



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

Karen Schimke
Executive Deputy Commissioner

July 19, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Hei Young Oh, M.D.
789 Walt Whitman Road
Melville, New York 11747

John Kase, Esq.
1325 Franklin Avenue
Garden City, New York

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

RE: In the Matter of Hei Young Oh, M.D.

Dear Dr. Oh, Mr. Kase and Mr. Smith:

Enclosed please find the Determination and Order (No. 95-151) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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.

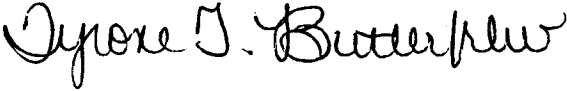
The notice of review served on the Administrative Review Board should be forwarded to:

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,

A handwritten signature in black ink that reads "Tyrone T. Butler". The signature is written in a cursive style with a large, prominent initial "T".

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

**IN THE MATTER
OF
HEI YOUNG OH, M.D.**

**HEARING COMMITTEE
DETERMINATION
AND ORDER**

BPMC-95-151

RICHARD N. PIERSON, M.D., Chairperson, **DANIEL W. MORRISSEY, O.P.**, and **DANIEL A. SHERBER, M.D.**, duly designated members of the State Board of Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 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. **STEPHEN BERMAS, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	January 24, 1995
Statement of Charges dated:	February 9, 1995
Pre-Hearing Conference:	April 3, 1995
Hearing Date:	April 7, 1995
Deliberation Date:	May 2, 1995

Place of Hearing: NYS Department of Health
5 Penn Plaza
New York, New York

Petitioner Appeared By: Peter J. Millock, Esq.
General Counsel
NYS Department of Health

BY: David W. Smith, Esq.

Respondent Appeared By: John Laurence Kase, Esq.

STATEMENT OF CHARGES

The Statement of Charges as amended has been marked as Petitioner's Exhibit 1 and hereto attached as Appendix A.

CREDIBILITY OF WITNESSES

The Hearing Committee found Dr. Walter Dzedzic, the expert witness for the Petitioner, to be well qualified and a highly credible witness.

By contrast, the Committee found Dr. Hei Young Oh, the Respondent, not to be responsive to questions. Although he appeared to be sincere, his answers were not complete and not helpful to the Committee. For example, when questioned about the reason for his departure from Deepdale Hospital, he failed to provide any information. Similarly, his answers to questions concerning Patient E's possible pregnancy were uninformative.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular

finding. Conflicting evidence, if any, has been considered and rejected in favor of the cited evidence.

1. Respondent is duly licensed and registered to practice medicine in the State of New York. (Ex. 2)
2. Respondent admitted to, and has been found guilty by the Commissioner of Health of, violating Article 33 of the N.Y. Public Health Law in prescribing of controlled substances in a manner inconsistent with Article 33 and the failure to maintain proper patient records. (Ex. 3)

PATIENT A

3. Respondent treated Patient A from January, 1992 through December, 1992. At no time did he obtain an adequate medical history or perform an adequate physical examination. (T. 21-27, 38-40; Ex. 4)
4. Respondent repeatedly prescribed Percocet and Valium for Patient A without justification and in excessive amounts. (T. 26-27; Ex. 4) During the 11 months Respondent treated Patient A, he gave her 47 prescriptions for controlled substances, including Percocet and Valium totalling about 2400 pills. (Ex. 4)
5. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient A. (T. 21-27; Ex. 4)
6. The care rendered by Respondent to Patient A failed to meet minimum acceptable medical standards. (T. 26-27; Ex. 4)

PATIENT B

7. Respondent treated Patient B from June, 1992 through March, 1993. At no time did he obtain an adequate medical history or perform an adequate physical examination. (T. 62-67; Ex. 5)
8. Respondent repeatedly prescribed various narcotics for Patient B, including Hycodan, without justification and in excessive amounts. (T. 66-67; Ex. 5) During the nine (9) months that Respondent treated Patient B, Respondent gave Patient B 32 prescriptions totalling approximately 256 oz. of liquid narcotics. (Ex. 5)
9. Respondent continued to prescribe narcotics for Patient B even though he knew that Patient B was addicted to them and wanted to stop. (T. 67, 157-58; Ex. 5)
10. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient B. (T. 62-68; Ex. 5)
11. The care rendered by Respondent to Patient B did not meet minimum acceptable medical standards. (T. 66-67; Ex. 5)

PATIENT C

12. Respondent treated Patient C from July, 1990 through November, 1993. At no time did Respondent obtain an adequate medical history or perform an adequate physical examination. (T. 76-87, 92-93; Ex. 6)

13. Without any work-ups, laboratory tests or physical examinations, Respondent repeatedly diagnosed Patient C with migraine headaches and repeatedly prescribed Tylenol with Codeine (Tylenol #4) without justification and in excessive amounts. (T. 86-87; Ex. 6)
14. During 33 months of treatment, Respondent gave Patient C 56 prescriptions resulting in a total of about 5400 pills. (Ex. 6) Despite the fact that Tylenol #4 was not providing Patient C with relief, Respondent continued to prescribe it. (T. 87; Ex. 6)
15. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient C. (T. 76-87; Ex. 6)
16. The care rendered by Respondent to Patient C did not meet minimum acceptable medical standards. (T. 86-87; Ex. 6)

PATIENT D

17. Patient D, the wife of Patient C, was treated by Respondent from December, 1991 through March, 1993. At no time did Respondent obtain an adequate medical history or perform an adequate physical examination. (T. 96-104; Ex. 7)
18. Respondent repeatedly made the unsupported diagnosis of migraine headaches and repeatedly prescribed Tylenol #4 without justification and in excessive amounts. (T. 103-04; Ex. 7)
19. During 19 months of treatment, Respondent gave Patient D 21 prescriptions totalling approximately 2100 pills. (Ex. 7) Even though Tylenol #4 provided no relief to Patient D, Respondent continued to prescribe it. (T. 103; Ex. 7)

20. According to the patient charts for C and D, Respondent prescribed for this husband and wife 100 tablets of Tylenol #4 every one to two weeks. (Ex. 6, 7)
21. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient D. (T. 96-104; Ex. 7)
22. The care rendered by Respondent to Patient D did not meet minimum acceptable medical standards. (T. 103-04; Ex. 7)

PATIENT E

23. Patient E was treated by Respondent from September, 1990 through April, 1993. At no time did Respondent obtain an adequate medical history or perform an adequate physical examination. (T. 112-117; Ex. 8)
24. Respondent repeatedly made unsupported diagnoses of Patient E ranging from headache to neck pain and continued to prescribe narcotics, particularly Vicodin ES, without justification and in excessive amounts. (T. 117-20; Ex. 8)
25. During 19 months of treatment, Respondent gave Patient E 79 prescriptions resulting in over 7000 pills. (Ex. 8) Respondent continued to prescribe narcotics for Patient E despite the facts that (1) she had a positive pregnancy test, (2) the narcotics were not working, and (3) Respondent knew Patient E was addicted to them. (T. 127; Ex. 8)
26. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient E. (T. 117-20; Ex. 8)

27. The care rendered to Patient E by Respondent did not meet minimum acceptable medical standards. (T. 117-20; Ex. 8)

CONCLUSIONS OF LAW

FIRST: Respondent engaged in professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Education Law Section 6530 (2) (McKinney Supp. 1995) as alleged in the First Specification of the Statement of Charges and based upon Findings of Fact 1 through 27, supra.

SECOND: Respondent engaged in professional misconduct by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Education law Section 6530 (32) (McKinney Supp. 1995) as alleged in the Second through Sixth Specifications of the Statement of Charges and based upon Findings of Fact 3, 5, 7, 10, 12, 15, 17, 23 and 26, supra.

THIRD: Respondent engaged in professional misconduct by reason of violating Article 33 of the Public Health Law within the meaning of N.Y. Education Law Section 6530 (9)(e) (McKinney Supp. 1995) as alleged in the Seventh Specification of the Statement of Charges are based upon Findings of Fact 2, supra.

DISCUSSION

Respondent failed to demonstrate any competence in the practice of medicine, nor any understanding of the principles of the practice of medicine, beyond the mechanics of prescribing and billing. By his substitution of the prescribing of medications for any of the proper functions of physicians to diagnose, treat, and prevent disease, he demonstrated a virtual vacuum of

medical competence, thereby exposing his patients to the risks of surviving his ignorance.

He failed to demonstrate a single instance of having utilized his training in general medicine, Internal Medicine, or Radiology to the benefit of any patient whose chart was examined (there were five such charts, each provided in its entirety). Also, in his responses to questioning from the Committee, he demonstrated no positive evidence of any medical competence or understanding.

No reason for his "retiring" from a staff Radiology position at Deepdale Hospital was provided, although it was requested. The trail of competence stops at this point. For the subsequent years of his practice, there is an admission of no effort at Continuing Education.

While his attorney suggested that Respondent's lack of proficiency in English was the cause of his problem, the Hearing Committee found that Respondent's vocabulary and understanding of English was far above a threshold of competence in English. Ignorance of the language was demonstrated not to be an issue; ignorance of medicine was well demonstrated.

The credible evidence has convinced the Hearing Committee that the Respondent does not possess the necessary skills and ability to properly practice medicine. There was a total failure of proof by Respondent that could demonstrate such skills and ability.

The Committee considered the alternative of focused retraining but could find no basis for concluding that it would be productive in this case. Respondent does not show any indication of having the necessary insight, motivation, or ability to make him a candidate for retraining.

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice medicine be REVOKED.

DATED: Albany, New York

7.14. 1995


RICHARD N. PIERSON, M.D. (Chair)

**DANIEL W. MORRISSEY, O.P.
DAVID A. SHERBER, M.D.**

TO: Hei Young Oh, M.D.
789 Walt Whitman Road
Melville, New York 11747

John Kase, Esq.
1325 Franklin Avenue
Garden City, New York

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

Tyran
ESP Carving Tube
room 2503

12237.

APPENDIX I

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

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IN THE MATTER : NOTICE
OF : OF
HEI YOUNG OH, M.D. : HEARING

-----X

TO: HEI YOUNG OH, M.D.
789 Walt Whitman Road
Melville, New York 11747

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 (McKinney 1990 and Supp. 1995) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1995). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the ~~21st~~ day of March, 1995, at 10:00 in the forenoon of that day at the Offices of the New York State Department of Health, 5 Penn Plaza, Sixth Floor, New York, New York, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and

you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

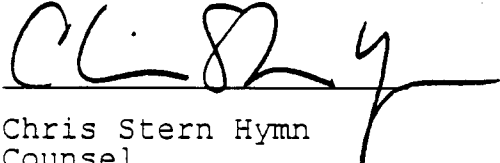
Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1995), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded*to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make

findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1995). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
January 24, 1995


Chris Stern Hymn
Counsel

Inquiries should be directed to: David W. Smith
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
5 Penn Plaza, Suite 601
New York, New York 10001
(212) 613-2617

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

-----X

IN THE MATTER : STATEMENT
OF : OF
HEI YOUNG OH, M.D. : CHARGES

-----X

HEI YOUNG OH, M.D., the Respondent, was authorized to practice medicine in New York State on July 23, 1982, by the issuance of license number 151015 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. By Stipulation and order dated September 2, 1994, Respondent entered into a Stipulation with the New York State Department of Health, Bureau of Controlled Substances, whereby Respondent admitted to, and the Commissioner of Health so found, violations of Article 33 of the N.Y. Public Health Law in that Respondent dispensed controlled substances to his patients ^{in a manner inconsistent with Article 33} ~~not in the good faith practice of~~ _{of the Public Health Law} ~~medicine~~ and did not maintain medical records which justified the prescriptions to such patients. Respondent was fined \$25,000.00, payment of \$20,000.00 of which was suspended pending lawful conduct by Respondent for two (2) years from the date of the Order and his right to issue prescriptions on official New York State Prescription forms was suspended, also for two (2) years.

[Amended as of 4/7/95]

- B. Between in or about January, 1992, and in or about December, 1992, Respondent treated Patient A at his office at 789 Walt Whitman Road, Melville, New York 11747, for tension and other medical conditions. (All patients are identified in the Appendix attached hereto).
1. Throughout the period, Respondent failed to perform an adequate physical examination or note such examination, if any.
 2. Throughout the period, Respondent failed to obtain an adequate medical history or note such history, if any.
 3. Throughout the period, Respondent inappropriately prescribed controlled substances, including Percocet and Valium.
- C. Between in or about June, 1992, and in or about March, 1993, Respondent treated Patient B for bronchitis and other medical conditions at his office at 789 Walt Whitman Road, Melville, New York 11747.
1. Throughout the period, Respondent failed to perform an adequate physical examination or note such examination, if any.
 2. Throughout the period, Respondent failed to obtain an adequate medical history or note such history, if any.
 3. Respondent knew Patient B was addicted to narcotics. Nevertheless, Respondent continually and inappropriately prescribed narcotics including Hycodan.
- D. Between in or about July, 1990, and in or about March, 1993, Respondent treated Patient C for headache and other medical

conditions at his office at 789 Walt Whitman Road, Melville, New York 11747.

1. Throughout the period, Respondent failed to perform an adequate physical examination or note such examination, if any.
2. Throughout the period, Respondent failed to perform an adequate medical history or note such history, if any.
3. Throughout the period, Respondent inappropriately issued prescriptions, Tylenol with Codeine No. 4, 100 tablets at a time, approximately one every one to two weeks.

E. Between in or about December, 1991, and in or about March, 1993, Respondent treated Patient D, the wife of Patient C, for headache and other medical conditions at his office at 789 Walt Whitman Road, Melville, New York 11747.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.
2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.
3. Throughout the period, Respondent inappropriately prescribed Tylenol with Codeine No. 4, 100 tablets at a time every one to two weeks.

F. Between in and about September, 1991, and in and about April, 1993, Respondent treated Patient E for Temporal Mandibular Joint dislocation and other medical conditions at his office at 789 Walt Whitman Road, Melville, New York 11747.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.
2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.
3. Throughout the period, Respondent inappropriately prescribed controlled substances for Patient E including Vicodin ES.

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 within the meaning of N.Y. Educ. Law Section 6530(2) (McKinney Supp. 1995). Specifically, Petitioner charges two or more of the following:

1. The facts in Paragraphs B and B1-3; C and C1-3; D and D1-3; E and E1-3 and/or F and F1-3.

SECOND THROUGH SIXTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1995). Specifically, Petitioner charges:

2. The facts in Paragraphs B and B1-2.
3. The facts in Paragraphs C and C1-2.
4. The facts in Paragraphs D and D1-2.

5. The facts in Paragraphs E and E1-2.
6. The facts in Paragraphs F and F1-2.

SEVENTH SPECIFICATION

. VIOLATION OF ARTICLE 33 OF THE PUBLIC HEALTH LAW

Respondent is charged with having been found guilty by the Commissioner of Health to be in violation of Article 33 of the Public Health Law within the meaning of N.Y. Educ. Law Section 6530(9)(e) (McKinney Supp. 1995). Specifically, Petitioner charges:

7. The facts in Paragraph A.

DATED: New York, New York

February 9, 1995



CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct