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

October 24, 1992

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Christina Y. Ko, M.D.
123 Route 24
Mendham, New Jersey 07945

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

RE: In the Matter of Christina Y. Ko, M.D.

Dear Dr. Ko and Mr. Stein:

Enclosed please find the Determination and Order (No. BPMC-92-75) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

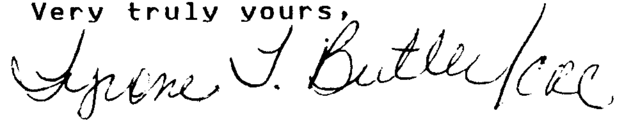
The notice of review served on the Administrative Review Board should be forwarded to:

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 MATTER OF CHRISTINA Y. KO, M.D.	**DETERMINATION AND ORDER**

ORDER NO. BPMC 92-75

Erwin Lear, M.D. Chairman, J.Larue Wiley, M.D. and **Sister Mary Murphy** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Sections 230 (1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Jane B. Levin, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this determination.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	June 16, 1992
Statement of Charges dated:	June 16, 1992
Pre-hearing conference:	July 6, 1992
Hearing dates:	July 15, 1992 July 16, 1992
Deliberation dates:	September 15, 1992
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.

Petitioner appeared by: Peter J. Millock, Esq.
General Counsel
NYS Department of Health
By: Paul Stein, Esq.
Associate Counsel

Respondent appeared Pro se.

WITNESSES

For the Petitioner:
1) Earl B. Brown, M.D.
2) Joseph Post, M.D.

For the Respondent:
1) Patient A
2) Hsin-Yuan Cheng
3) Christina Y. Ko, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion; with incompetence on more than one occasion; and with failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers of

exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. Christina Y. Ko, M.D. the Respondent, was authorized to practice medicine in New York State on May 19, 1978 by the issuance of license number 134406 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 through December 31, 1992 (Pet.'s Ex. 3).

2. Respondent limits her practice to the treatment of diseases of the skin and respiratory tract. (T218)

3. Respondent's practice was to spend 30 to 40 minutes with each patient. (T198)

4. Respondent's medical record keeping system was to note essential items and omit negatives. (T198)

5. Celestone is a synthetic corticosteroid. It is an anti-inflammatory drug used by allergists for the treatment of asthma that does not respond to simpler drugs and for the treatment of severe allergic rhinitis that does not respond to simpler medications. (T32)

6. There is a risk associated with the long term use of Celestone. If it is used for a long time, the patient should be closely monitored because of the possibility of developing peptic

ulcers. It subdues the adrenal gland so that there is no response in times of stress. It can raise blood pressure. It can cause fracture of a vertebra. (T33)

7. Respondent is aware of the contraindications for long term use of corticosteroids. (T196)

8. As a general rule, short term corticosteroids are very safe medications. (T56)

FINDINGS OF FACT AS TO PATIENT A

9. Between May 21, 1978 and April 29, 1987, on approximately 15 occasions, Respondent treated Patient A, a 26 year old male, for various complaints of stuffy nose, runny nose, sore throat, tight breathing, coughing and sneezing, at her medical offices at 2 Mott Street, New York, N.Y. (T36, Pet.'s Ex. 4)

10. Respondent's medical records for Patient A demonstrate that Respondent obtained and noted an acceptable medical history, although the patient's blood pressure was not documented. (T225, Pet.'s Ex. 4)

11. Respondent prescribed the corticosteroid Celestone for Patient A on approximately eight occasions over an eight year period. (T40-41, Pet.'s Ex. 4)

12. On May 22, 1979, Respondent prescribed and administered by injection the corticosteroid Depomedrol for Patient A. (T38-41, Pet.'s Ex. 4)

13. It is all right to use both Celestone and Depomedrol because the two medications have differing onsets of action. (T59-

60)

14. Respondent performed and documented an allergy work-up for Patient A. (T201, Pet.'s Ex. 4)

CONCLUSIONS AS TO PATIENT A

15. The Respondent performed and documented a proper physical examination and allergy work-up for Patient A.

16. Respondent's short term prescriptions for intermittent corticosteroid use over an eight year period by Patient A were appropriate and posed none of the risks associated with long term use of these medications.

FINDINGS OF FACT AS TO PATIENT B

17. On May 21, 1983, Respondent treated Patient B, a 21 year old male, for complaints of fever and a rash over his entire body and made a diagnosis of German Measles, at her medical offices at 2 Mott Street, New York, N.Y. (T62, 64-5, Pet.'s Ex. 5)

18. Respondent performed and documented an adequate history and physical examination of Patient B, but did not document blood pressure or an examination of the lungs. (T63, Pet.'s Ex. 5)

19. Respondent prescribed the antibiotic Ultracef, which was not contraindicated, but not necessarily helpful for this condition. (T66)

20. Respondent prescribed Celestone for the patient's itch and redness, which was not inappropriate in the dose given and was

not likely to cause any adverse effects. (T202)

CONCLUSIONS AS TO PATIENT B

21. Respondent obtained and documented an adequate medical history for a young male patient with German Measles.

22. Respondent's prescriptions of Celestone and Ultracef were not likely to cause any adverse effects.

23. Respondent's short term prescription of a corticosteroid for this patient posed none of the risks associated with long term use.

FINDINGS OF FACT AS TO PATIENT C

24. Between September 20, 1982 and October 1986, on approximately 16 occasions, Respondent treated Patient C, a 27 year old female, for various complaints of runny nose, stuffiness, tight breathing and wheezing, at her medical offices at 2 Mott Street, New York, N.Y. (T72, Pet.'s Exs. 6 and 6a)

25. Respondent performed and documented an adequate history and physical examination of Patient C. (T73, Ex. 6 and 6a)

26. Respondent did not perform a blood work-up on Patient C (T77) but does perform routine laboratory screening tests when she thinks it necessary (T199). Blood screening tests are appropriate, sometimes (T78).

27. Respondent appropriately prescribed the corticosteroid Celestone for Patient C on approximately 12 occasions over a three

year period. (T35-6, 202, Pet.'s Ex. 6 and 6a)

28. Respondent did not prescribe Celestone for long term use by Patient C. (T202)

29. Respondent performed and documented an adequate workup for allergies for Patient C. (T96, Pet.'s Ex. 6 and 6a)

30. Respondent's treatment record of Patient C documents immunotherapy treatment. (T83, Pet.'s Ex. 6a)

CONCLUSIONS AS TO PATIENT C

31. Respondent performed and documented an adequate history and physical for Patient C, including an allergy work-up and immunotherapy. No blood work-up was indicated for Patient C.

32. Respondent's short term prescriptions for intermittent corticosteroid use over an three year period by Patient C were appropriate and posed none of the long term risks associated with long term use of these medications.

FINDINGS OF FACT AS TO PATIENT D

33. On July 12, 1980, October 31, 1981, November 15, 1981 and October 10, 1982, Respondent treated Patient D, a 5 year old male, for various nasal bronchial complaints, at her medical offices at 2 Mott Street, New York, N.Y. (T99-101, Pet.'s Ex. 7)

34. Respondent did not document an adequate history for Patient D. (T99, Pet.'s Ex. 7)

35. On October 31, 1981, Respondent diagnosed Patient D as

having chronic bronchitis. (T101-2, Pet.'s Ex. 7)

36. Bronchitis may be of viral or bacterial origin, and in children it is mostly viral. (T107)

37. Antibiotics are useful for bacterial infections but have no place in treatment of viral infections. (T66)

38. On November 15, 1981 Respondent diagnosed Patient D as having an upper respiratory infection. (T103, Pet.'s Ex. 7)

39. On October 10, 1982, Respondent saw Patient D, who was complaining of a runny nose. Respondent observed that his turbinates were swollen. (T103-4, Pet.'s Ex. 7)

40. Respondent did not prescribe an antibiotic for Patient D. (T35-6, 101, 104-5, 112 Pet.'s Ex. 7)

41. Respondent treated patient intermittently for over two years for the same symptomatology with no indication of deterioration secondary to an uncontrolled bacterial infection. (Pet.'s Ex. 7)

42. At the October 31, 1981, November 15, 1981 and October 10, 1982 visits Respondent prescribed small doses of the corticosteroid Celestone for Patient D. (T203-4, Pet.'s Ex. 7)

43. Respondent gave instructions to the mother of Patient D about the medication, but failed to document these on the patient's record. (T204, Pet.'s Ex. 7)

CONCLUSIONS AS TO PATIENT D

44. Respondent failed to document an adequate history for Patient D.

45. Respondent's decision not to prescribe an antibiotic for Patient D was appropriate since Patient D's illness was probably viral in origin.

46. Patient D was not exposed to the long term risks of corticosteroid use because only small amounts were prescribed on three occasions.

47. No allergy work-up was indicated for Patient D.

FINDINGS OF FACT AS TO PATIENT E

48. On December 18, 1984, Respondent treated Patient E, an 8 year old male, for complaints of a golf ball size mass below the chin on the left side, at her medical offices at 2 Mott Street, New York, N.Y. (T123-4, Pet.'s Ex. 8)

49. Respondent failed to document an adequate history for Patient E. (T123)

50. Respondent diagnosed Patient E's mass palpable below the chin on the left side as a tender and mobile lymph node. (T124, Pet.'s Ex. 8)

51. Patient E's father would not consent to a blood test for his son. (T232)

52. Respondent prescribed the corticosteroid Celestone in a small dose for eight days for Patient E. (T125, Pet.'s Ex. 8)

CONCLUSIONS AS TO PATIENT E

53. Respondent failed to document an adequate history for

Patient E.

54. Although a blood work-up might have been indicated for Patient E, Respondent was not able to obtain parental consent.

55. There was no clear evidence in the record as to whether Celestone was inappropriately prescribed for Patient E. (T131)

56. Patient E was not exposed to the risks of long term corticosteroid use because only a small amounts was prescribed on a single occasion.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous.)

FIRST SPECIFICATION:
(Negligence on more than one occasion)

NOT SUSTAINED as to Paragraphs A and A1-6; B and B1-4; C and C1-6; D and D1-7; and/or E and E1-5.

SECOND SPECIFICATION:
(Incompetence on more than one occasion)

NOT SUSTAINED as to Paragraphs A and A1-6; B and B1-4; C and C1-6; D and D1-7 and/or E and E1-5.

THIRD SPECIFICATION:
(Failure to maintain record)

NOT SUSTAINED as to Paragraphs A and A1, 2, 5 and 6; B and B1-2 and 4; C and C1-3 and 5-7; D6-7; E3 and 5.

SUSTAINED as to Paragraphs D and D1; E and E1-2.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

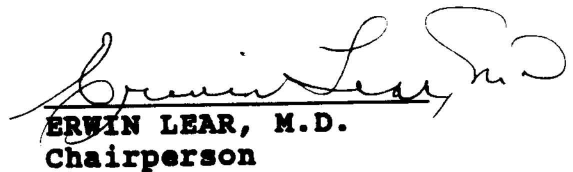
The Hearing Committee unanimously determines that Respondent should be censured and reprimanded for her poor record keeping. The Committee strongly urges the Respondent to develop a better record keeping practice pattern.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT

1. Respondent is hereby censured and reprimanded for her poor record keeping.

Dated: New York, New York
September 26, 1992



ERWIN LEAR, M.D.
Chairperson

J. LARUE WILEY, M.D.
SISTER MARY MURPHY

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

IN THE MATTER OF CHRISTINA Y. KO, M.D.	:	STATEMENT OF CHARGES

Christina Y. Ko, M.D., the Respondent, was authorized to practice medicine in New York State on May 19, 1978 by the issuance of license number 134406 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 through December 31, 1992.

FACTUAL ALLEGATIONS

A. Between on or about May 27, 1987 and April 29, 1987, on approximately 15 occasions, Respondent treated Patient A (patients' names appear in the attached Appendix), a 26 year old male, for various complaints of stuffy nose, runny nose, sore throat, tight breathing, coughing, and sneezing, at her medical offices at 2 Mott Street, New York, New York.

1. Respondent failed throughout the period of treatment to obtain and note an adequate history.

2. Respondent failed throughout the period of treatment to perform and note an adequate physical examination.

3. Respondent inappropriately prescribed the corticosteroid Celestone for Patient A on approximately ten occasions between on or about May 22, 1979 and April 19, 1986.

4. On or about May 22, 1979, Respondent inappropriately prescribed the corticosteroid Depomedrol for Patient A.

5. Respondent failed throughout the period of treatment to perform a proper workup for allergies or to note any such workup.

6. Respondent failed to evaluate the risk to Patient A of the continued use of Celestone or to note any such evaluation.

B. On or about May 21, 1983, Respondent treated Patient B, a 21 year old male, for complaints of fever and a rash over his entire body and made a diagnosis of German measles, at her medical offices at 2 Mott Street, New York, New York.

1. Respondent failed to obtain and note an adequate history.

2. Respondent failed to perform and note an adequate physical examination.

3. Respondent inappropriately prescribed the cortocosteroid Celestone and the antibiotic Ultracef.

4. Respondent failed to evaluate the risk to Patient B of the use of Celestone or to note any such evaluation.

C. Between on or about September 20, 1982 and October 22, 1986, on approximately 16 occasions, Respondent treated Patient C, a 27 year old female, for various complaints of running nose, stuffiness, tight breathing and wheezing, at her medical offices at 2 Mott Street, New York, New York.

1. Respondent failed throughout the period of treatment to obtain and note an adequate history.

2. Respondent failed throughout the period of treatment to perform and note an adequate physical examination.

3. Respondent failed to perform any blood workup on Patient C at any time during the period of treatment or to record any blood workup in the treatment record of Patient C.

4. Respondent inappropriately prescribed the corticosteroid Celestone for Patient C on approximately twelve occasions between on or about April 21, 1983 and August 6, 1986.

5. Respondent failed to evaluate the risk to Patient C of the continued use of Celestone or to note any such evaluation.

6. Respondent failed throughout the period of treatment to perform a proper workup for allergies or to note any such workup.

7. In a letter from Respondent in Patient C's file, Respondent states that Patient C had been in immunotherapy from 1983 up to 1985. There is no record of any immunotherapy treatment in Respondent's treatment record of Patient C.

D. On or about July 12, 1980, March 10, 1981, November 15, 1981, and October 10, 1982, Respondent treated Patient D, a 5 year old male, for various nasal and bronchial complaints, at her medical offices at 2 Mott Street, New York, New York.

1. Respondent failed throughout the period of treatment to obtain and note an adequate history.

2. On or about March 10, 1981, Respondent diagnosed Patient D as having chronic bronchitis. Nevertheless, Respondent failed to order an antibiotic for Patient D.

3. On or about November 15, 1981, Respondent diagnosed Patient D as having an upper respiratory infection. Nevertheless, Respondent failed to order an antibiotic for Patient D.

4. On or about October 10, 1982, Respondent saw Patient D, who was complaining of a runny nose. Respondent observed that his turbinates were swollen. Nevertheless, Respondent failed to order an antibiotic for Patient D.

5. At the March 10, 1981, November 15, 1981, and October 10, 1982 visits, Respondent inappropriately prescribed the corticosteroid Celestone.

6. Respondent failed to evaluate the risk to Patient D of the use of Celestone or to note any such evaluation.

7. Respondent failed throughout the period of treatment to perform a proper workup for allergies or to note any such workup.

E. On or about December 18, 1984, Respondent treated Patient E, an 8 year old male, for complaints of a golf ball size mass below the chin on the left side, at her medical offices at 2 Mott Street, New York, New York.

1. Respondent failed to obtain and note an adequate history.

2. Respondent failed to perform and note an adequate physical examination.

3. Respondent diagnosed Patient E's mass palpable below the chin on the left side as a tender and mobile lymph node. Nevertheless, Respondent failed to order, perform and note appropriate blood tests and other diagnostic tests and procedures.

4. Respondent inappropriately prescribed the corticosteroid Celestone.

5. Respondent failed to evaluate the risk to Patient E of the use of Celestone or to note any such evaluation.

SPECIFICATION OF CHARGES

FIRST 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 that Respondent committed at least two of the following:

1. The facts contained in Paragraphs A and A1-6; B and B1-4; C and C1-6; D and D1-7; and/or E and E1-5.

SECOND 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 that Respondent committed at least two of the following:

2. The facts contained in Paragraphs A and A1-6; B and B1-4; C and C1-6; D and D1-7; and/or E and E1-5.

THIRD THROUGH SEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORD

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

3. The facts contained in Paragraphs A and A1, 2, 5 and 6.

4. The facts contained in Paragraphs B and B1-2 and 4.

5. The facts contained in Paragraphs C and C1-3 and 5-7.

6. The facts contained in Paragraphs D and D1, 6 and 7.

7. The facts contained in Paragraphs E and E1-3 and 5.

DATED: New York, New York
June 16, 1992

CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct