will not support a finding of negligence. In so finding, the Committee concludes

that under the allegations sustained regarding patient B, although Dr. Sang Han did not actually see this patient every time he issued a prescription, there was no negligence since he was familiar with the patient and his condition. He had an ongoing relationship with the patient and thus there was no need for an office visit each time he continued the course of treatment by providing a prescription. This is in significant contrast to Patient A wherein there was no relationship whatsoever when the prescriptions for which Dr. Sang Han is cited were issued. As stated earlier, the Committee found that by his own conduct, Dr. Sang Han demonstrated the importance of developing a relationship with a patient during the prescribing of controlled substances. Only by familiarizing himself with the condition of the patient can a physician appropriately provide care and treatment. The prescription of controlled substances is a potentially dangerous aspect of care and treatment which warrants, at least, an ongoing familiarity with the patient.

Turning to Allegation C, the Committee did not sustain any of the allegations, therefore Allegation C cannot form the basis for a finding of misconduct.

The Second Specification is **NOT SUSTAINED.**

SPECIFICATION THREE

In the Third Specification, Dr. Sang Han is charged with incompetence on more than one occasion. As alluded to previously, even under the subdivisions of Allegations A and B which were sustained, the Committee finds no evidence of

incompetence on the part of Dr. Sang Han. The Committee finds that Dr. Sang Han knew what was necessary for a practitioner to be acting consistent with accepted standards of medicine when prescribing analgesic controlled substances. He demonstrated appropriate levels of knowledge in the types of drugs prescribed, the quantities given, the kinds of examinations provided and his attempts, when appropriate, to try other than pharmacological treatment for his patients. Accordingly, based upon the above discussion and utilizing the definitions previously set forth the Committee finds:

The Third Specification is **NOT SUSTAINED.**

SPECIFICATION FOUR AND FIVE

The Fourth and Fifth Specifications allege fraud base upon bills submitted for treatment of Patient A (the Fourth Specification) and Patient B (the Fifth Specification). The Committee finds that all the bills submitted for Patient A were attributable to Dr. Jung Han. Therefore, the Fourth Specification does not relate to Dr. Sang Han.

The Fourth Specification is **NOT SUSTAINED.**

The Fifth Specification alleges fraud based upon bills submitted for treatment of Patient B. The Committee finds that for every date listed in the charges there was either no bill submitted or a visit recorded in Dr. Sang Han's office records. The Committee can find absolutely no evidence of fraud under the proof submitted. Accordingly the Committee finds:

The Fifth Specification is **NOT SUSTAINED.**

SPECIFICATION SIX, SEVEN AND EIGHT

The Sixth, Seventh and Eighth Specifications charge Dr. Sang Han with substandard record keeping in reference to Patient A (the Sixth Specification), Patient B (the Seventh Specification) and Patient C (the Seventh Specification). With regard to Patient A, the Committee finds that some of Dr. Sang Han's notes were kept in Dr. Jung Han's office record of this patient. This would have made it difficult for a subsequent reader to follow Dr. Sang Han's care of this patient. In fact, Dr. Sang Han admitted he failed to keep a record of each and every visit by this patient. Still, under all the facts and circumstances, the Committee cannot find serious fault with Dr. Sang Han's record keeping regarding this patient. He was treating this patient for chronic pain and knew the patient was being followed by a neurologist with whom he shared an office. Analyzing Dr. Sang Han solely from the perspective of record keeping, the committee finds that while his record for this patient were far from stellar, his lapses in record keeping did not rise to the level of misconduct. Therefore, the Committee finds:

The Sixth Specification is **NOT SUSTAINED.**

Under the Seventh Specification, Dr. Sang Han is charged with sub standard record keeping in regard to Patient B. The Committee has reviewed Dr. Sang Han's records and finds that with the exception of the lack of entries for certain prescriptions given without actual visits, the records kept by Dr. Sang Han generally met accepted standards of medical record keeping as set forth

earlier. Therefore the Committee finds:

The Seventh Specification is **NOT SUSTAINED.**

The Eighth Specification alleges Dr. Sang Han did not keep appropriate records for Patient C. The Committee has reviewed the office chart for Patient C and finds the records meet the standards set forth above for medical records. Therefore the Committee finds:

The Eighth Specification is **NOT SUSTAINED.**

CONCLUSIONS

REGARDING

PENALTY

AND ORDER

The State has established that Dr. Jung Han has serious deficiencies in her knowledge of the appropriate way to keep and manage office records. The State has also established that Dr. Sang Han was grossly deficient on one occasion when he prescribed controlled substances presumably simply because his practice partner asked him to do so. The pattern of office management of these two physicians, in concert, is abysmal. There were instances when Dr. Sang Han made what amounted to his practice notes in the record belonging to Dr. Jung Han. There were instances when it was virtually impossible to distinguish just whose responsibility given treatment was attributable. Such careless and sub-standard practice activities cannot be tolerated.

However, there was no showing of incompetence by either practitioner. Indeed, it is questionable if Dr. Sang Han would

have committed gross negligence but for the fact that these two physicians do not understand how to manage a private practice.

As a general proposition, the Committee was favorably impressed with the two respondents' desires and potential to provide quality care. The Committee believes that the potential for rehabilitation and improvement is definite.

Therefore, it is hereby **ORDERED THAT:**

Respondents shall be immediately placed on **PROBATION.**

Furthermore it is hereby **ORDERED THAT:**

The said probation shall continue for a minimum period of two years. At the end of the said two year period, the monitor, as described below, with the approval of the Director of the Office of Professional Medical Conduct or his or her designee (hereinafter referred to as "the Director"), shall determine when Respondent Jung Han and Respondent Sang Han are ready to resume practice without a monitor. Furthermore, it is hereby **ORDERED THAT:**

During the period of probation Respondents shall be **MONITORED** pursuant to Section 230 (18)(a)(i),(ii), and (iii) of the Public Health Law. More specifically, Respondents shall obtain a practice monitor who shall be approved by the Director. Under the auspices of the monitor, Respondent Dr. Jung Han and Respondent Dr. Sang Han shall be subject to a review of all records pertaining to patients. They may be required to visit members of the board as directed by the practice monitor or the director. The goal of the practice monitor shall include, but not

necessarily be limited to, requiring that the records of both respondents comply with accepted principles of accuracy, completeness and legibility. Furthermore it is hereby **ORDERED THAT:**

All of the above shall be at Respondents' expense.

DATED: Albany, New York
[illegible] 13 , **1993**

ROBERT J. O'CONNOR, M.D.
Chairperson

ALBERT B. ACCETOLA, Jr., M.D.
MORTON M. KLEINMAN

APPENDIX I

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
SANG HAN, M.D.	:	CHARGES

----------X

SANG HAN, M.D., the Respondent, was authorized to practice medicine in New York State on August 27, 1982 by the issuance of license number 151423 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 to December 31, 1992.

FACTUAL ALLEGATIONS

A. Between in or about June, 1987 and in or about April, 1989, Respondent treated Patient A (all patient names appear in the Appendix) for a herniated lumbar disc and other medical conditions at the office he shared with his wife, Jung Han, M.D., at 75 Briarcliff Road, Staten Island, New York.

1. Throughout the period, Respondent failed to obtain and note an adequate history.

2. On the following dates, Respondent prescribed controlled substances for Patient A without seeing him, without making an evaluation of him and without making a note of such visit or evaluation, if any:

(i) March 22, 1987;

(ii) April 14, 1987;

(iii) May 21, 1987;

(iv) August 22, 1988;

(v) February 23, 1989.

3. Throughout the period, Respondent inappropriately prescribed large quantities of controlled substances including Percocet, Valium, Xanax and Chloral Hydrate.

4. In or about the latter part of 1987, Respondent learned that Patient A was a substance abuser, going from doctor to doctor to obtain prescriptions for controlled substances. Nevertheless, Respondent failed to note such information and continued to inappropriately prescribe controlled substances for Patient A.

5. On or about September 29, 1987, Patient A attempted suicide by overdosing on Percocet. Eventhough Respondent was aware of this, he failed to note it and inappropriately continued to prescribe controlled substances for Patient A thereafter, including Percocet.

6. Respondent knowingly and intentionally submitted bills to Workmen's Compensation and Medicare pertaining to Patient A as follows :

a) Bills were submitted to Workmen's Compensation seeking payment for office visits purportedly made by Patient A on the following dates when, in fact, no such visit occurred:

(i) September 4, 1986;
(ii) ~~September~~ OCTOBER 14, 1986; B AMENDED 6/29/92
(iii) December 1,2,3, 1986;
(iv) April 14, 1987 B AMENDED 6/29/92
(v) May 1, 1987;
(vi) May 13, 1987;
(vii) June 27, 1987;
(viii) December 19, 1988.

b) A bill was submitted to Medicare seeking payment for an office visit purportedly made by Patient A on the following date, when, in fact, no such such visit occurred: June 9, 1989.

B. Between in or about July, 1989 and in or about April, 1990, Patient B was treated for narcolepsy and other medical conditions by Respondent at the office he shared with his wife, Jung Han, M.D., at 75 Briarcliff Road, Staten Island, New York.

1. Throughout the entire period, Respondent failed to obtain and note an adequate history.

2. Throughout the entire period, Respondent failed to perform and note an adequate physical examination.

3. Throughout the period, Respondent inappropriately prescribed controlled substances for Patient B, including Dexedrine and Ritalin.

4. Respondent knowingly and intentionally submitted the following bills pertaining to

Patient B to Medicare through Empire Blue Cross/Blue Shield seeking payment for office visits allegedly made by Patient B, when, in fact, no such visits occurred:

(i) July 2, 1988;

(ii) July 9, 1988;

(iii) December 29, 1988;

(iv) April 1, 1989;

(v) June 4, 1989;

(vi) June 30, 1989.

5. On the following dates, Respondent prescribed controlled substances for Patient B without seeing him, evaluating him and without making a note of such visit or evaluation, if any:

~~(i) June 4, 1988;~~ B WITHDRAWN 6/29/92

(ii) August 6, 1988;

(iii) October 1, 1988;

(iv) October 27, 1988;

(v) December 29, 1988.

C. Between in or about June, 1987 and in or about June, 1989, Respondent treated Patient C for lower back pain and other medical conditions at the office he shared with his wife, Jung Han, M.D., at 75 Briarcliff Road, Staten Island, New York.

ERROR B NOT WITHDRAWN WITHDRAWN 6/29/92 JB

1. Throughout the period, Respondent inappropriately prescribed Dilaudid for Patient C every three to four weeks.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with practicing the profession with gross negligence on a particular occasion under N.Y. Educ. Law Section 6530(4), (McKinney Supp. 1992), in that Petitioner charges:

1. The facts in Paragraphs A and A1 - 5.

SECOND SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3),(McKinney Supp. 1992) in that Petitioner charges two or more of the following:

2. The facts in Paragraphs A and A1-5; B and B1-3, 5; and/or C and C1.

THIRD SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530 (5) (McKinney Supp. 1992), in that Petitioner charges two or more of the following:

3. The facts in Paragraphs A and A 1-5; B and B 1-3, 5; and/or C and C 1.

FOURTH AND FIFTH SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2), (McKinney Supp. 1992), in that Petitioner charges:

4. The facts in Paragraphs A and A6 (a) and (b)

5. The facts in Paragraphs B and B4 (a).

SIXTH THROUGH EIGHTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS WHICH ACCURATELY REFLECT EVALUATIONS AND TREATMENT

Respondent is charged with professional misconduct under N.Y. Educ. Law 6530(32) (McKinney Supp. 1992), in that she failed to maintain a record for each patient which accurately reflects her evaluation and treatment of the patient. Petitioner charges:

6. The facts in Paragraphs A and A1 - 5;

7. The facts in Paragraphs B and B1- 3, and 5;

8. The facts in Paragraphs C and C1.

DATED: New York, New York
May 14, 1992

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct

APPENDIX II

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
JUNG HAN, M.D.	:	CHARGES

----------X

JUNG HAN, M.D., the Respondent, was authorized to practice medicine in New York State on May 1, 1981 by the issuance of license number 145890 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1991 to December 31, 1992.

FACTUAL ALLEGATIONS

A. Between in or about June, 1987 and in or about April, 1989, Respondent treated Patient A (all patient names appear in the Appendix) for a herniated lumbar disc and other medical conditions at the office she shared with her husband, Sang Han, M.D., at 75 Briarcliff Road, Staten Island, New York.

1. Throughout the period, Respondent failed to obtain and note an adequate history.

2. On the following dates, Respondent prescribed controlled substances for Patient A without seeing him, without making an evaluation of him and without making a note of such visit or evaluation, if any:

(i) March 22, 1987;

(ii) April 14, 1987;

(iii) May 21, 1987;

(iv) August 22, 1988;

~~(v) February 23, 1989.~~ WITHDRAWN 8/4/92 B

3. Throughout the period, Respondent inappropriately prescribed large quantities of controlled substances including Percocet, Valium, Xanax and Chloral Hydrate.

4. In or about the latter part of 1987, Respondent learned that Patient A was a substance abuser, going from doctor to doctor to obtain prescriptions for controlled substances. Nevertheless, Respondent failed to note such information and continued to inappropriately prescribe controlled substances for Patient A.

5. On or about September 29, 1987, Patient A attempted suicide by overdosing on Percocet. Eventhough Respondent was aware of this, she failed to note it and inappropriately continued to prescribe controlled substances for Patient A thereafter, including Percocet.

6. Respondent knowingly and intentionally submitted bills to Workmen's Compensation and Medicare pertaining to Patient A as follows:

a) Bills were submitted to Workmen's Compensation seeking payment for office visits purportedly made by Patient A on the following dates when, in fact, no such visit occurred:

(i) September 4, 1986;

(ii) ~~September~~ OCTOBER 14, 1986; AMENDED 6/29/92 JB

(iii) December 1,2,3, 1986;

(iv) April 14, 1987 AMENDED 6/29/92 JB

(v) May 1, 1987;

(vi) May 13, 1987;

(vii) June 27, 1987;

(viii) December 19, 1988.

b) A bill was submitted to Medicare seeking payment for an office visit purportedly made by Patient A on the following date, when, in fact, no such such visit occurred: June 9, 1989.

B. Between in or about July, 1989 and in or about April, 1990, Patient B was treated for narcolepsy and other medical conditions by Respondent at the office she shared with her husband, Sang Han, M.D., at 75 Briarcliff Road, Staten Island, New York.

1. Throughout the entire period, Respondent failed to obtain and note an adequate history.

2. Throughout the entire period, Respondent failed to perform and note an adequate physical examination.

3. Throughout the period, Respondent inappropriately prescribed controlled substances for Patient B, including Dexedrine and Ritalin.

4. Respondent knowingly and intentionally submitted the following bills pertaining to

Patient B to Medicare through Empire Blue Cross/Blue Shield seeking payment for office visits allegedly made by Patient B, when, in fact, no such visits occurred:

(i) July 2, 1988;

(ii) July 9, 1988;

(iii) December 29, 1988;

(iv) April 1, 1989;

(v) June 4, 1989;

(vi) June 30, 1989.

5. On the following dates, Respondent prescribed controlled substances for Patient B without seeing him, evaluating him and without making a note of such visit or evaluation, if any,

~~(i) June 4, 1988;~~ WITHDRAWN 6/29/92 JB

(ii) August 6, 1988;

(iii) October 1, 1988;

(iv) October 27, 1988;

(v) December 29, 1988.

C. Between in or about June, 1987 and in or about June, 1989, Respondent treated Patient C for lower back pain and other medical conditions at the office she shared with her husband, Jung Han, M.D., at 75 Briarcliff Road, Staten Island, New York.

WITHDRAWN 6/29/92 JP

1. Throughout the period, Respondent inappropriately prescribed Dilaudid for Patient C every three to four weeks.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with practicing the profession with gross negligence on a particular occasion under N.Y. Educ. Law Section 6530(4), (McKinney Supp. 1992), in that Petitioner charges:

1. The facts in Paragraphs A and A1 - 5.

SECOND SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3),(McKinney Supp. 1992) in that Petitioner charges two or more of the following:

2. The facts in Paragraphs A and A1-5; B and B1-3,5; and/or C and C1.

THIRD SPECIFICATION

PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530 (5) (McKinney Supp. 1992), in that Petitioner charges two or more of the following:

3. The facts in Paragraphs A and A 1-5; B and B 1-3,5; and/or C and C 1.

FOURTH AND FIFTH SPECIFICATIONS

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently under N.Y. Educ. Law Section 6530(2), (McKinney Supp. 1992), in that Petitioner charges:

4. The facts in Paragraphs A and A6 (a) and (b);

5. The facts in Paragraphs B and B4 (a).

SIXTH THROUGH EIGHTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS WHICH ACCURATELY REFLECT EVALUATION AND TREATMENT

Respondent is charged with professional misconduct under N.Y. Educ. Law 6530(32) (McKinney Supp. 1992), in that he failed to maintain a record for each patient which accurately reflects his evaluation and treatment of the patient. Petitioner charges:

6. The facts in Paragraphs A and A1 - 5;

7. The facts in Paragraphs B and B1 -3, and 5;

8. The facts in Paragraphs C and C1.

DATED: New York, New York
May 14, 1992

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct