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

March 13, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Mark Hankin, Esq.
255 Broadway
New York, New York 11201

Sung Dam Tan, M.D.
93 Sanford Street
Yonkers, New York 10704

Dianne Abeloff, Esq.
NYS Dept. of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: In the Matter of Sung Dam Tan
Effective Date: 03/20/95

Dear Mr. Hankin, Ms. Abeloff and Dr. Tan :

Enclosed please find the Determination and Order (No. 94-95) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Corning Tower, Room 438
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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER

OF

SUNG DAM TAN, M.D.

ADMINISTRATIVE REVIEW BOARD REMAND ORDER ARB NO. 94-95A

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on February 17, 1994 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) November 22, 1994 Supplemental Determination in the case of Dr. Sung Dam Tan (Respondent). The Review Board remanded this case to the Hearing Committee on October 4, 1994, so that the Hearing Committee could answer certain questions concerning how the Committee reached their initial Determination. James F. Horan served as Administrative Officer to the Review Board. Mark L. Hankin, Esq. has appeared for the Respondent in this proceeding. Dianne Abeloff, Esq. has appeared for the Office of Professional Medical Conduct (Petitioner). By letter dated December 13, 1994, both parties received a copy of the Hearing Committee's Supplemental Determination and both parties were advised that they had thirty days to submit additional briefs. Neither party submitted a brief.

SCOPE OF REVIEW

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

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

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

INITIAL HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent, an anesthesiologist, with gross negligence and negligence on more than one occasion arising from the care of five persons, Patients A through E. In the cases of Patients B and E, the Respondent provided the anesthesia to the patients. In the case of Patient A, a nurse anesthetist provided the anesthesia, in an outpatient facility.

The Hearing Committee found that the Respondent was grossly negligent in the cases of patients A, B, C and E. The Hearing Committee found the Respondent was negligent on more than one occasion based on their Findings of Fact 3 through 19, which appear at pages 4 through 20 of the Hearing Committee's Determination. In the case of Patient A, the Hearing Committee found that the Respondent was responsible for the actions of a nurse anesthetist. The Committee found that the Respondent was not supervising the nurse properly, and that the Respondent failed to intubate and re-oxygenate Patient A in a timely manner, after Patient A became distressed and the nurse sent for the Respondent. The Committee also found that the Respondent had failed to initiate closed chest heart massage on Patient A. In the case of Patient B, the Committee found that the Respondent did not adequately monitor Patient B and manage his airway for thirty minutes during a surgical procedure. In the case of Patient C, who was undergoing a Caesarean Section, the Committee found that the Respondent failed to adequately observe the Patient in the Delivery Room and that the Respondent failed to administer calcium chloride to the Patient in a timely manner. As to Patient E, the Committee found that the Respondent failed to intubate the Patient properly and that the Respondent permitted Patient E's surgeon to commence surgery when the Patient did not have a viable airway.

The Committee stated that the credible evidence had convinced them that the Respondent does not possess the necessary skills to properly monitor, assess and respond to life threatening anesthetic complications and that the Respondent does not accept or recognize his responsibility for patients. The Committee voted to revoke the Respondent's license to practice medicine in New York State. The Committee stated that they had considered alternative sanctions, but concluded that there was no indication that the Respondent would benefit from focused retraining.

INITIAL REQUESTS FOR REVIEW

In his brief to the Board following the Initial Hearing Committee Determination, the Respondent challenged the Hearing Committee's findings of fact, conclusions and penalty, and the Respondent raised a procedural objection as to the make up of the Hearing Committee. Further, the Respondent contended that the Hearing Committee substituted its own judgement in arriving at one of its findings concerning Patient C (Respondent's brief pp. 19-20). The Respondent challenged the Hearing Committee's findings as to which hearing witnesses were credible and challenged the basis for all the Committee's findings of fact. The Respondent challenged the Committee's conclusion that the Respondent was guilty of negligence on more than one occasion and gross negligence. The Respondent noted on that point that the Hearing Committee concluded that the Respondent lacked necessary skills (Hearing Committee Determination Page 22), which is the basis for a finding relating to incompetence not negligence. The Respondent also contended that the Hearing Committee's Determination was not clear as to whether the Committee found the Respondent guilty of negligence in the case of Patient D. The Respondent argued that even accepting all the Committee's findings and its conclusion, the penalty of revocation was too severe. The Respondent argued that in the case of a physician who lacks skills, the physician should have the opportunity to undergo retraining to improve those skills.

The Petitioner urged the Review Board to uphold the Hearing Committee's Determination and Penalty. The Petitioner argued that the Review Board lacks the authority to grant the relief which the Respondent's brief requested.

REMAND DETERMINATION

Following deliberations on September 16, 1994 the Review Board voted to remand this case to the Hearing Committee for further deliberations, because the Review Board was unable to complete our review of this case without additional information from the Hearing Committee concerning how the Committee reached their Determination. The Board directed the Hearing Committee to issue a Supplemental Determination with the answers to four questions which we set out below:

1. What was the basis for the Hearing Committee's Determination that the Respondent had failed to administer calcium chloride to patient C in a timely manner (Finding of Fact 14, HC Det. p. 14)?

2. Did the Committee find that the Respondent was guilty of negligence in the treatment of Patient D?

3. How did the Committee reach their conclusions that the Respondent was guilty of gross negligence and negligence on more than one occasion. Specifically, what Findings of Fact indicate that the Respondent, in his care of the patients in this case, failed to exercise the care which a reasonably prudent physician would have exercised under the circumstances, and, what Findings of Fact demonstrate that the Respondent's acts of negligence in caring for Patient A, B, C and E were of an aggravated or egregious character?

4. How did the Committee conclude that the Respondent's misconduct could not be addressed through retraining?

The Remand Order provided that the Hearing Committee's Penalty would remain stayed during the period of the remand and until the Review Board issues its Final Determination in this matter.

SUPPLEMENTAL HEARING COMMITTEE DETERMINATION

The Hearing Committee rendered its Supplemental Determination on November 22, 1994. The Committee's answers to the questions from the Review Board Remand Order follow below.

Question 1

"The Hearing Committee determined that the Respondent had failed to administer calcium chloride to Patient C in a timely manner because Patient C was unresponsive for more than thirty minutes, had marked respiratory acidosis and was not breathing on her own. T 344-349 (especially T 345 line 17 and T 346), 355, 362 and 607."

Question 2

"The Hearing Committee determined that Respondent was guilty of negligence in the treatment of Patient D as set forth in its Finding of Fact 15. Respondent failed to request appropriately labeled bottles as a prudent physician would have done."

Question 3

"As set forth in its SECOND Conclusion of Law, the Hearing Committee determined that its Finding of Fact Nos. 3 through 19 indicated that the Respondent failed to exercise the care which a reasonably prudent physician would have exercised under the circumstances in the cases of Patients A, B, C, D and E.

"As set forth in its FIRST Conclusion of Law, the Hearing Committee determined that its Findings of Fact Nos. 3 through 14 and 16 through 19 indicated that the Respondent's acts of negligence in caring for Patients A, B, C and E were of an aggravated or egregious character."

Question 4

"The Hearing Committee determined that the Respondent's misconduct could not be addressed through retraining because of (1) his lack of insight into the problems of Patients A, B, C, D and E, (2) his lack of motivation to learn and (3) his lack of ability to learn through retraining."

"(1) Insight:

Lack of insight can be shown on a patient by patient basis. All transcript citations are from Dr. Tan's testimony only."

"Patient A:

1. Tan did the preoperative assessment. T544, L11-19

2. Tan abandoned the patient to the CRNA without the patient's consent T 545, L1-10 and ordered the CRNA to do the case T 545, L9.

3. Tan signed the preoperative forms to obtain the Medicaid reimbursement because he was under the impression that CRNAs could not be reimbursed directly T 550, L10-14."

"Patient B:

1. Tan persisted in believing a small amount of lidocaine caused this patient's problem T582, L8-23.

"2. He continued to defend this theory using the anatomic impossibility of an intravenous injection of a small amount of lidocaine reaching the brain undiluted and having a direct effect on the brain T590, L10-19."

"Patient C:

1. Tan testified that he knew he should do something to help this patient but did not act because he alleged he could not get the surgeon's permission and did not document the latter in the medical record T600, L21-25 and T601, L1-23.

2. His testimony with regard to this patient shows complete lack of insight and ability to handle problems in anesthesia T602, L13-25, T603 and T604, L1-10."

"Patient D:

Even in the situation of an obviously innocent error as what happened to this patient (switching an IV bag or bottle). Tan was unable to admit he may have made an error" T613, L10-14."

"Patient E:

Tan persisted in believing the impossible despite peer testimony to the opposite:

1. The capnograph worked for him on the patient immediately previous to this patient without any problem T624, 20-25 and T626, L1-3.

2. Despite the foregoing, he does not believe that the capnograph was not broken T623, L4-15.

3. He would give no credence to the hospital report alleging that there may have been an esophageal intubation T629, L20-23.

4. He gave no credence to an anesthesia department conference that also concluded that there probably was an esophageal intubation T630, L10-25 and T631, L1-9."

"All of the above testimony of Tan could not be believed by the Committee because of the affirmative testimony of Dr. Andree which the Committee found more logical and plausible medically."

"(2) Motivation

Because of all the references under the Insight heading, supra, but especially because of items 3 and 4 pertaining to Patient E, the Hearing Committee determined that Respondent does not have the motivation to learn."

"(3) Ability

The Hearing Committee concluded that Respondent does not have the ability to learn in light of the following:

(a) Respondent testified that 'Almost every year, I attend one review course.' T530, L3-9

(b) Respondent subscribes to anesthesia journals and video tapes. T530, L17-22

(c) Respondent has taken courses to pass the Board certifying examinations for the past eleven years. T549, L13-19"

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below, the briefs which counsel have submitted and the Hearing Committee's Supplemental Determination

First, the procedural issues, such as the make up of the Hearing Committee, are beyond the Review Board's authority. The Review Board may remand a case to the Hearing Committee, but we can not order a new hearing or change the members on the panel.

The Review Board votes to sustain the Hearing Committee's Determination that the Respondent was negligent in his care for Patients A through E and grossly negligent in his care for Patient A, B, C and E. The Committee's Determination on negligence is consistent with their findings that the Respondent failed, in his care for all five patients, to exercise the care which a reasonably prudent physician would have exercised under the circumstances. The Committee's Determination that the Respondent's negligent acts in the care of patients A, B, C and E were aggravated and egregious in character are consistent with the Committee's findings of fact 4 through 14 and 16 through 19. Those findings indicated that the Respondent in caring for Patient A, had failed to properly supervise the nurse anesthetist, failed to reintubate and reoxygenate the patient in a timely manner and failed to initiate closed heart massage on the Patient. In the case of Patient B, the findings indicated that the Respondent did not manage the patient's airway for thirty minutes during a surgical procedure. In the case of Patient C, the Committee found that the Respondent failed to adequately observe the Patient in the delivery room and failed to administer calcium chloride to the Patient in a timely manner. In the case of Patient E, the Committee found that the Respondent failed to intubate the Patient properly and that the Respondent allowed the surgeon to commence surgery without a viable airway.

The Review Board finds that the Hearing Committee's findings are supported by the testimony and evidence in the record. The Committee as the finder of fact is the proper party to assign weight to the exhibits and determine which witnesses are credible.

The Review Board sustains the hearing Committee's Determination to revoke the Respondent's license to practice medicine in New York State. The Respondent was guilty of repeated and egregious acts of negligence in his care of the patients involved in this case. The Respondent's continued practice of medicine in this State would clearly present a danger to the public. The Hearing Committee considered whether retraining could correct the Respondent's dangerous pattern of practice. The Committee determined that the Respondent lacked the insight, motivation and ability to learn through retraining.

The Committee's Determination to revoke the Respondent's license is consistent with the Committee's findings concerning the Respondent's repeated and egregious misconduct and is appropriate to protect the public health.

ORDER

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

1. The Review Board **SUSTAINS** the Hearing Committee's Determination finding the Respondent guilty of professional misconduct.

2. The Review Board **SUSTAINS** the Hearing Committee's Determination to revoke the Respondents license to practice medicine in New York State.

ROBERT M. BRIBER

SUMNER SHAPIRO

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF SUNG DAM TAN, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the FINAL Determination and Order in the Matter of Dr. Tan.

DATED: Albany, New York

March , **1995**

ROBERT M. BRIBER

IN THE MATTER OF SUNG DAM TAN, M.D.

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

DATED: Delmar, New York

March 3, **1995**

Sumner Shapiro

SUMNER SHAPIRO

IN THE MATTER OF SUNG DAM TAN, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the FINAL Determination and Order in the Matter of Dr. Tan.

DATED: Brooklyn, New York

_____, 1995

WINSTON S. PRICE, M.D.

IN THE MATTER OF SUNG DAM TAN, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the FINAL Determination and Order in the Matter of Dr. Tan.

DATED: Roslyn, New York
Feby 27, **1995**

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF SUNG DAM TAN, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the FINAL Determination and Order in the Matter of Dr. Tan.

DATED: Syracuse, New York
28 Feb **, 1995**

William A Stewart

WILLIAM A. STEWART, M.D.

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

October 4, 1994

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Sung Dam Tan, M.D.
93 Sanford Street
Yonkers, New York 10704

Mark L. Hankin, Esq.
Ross, Suchoff, Taroff, Egert & Hankin, P.C.
255 Broadway
New York, New York 10007

Dianne Abeloff, Esq.
N.Y.S. Dept. of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

RE: IN THE SUNG DAM TAN , M.D.

Dear Parties:

The Administrative Review Board for Professional Medical Conduct has issued the enclosed Determination and Order remanding this case to the Original Hearing Committee, for the reasons stated in the Determination.

The Procedures for the Remand are set out in the Determination.

Sincerely,

Tyrone T. Butler (by)
Tyrone T. Butler
Director
Bureau of Adjudication

Enclosure

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

September 20, 1994

Stephen Bermas, Esq.
9 Shelter Bay Drive
Great Neck, New York 11024

RE: Sung Dam Tan, M. D.

Dear Judge Bermas:

The Administrative Review Board for Professional Medical Conduct has remanded Dr. Tan's case to the Hearing Committee for the reasons and under the conditions which are set out in the Board's attached Determination.

If the Hearing Committee has any questions concerning the procedure for the Remand, you can communicate those questions to the Board by letter from you to me. The parties to this case should receive copies of any such correspondence.

Sincerely,

James F. Horan
Administrative Law Judge

Enclosure

cc: Mr. Hankin
Ms. Abeloff
Dr. Vacanti
Mr. Horrigan
Dr. Haynes

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

IN THE MATTER

OF

SUNG DAM TAN, M.D.

ADMINISTRATIVE REVIEW BOARD REMAND ORDER
ARB NO. 94-95R

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on September 16, 1994 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) June 23, 1994 Determination finding Dr. Sung Dam Tan (Respondent) guilty of professional misconduct. The Respondent requested the Review through a Notice which the Board received on July 6, 1994. James F. Horan served as Administrative Officer to the Review Board. Mark L. Hankin , Esq. filed a brief for the Respondent on August 9, 1994. Dianne Abeloff, Esq. filed a reply brief for the Office of Professional Medical Conduct (Petitioner) on August 18, 1994.

SCOPE OF REVIEW

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

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

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent, an anesthesiologist, with gross negligence and negligence on more than one occasion arising from the care of five persons, Patients A through E. In the cases of Patients B through E, the Respondent provided the anesthesia to the patients. In the case of Patient A, a nurse anesthetist provided the anesthesia, in an outpatient facility.

The Hearing Committee found that the Respondent was grossly negligent in the cases of Patients A, B, C and E. The Hearing Committee found the Respondent was negligent on more than one occasion based on their Findings of Fact 3 through 19, which appear at pages 4 through 20 of the Hearing Committee's Determination. In the case of Patient A, the Hearing Committee found that the Respondent was responsible for the actions of the nurse anesthetist. The Committee found that the Respondent was not supervising the nurse properly, and that the Respondent failed to intubate and re-oxygenate Patient A in a timely manner, after Patient A became distressed and the nurse sent for the Respondent. The Committee also found that the Respondent had failed to initiate closed chest heart massage on Patient A. In the case of Patient B, the Committee found that the Respondent did not adequately monitor Patient B and manage his airway for thirty minutes during a surgical procedure. In the case of Patient C, who was undergoing a Caesarean Section, the Committee found that the Respondent failed to adequately observe the Patient in the Delivery Room and that the Respondent failed to administer calcium chloride to the Patient in a timely manner. As to Patient E, the Committee found that the Respondent failed to intubate the Patient properly and that the Respondent permitted Patient E's surgeon to commence surgery when the Patient did not have a viable airway.

The Committee stated that the credible evidence had convinced them that the Respondent does not possess the necessary skills to properly monitor, assess and respond to life threatening anesthetic complications and that the Respondent does not accept or recognize his responsibility for patients. The Committee voted to revoke the Respondents license to practice

medicine in New York State. The Committee stated that they had considered alternative sanctions , but concluded that there was no indication that the Respondent would benefit from focused retraining.

REQUESTS FOR REVIEW

The Respondent challenges the Hearing Committee's findings of fact, conclusions and penalty. The Respondent raised a procedural objection as to the make up of the Hearing Committee. Further, the Respondent contends that the Hearing Committee substituted its own judgement in arriving at one of its findings concerning Patient C (Respondent's brief pp. 19-20). The Respondent challenges the Hearing Committee's findings as to which witnesses are credible and challenges the basis for all the Committee's findings of fact. The Respondent challenges the Committee's conclusion that the Respondent was guilty of negligence on more than one occasion and gross negligence, noting that the Hearing Committee concluded that the Respondent lacked necessary skills (Hearing Committee Determination Page 22), which is the basis for a finding relating to incompetence not negligence. The Respondent also contends that the Hearing Committee's Determination is not clear as to whether the Committee found that the Respondent was guilty of negligence in the case of Patient D. The Respondent argues that even accepting all the Committee's findings and its conclusion, the penalty of revocation is too severe. The Respondent argues that in the case of a physician who lacks skills, the physician should have the opportunity to undergo retraining to improve those skills

The Petitioner urges the Review Board to uphold the Hearing Committee's Determination and Penalty. The Petitioner argues that the Review Board lacks the authority to grant the relief which the Respondent's brief requests.

REMAND DETERMINATION

The Review Board has considered the record below and the briefs which counsel have submitted.

The Review Board votes to remand this case to the Hearing Committee for further deliberations, because the review Board is unable to complete our review of this case without additional information from the Hearing Committee concerning how the Committee reached their

Determination. We direct the Hearing Committee to answer the questions which we set out below and to issue a Supplemental Determination.

1. What was the basis for the Hearing Committee's Determination that the Respondent had failed to administer calcium chloride to Patient C in a timely manner (Finding of Fact 14, HCDet. p. 14)?

2. Did the Committee find that the Respondent was guilty of negligence in the treatment of Patient D?

3. How did the Committee reach their conclusions that the Respondent was guilty of gross negligence and negligence on more than one occasion. Specifically, what Findings of Fact indicate that the Respondent, in his care of care of the patients in this case, failed to exercise the care which a reasonably prudent physician would have exercised under the circumstances, and, what Findings of Facts demonstrate that the Respondent's acts of negligence in caring for Patients A, B, C and E were of an aggravated or egregious character?

4. How did the Committee conclude that the Respondent's misconduct could not be addressed through retraining?

The Committee should serve their Supplemental Determination upon the Review Board and the parties. To expedite the process, the Committee may conduct their deliberation by telephone conference. If the Hearing Committee has any questions concerning this Remand Order, they may submit the question to the Review Board through a letter from the Hearing Committee's Administrative Officer to our Administrative Officer. Since the Supplemental Determination will add to the record in this case, each party shall have thirty days from the receipt of the Supplemental Determination to submit additional briefs and seven days from the receipt of their adversary's brief to submit reply briefs to the Review Board. The Hearing Committee's Penalty shall remain stayed during the period of the remand and until the Review Board issues its Final Determination in this matter.

ORDER

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

1. The Review Board **remands** this case to the Hearing Committee on Professional Medical Conduct, so that the Hearing Committee may conduct additional deliberations, answer the questions which the Review Board poses in this Remand Order and issue a Supplemental Determination.

2. The Hearing Committee's Penalty in this case shall remain stayed during the remand period.

3. The Hearing Committee shall serve copies of their Supplemental Determination on the Review Board and the parties, and shall provide the parties with copies of any correspondence between the Committee and the Review Board.

ROBERT M. BRIBER
SUMNER SHAPIRO
WINSTON S. PRICE, M.D.
EDWARD SINNOTT, M.D.
WILLIAM A. STEWART, M.D.

IN THE MATTER OF SUNG DAM TAN, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Tan.

DATED: Albany, New York

9/30, **1994**

ROBERT M. BRIBER

IN THE MATTER OF SUNG DAN TAN, M.D.

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

DATED: Delmar, New York

7/30/94, **1994**

SUMNER SHAPIRO

IN THE MATTER OF SUNG DAM TAN, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Tan.

DATED: Brooklyn, New York

_____, 1994

WINSTON S. PRICE, M.D.

IN THE MATTER OF SUNG DAM TAN, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Tan.

DATED: Roslyn, New York
Septbr 26, **1994**

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF SUNG DAM TAN, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Tan.

DATED: Syracuse
Albany, New York
30 Sept., **1994**

William A Stewart

WILLIAM A. STEWART, M.D.