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

June 23, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

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

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

RE: In the Matter of Sung Dam Tan, M.D.

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

Enclosed please find the Determination and Order (No. 94-95) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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), "(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
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
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IN THE MATTER	:	**HEARING COMMITTEE**
OF	:	**DETERMINATION**
SUNG DAM TAN, M.D.	:	**AND ORDER**
----------x		NO. BPMC-94-95

Charles J. Vacanti, M.D., Chairperson, **Milton Haynes, M.D.**, and **Dennis Horrigan,**, 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 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:	February 22, 1994
Statement of Charges dated:	February 22, 1994
Pre-Hearing Conference:	March 25, 1994
Hearing Dates:	March 28 and 29, April 15 and 19, 1994

Panel Member Absence:	Dr. Milton Haynes and Mr. Dennis Horrigan were not present at parts of the Hearings. See their affirmations attached here as Appendices A and B.
Deliberation Dates:	May 23, 1994 *
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: Dianne Abeloff
Respondent Appeared By:	Mark Hankin, Esq.

STATEMENT OF CHARGES

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

CREDIBILITY OF WITNESSES

Dr. Ronald Andree was a credible witness whose testimony was based solely upon the medical records of Patients A, B, C, D and E. He demonstrated that these medical records were in-

* Proposed Findings and Memoranda were due by May 6, 1994. Although Respondent's were not received until May 10, 1994, they were fully considered by the Hearing Committee in order not to penalize the Respondent for his counsel's lateness.

consistent with the clinical status of the patients.

By contrast, Dr. Allan Reed testified that he relied on information given to him by Respondent's counsel in addition to the medical records of Patients A, B, C, D and E. Furthermore, he attempted to justify any inconsistencies between these medical records and the clinical status of the patients. He selected data which supported his opinion and rejected data which did not. The Hearing Committee did not find him to be a credible witness.

Dr. Laura Hopgood was found to be a credible witness who did not have any personal interest to protect.

Dr. Sung Dam Tan's testimony was characterized by excuses and reasons why he was correct with each of Patients A, B, C, D and E. He did not recognize any errors in his acts. Despite signing pre-operative findings, post-operative findings and anesthesia records of a patient, he denied the existence of a doctor-patient relationship. The Hearing Committee did not find him to be a credible witness.

FINDINGS OF FACT

Numbers in parentheses 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 cited evidence.

1. Sung Dam Tan, M.D., the Respondent, was authorized to practice medicine in New York State on October 29, 1982 by the issuance of license number 152228 by the New York State Education Department. (Ex. 2)

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period December 1, 1993 to January 31, 1994, from 93 Stanford Street, Yonkers, New York 10704. (Ex. 2)

3. In an outpatient facility where an anesthesiologist and a nurse anesthetist are present, as was the arrangement at OB/GYN Pavilion, the anesthesiologist is responsible for the actions that the nurse anesthetist takes. (T. 197, 198, 238)

PATIENT A

4. In an outpatient facility where there is not an anesthesiologist present, the facility could make an agreement with the surgeon to assume the responsibility for the nurse anesthetist. This was not the situation at OB/GYN Pavilion.

Dr. Lieber did not assume responsibility for supervising C.R.N.A Shaw. (T. 29, 198, 430, 431)

5. C.R.N.A. Shaw was assigned to Patient A by the Respondent (T.463, l 12-19) and was supervised by the Respondent. (T.430-1) Shaw believed Respondent was her supervisor and that he was the physician who supervised and assisted her (T. 29, 198, 430, 431).

6. An anesthesiologist should not be administering anesthesia to his own patients when he is supervising a nurse anesthetist because he would not be free to help the nurse anesthetist. Respondent was administering anesthesia to his own patients at the same time that he should have been available to supervise C.R.N.A Shaw. (T. 211, 212, 538, 547).

7. On or about August 16, 1991, Patient A went to Ob/Gyn Pavilion, 999 third Avenue, Brooklyn, N.Y. for termination of a 16 week pregnancy. The abortion, performed by a gynecologist, began at or about 9:30 AM and was concluded without incident at or about 9:35 AM. The gynecologist left the operating room at the conclusion of the procedure. The anesthesia was provided by a C.R.N.A. The anesthetic agent was Brevital. At the conclusion of the procedure and after the gynecologist left the room, Patient A became distressed. The C.R.N.A called for assistance. Respondent arrived a few

minutes later and intubated the patient. Dr. Laura Hopgood, not the Respondent, attempted CPR on the patient. An ambulance was called and Patient A was taken to Lutheran Hospital, Brooklyn, N.Y. Patient A is alive, but brain dead. (T. 29-32, 432-40)

8. Respondent failed to intubate and re-oxygenate Patient A in a timely manner in that:

A. C.R.N.A Shaw was about to transfer Patient A from the O.R. table to the stretcher for transport to the recovery room when Patient A began coughing or bucking badly. C.R.N.A. Shaw suctioned the patient and tried to maintain an airway, but realized that she needed assistance from her supervisor, the anesthesiologist, Respondent. C.R.N.A Shaw sent an orderly to get Respondent. While the orderly went to get Respondent, C.R.N.A. Shaw tried to bag the patient; however, the oxygen tank was out of oxygen. When the orderly came back from calling Respondent, C.R.N.A Shaw sent him out to get an anesthesia machine from one of the other operating rooms. Respondent did not return with the orderly who had been sent to get him; however, one of the technicians told C.R.N.A Shaw that she had seen Respondent walk by the room, look around and leave. C.R.N.A Shaw did not see them because her back was facing the doorway. (T. 434-

439, 466, 462).

B. The orderly returned with the anesthesia machine, but the two oxygen tanks on the machine were empty. The orderly went into another operating room to get another anesthesia machine. Respondent still had not come to the assistance of the patient or the C.R.N.A. (T. 439-440)

C. C.R.N.A. Shaw sent someone a second time to tell Respondent that his help was needed. (T. 440, 479, 488, 522)

D. Once Respondent arrived, he saw the condition of the patient and intubated her. (T. 441)

E. Dr. Lieber and Hobgood entered the O.R. in response to a page. When they entered the room the patient, although intubated, was blue, cold and cyanotic. (T. 125)

9. Respondent failed to initiate closed chest cardiac massage on Patient A in a timely manner in that:

A. During the procedure Patient A was not attached to an EKG monitor. (T. 441)

B. Dr. Hobgood was shocked at the condition of the patient when she entered the room. Dr. Hobgood asked what happened and what were the patient's vital signs. She received no answers. Dr. Hobgood checked for a pulse herself. She checked the radial artery, the femorals, and the carotids, but found no pulse. (T. 125-128)

C. Dr. Hobgood noted that the patient was not hooked up to and EKG. She asked that the patient be hooked to an EKG and that a stethoscope and a sphygmometer be brought to the O.R. After listening for heart sounds, not hearing any and not obtaining any pulse, Dr. Hobgood concluded that the patient's heart was not pumping. Dr. Hobgood performed closed cardiac massage. (T. 129, 172, 176, 177, 180, 185)

D. Respondent never told either Dr. Lieber or Dr. Hobgood not to do CPR or fire the defibrillator because the patient had a heartbeat. (T. 170)

E. Inasmuch as Patient A was intubated, blue, cold and pulseless, closed cardiac massage should have been started by Respondent. Respondent, after he established an airway and oxygenated the patient, needed to ascertain the patient's cardiovascular status. This patient needed cardiac massage; Respondent's failure to initiate CPR

fell below accepted medical standards. (T. 209, 210, 242, 61)

F. Although the anesthesia record is silent about cardiac arrest, Respondent administered epinephrine and bicarbonate, drugs commonly used in cardiac arrest situations. (T. 134, 164, 569)

G. Patient A's pupils were dilated when the ambulance arrived. Dilated pupils suggest that the circulation had failed and there was evidence of brain injury. (T. 99, 247)

PATIENT B

10. On or about December 8, 1988, Patient B went to Beekman Downtown Hospital, N.Y., N.Y. for outpatient ambulatory surgery, excision of a lesion of the lower eyelid. The procedure was performed under local anesthesia. Patient B had a history of hypertension, tuberculosis, chronic pulmonary disease, and cardiac arrhythmia. Upon Patient B's arrival in the O.R., his blood pressure was 210/115. Respondent gave him Procardia 10 mgm. and Fentanyl 50 MCG. Local infiltration by the surgeon was followed by a grand mal seizure. Respondent injected 100mgm. Pentothal and intubated Patient B. Patient B arrested, but was successfully resuscitated by Respondent.

(Ex. 5, T. 239, 295, 297)

11. Respondent failed to adequately monitor Patient B and manage his airway for the first 30 minutes of the surgical procedure in that:

A. After the administration of the Fentanyl and the Inapsine, the blood pressure tended downward from the time they were given, about 10:05 to about 10:35 AM. Over a period of about a half hour the blood pressure levels descended to 120/60. The pulse rate fell from about 78 to around 40 in that same time. (Ex. 5, pp.66)

B. The doses of Fentanyl and Inapsine were not larger than normal, but as Patient B was an older patient, Respondent should have been prepared for an exaggerated reaction to the medication. He was not. Patient B developed bradycardia, the slowing of his pulse as a result of impaired breathing. (T. 306, 316)

C. Careful monitoring is a vital skill for an anesthesiologist in order to ascertain how a patient is doing during an operation to ensure that the level of anesthesia is correct, and to forewarn of difficulties that may be coming for a patient. (T. 305)

D. The monitoring and management of the anesthetic in this case by Respondent was not in accordance with good standards. At 10:35 AM during the administration of a local anesthetic to the patient's eye, the patient complained of numbness, and then developed a grand mal seizure, indicating an adverse reaction to the preceding events. The adverse reactions occurred because of the rapid fall of blood pressure and the decline in pulse rate which were not responded to by the anesthesiologist in the 10 to 15 minutes before the event occurred. By at least 10:25 AM when the pulse rate went rather abruptly from 70 to 60, the anesthesiologist should have given oxygen and supportive ventilation. (T. 300, 306, 307, 319, 323, 325-327).

E. The anesthesia chart did not accurately reflect the Respondent's conduct. The chart showed that at 10:24 AM the respiration went from spontaneous to controlled, which meant that the anesthesiologist had taken over the breathing of the patient. Respondent could not have controlled Patient B's breathing at that point. According to the chart, Respondent would have placed the mask over the patient's face at the same time that the surgeon was injecting the anesthetic into the patient's eye. The surgeon and the anesthesiologist cannot work simultaneously in the same area. The chart also

indicated that oxygen was not begun until 10:30 AM. Therefore, according to the chart, Patient B would have been ventilated for five minutes on room air. The resident's note which appeared on page 153 indicated that "two minutes passed before that patient produced a grand mal seizure, which lasted two minutes in duration. An oral airway was then placed and the patient well oxygenated with the mask." From the time sequence, the mask was probably placed on patient between 10:35 a.m. to 10:40 a.m., not 10:25 a.m. In addition, if Respondent had intervened, the patient's blood pressure would have risen; it did not. (Ex. 5,p.66; T. 301, 328, 332-334, 337, 745).

F. Patient B's grand mal seizure was caused by lack of oxygen, not Lidocaine. The dose of Lidocaine was too small to cause a problem. (T. 311, 330)

PATIENT C

12. On or about November 29, 1989, at Beekman, Patient C, a 27 year old preeclamptic woman was undergoing a Caesarean Section under epidural anesthesia with a magnesium sulfate infusion running. Patient C became progressively more obtunded during the procedure. By the completion of the procedure she was hypoventilating and unresponsive. Patient C's arterial blood gases showed ph 6.8 and pC02

of 125. The obstetrician gave the patient calcium gluconate and she became responsive. Respondent administered calcium chloride, which resulted in Patient C's full recovery. (Ex. 6, T. 339, 340, 343, 363)

13. Respondent failed to adequately observe Patient C in the delivery room in that:

A. Patient C had a marked respiratory depression. Respondent failed to observe that Patient C's pupils were fixed and dilated, to observe the change in the patient's mental status or level of wakefulness, and to respond to these changes. Patient C became severely unresponsive for more than half an hour and had a marked respiratory acidosis, confirmed by blood gas. (T. 343, 363, Ex. 6, p. 32)

B. Respondent's conduct fell below accepted medical conduct because he failed to adequately monitor the patient. A prudent anesthesiologist would not allow the patient to have the degree of respiratory depression suffered by Patient C without noticing it and acting upon it by administering calcium. Patient C's carbon dioxide level was allowed to rise to the alarming level of 125 or 135 before

calcium gluconate was given. (T. 344, 349, 355, 361, 362, 372)

C. Patient C's anesthesia record contained inaccuracies. Given this patient's blood gases which indicated that the patient had marked respiratory depression, and that she was receiving oxygen by mask for two hours, the end tidal carbon dioxide reading consistently could not have been 33. (Ex. 6, T. 357, 363, 372)

14. Respondent failed to administer calcium chloride to Patient C in a timely manner. Patient C suffered from magnesium sulfate overdose, not a seizure, because she immediately improved upon the administration of an antidote for magnesium sulfate overdose. (T. 355, 362)

PATIENT D

15. On or about September 1, 1987, at Mid-Island Hospital, Bethpage, N.Y., Patient D, a 82 year old male, was prepped for insertion of a permanent pacemaker. Two I.V. solutions were prepared and hung; one bag contained a 5% Dextrose and Water (D&W)-500cc solution, the other bag contained a 5% (D&W) with 2 gms of Lidocaine. Respondent started the IV infusion with the Lidocaine solution, not

the solution requested by the surgeon. Patient D convulsed and was successfully resuscitated. Respondent failed to identify the correct I.V. solution prior to beginning its infusion. (Ex. 8, 9; T. 268)

PATIENT E

16. On or about March 17, 1989, at Beekman, Patient E, a 44 year old morbidly obese woman was admitted for a colon resection. Preoperative evaluation showed a history of chest pain and shortness of breath after 5 blocks. A medical consultation was recommended, but never obtained. On or about March 24, 1989, a C.R.N.A. under Respondent's supervision induced Patient E with Pentothal and fentanyl. The patient was then intubated. Following intubation, Patient E's ETC02 read 10 on the capnograph/capnometer. Within 10 minutes the patient had bradycardia, arrested and died. (Ex. 10, T. 384, 385, 387, 401, 408-410, 413, 414, 417)

17. Respondent administered anesthesia to Patient E without obtaining a medical consultation, or explaining in his records his reasons for failing to obtain a medical consultation. Respondent was not required to obtain a consultation solely because another anesthesiologist recommended a consultation. However, he needed to

indicate in his notes the reasons he did not obtain a consultation, e.g. after his own personal evaluation of the information in the record he determined that it was safe to proceed with the operation. A note was necessary to permit a reviewing physician to know what the Respondent did and his reasons. (T. 387, 408-410, 413, 414, 417)

18. Despite all the clinical signs that Patient E was not correctly intubated, Respondent failed to ascertain that there was either a pharyngeal or esophageal intubation in that:

A. A pharyngeal intubation means that the endotracheal tube was incorrectly placed in the pharynx not the trachea. Indications of a pharyngeal intubation are poor oxygenation, distention of the stomach, weak breath sounds, and low excretion of carbon dioxide. (T. 389)

B. An esophageal intubation is the incorrect insertion of the trachea tube into the esophagus. The indications of a pharyngeal intubation and an esophageal intubation are the same except with an esophageal intubation there is a great deal of distention of the stomach. (T. 390)

C. The intubation in this case was not directly into the trachea. During the course of inserting the central line, the endotracheal tube appeared to have been dislodged. The patient became anoxic. T. 392, 393)

D. The New York Downtown Hospital incident report, required by law to be filed with the N.Y.S. Department of Health, indicated that upon examination the endotracheal tube was in the esophagus not in the trachea. The medical examiner in the autopsy report found that the stomach was distended by large amount of gas. This finding resulted from the endotracheal tube being in the esophagus and the gas went into the stomach rather than into the trachea. (Ex. 12, 13, T. 399, 400, 405, 406)

E. The medical examiner's notation that there was edema of the mucosal and submucosal tissue of the pharynx was consistent with his finding of a nasogastric tube having been inserted in Patient E. (T. 407)

F. Respondent failed to respond to the sudden change

in Patient E's vital signs, especially given the obesity of this patient. Obese patients have a difficult airway to visualize and to intubate. Their heads and necks are heavy; therefore, the endotracheal tube can be dislodged from the movement of their heads and necks. The anesthesia complications which can arise as a result of obesity are well known to anesthesiologists. (T. 392, 394)

G. Respondent's care of Patient E fell below accepted medical standards. After the bradycardia, Respondent should have immediately thought of the possibility of dislodgement of the endotracheal tube, checked its located and listened for breath sounds. His failure to pay sufficient attention to evaluating the placement of the endotracheal tube, particularly following the change in pulse rate, led to the failure of the resuscitation, and ultimately to the arrest and death of Patient E. (T. 395, 398, 414, 421, 422)

H. A capnometer gives a read-out of the patient's end-tidal carbon dioxide level. This is a particularly vital monitor in an obese patient. (T. 395)

I. The consistent read-out of 10 on the capnometer indicated that there was a problem with the meter or the tube placement. Nothing in the record indicated that Respondent was cognizant of a problem with the meter. He continued to record the reading of 10 throughout the procedure as if he believed in the validity of the reading. He failed to request another meter, nor did he note anywhere that the meter was broken. However, Respondent failed to respond to the consistently low read-outs of 10. If the saturation levels had been recorded accurately, a reasonably prudent anesthesiologist would immediately have been alerted to a problem with the airway. (T. 421)

J. To proceed with a malfunctioning capnometer in this proceeding deviated from accepted standards. If the capnometer was faulty, it should have been changed. (T. 395, 396)

19. Respondent permitted the surgeon to begin extensive abdominal surgery on Patient E without a viable airway in the patient in that:

A. The anesthesia report contained false entries. There was a significant inconsistency between the

blood gases reported by the lab and the oximetry readings reported by Respondent. The patient was severely hypoxic at the same time the recorded oximetry readings showed essentially normal oxygen saturation. (T. 402)

B. Patient E did not have a patent (viable) airway. Respondent failed to adequately ensure that the patient had a patent airway. Respondent did not inform the surgeon that there was or may have been an airway problem and simply allowed him to begin surgery. (T. 397, 398)

CONCLUSIONS OF LAW

FIRST: Respondent engaged in professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Education Law Section 6530(4) (McKinney Supp. 1994), as alleged in the First, Second, Third and Fifth Specification of the Statement of Charges, and based upon Findings of Fact Nos. 3 through 14, and 16 through 19.

SECOND: 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(3) (McKinney Supp. 1994), as alleged in the Sixth Specification of the Statement of Charges and based upon Findings of Fact 3 through 19.

THIRD: Respondent did not engage in professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Education Law Section 6530(4) (McKinney Supp. 1994) as alleged in the Fourth Specification of the Statement of Charges.

DETERMINATION AND ORDER

The Hearing Committee determines and orders that Respondent's license to practice medicine be revoked.

The credible evidence has convinced the Committee that Respondent does not possess the necessary skills to properly monitor, assess and respond to life threatening anesthetic complications. Furthermore, the credible evidence establishes that Respondent does not accept or recognize his responsibility for patients. Instead, he repeatedly sought to place the responsibility elsewhere.

The Hearing Committee considered alternative sanctions but concluded that there was no indication that Respondent would benefit from focused retraining.

Dated: June 16, 1994

Charles J. Vacanti

Charles J. Vacanti, M.D.
Chairperson

Milton Haynes, M.D.
Dennis Horrigan

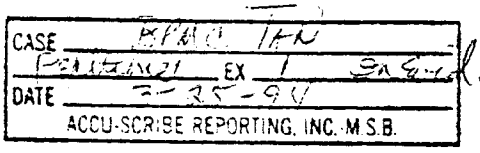
STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER : NOTICE

OF : OF

SUNG DAM TAN, M.D. : HEARING

TO: SUNG DAM TAN, M.D.
93 Sanford Street
Yonkers, N.Y. 10704



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230, as amended by ch. 606, Laws of 1991 and N.Y. State Admin. Proc. Act Secs. 301-307 and 401 (McKinney 1984 and 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 28 day of March, 1994 at 9:30 in the forenoon of that day at 5 Penn Plaza, 6th fl., N.Y., N.Y. 10001 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 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, as amended by ch. 606, Laws of 1991, 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 or sanction to be imposed or appropriate action to be taken.

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, AS ADDED BY CH. 606, LAWS OF 1991. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
February 22, 1994

Chris Stern Hyman
Counsel

Inquiries should be directed to: Dianne Abeloff
Associate Counsel
5 Penn Plaza
N.Y., N.Y. 10001

Telephone No.: 212-613-2615

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

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IN THE MATTER	:	STATEMENT
OF	:	OF
SUNG DAM TAN, M.D.	:	CHARGES

----------X

SUNG DAM TAN, M.D., the Respondent, was authorized to practice medicine in New York State on October 29, 1982 by the issuance of license number 152228 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 December 1, 1993 through January 31, 1994 from 93 Sanford Street, Yonkers, New York, 10704.

FACTUAL ALLEGATIONS

PATIENT A

A. On or about August 16, 1991, Patient A (the identity of Patient A and the other patients is contained in the Appendix) went to Ob/Gyn Pavilion, 999 Third Avenue, Brooklyn, N.Y. for termination of a 16 week pregnancy. The abortion, performed by a gynecologist, began at or about 9:30 a.m. and was concluded without incident at or about 9:35 a.m. The gynecologist left the operating room at the conclusion of the procedure. The anesthesia was provided

by a C.R.N.A. The anesthetic agent was Brevital. At the conclusion of the procedure and after the gynecologist left the room, Patient A became distressed. The C.R.N.A. called for assistance. Respondent arrived a few minutes later and intubated the patient. Another physician, not the Respondent, attempted CPR on the patient. An ambulance was called and Patient A was taken to Lutheran Hospital, Brooklyn, N.Y. Patient A is alive, but brain dead.

1. Respondent failed to intubate and re-oxygenate Patient A in a timely manner.

2. Respondent failed to initiate closed chest cardiac massage in a timely manner.

PATIENT B

B. On or about December 8, 1988, Patient B went to Beekman Downtown Hospital, N.Y., N.Y. (Beekman), for outpatient ambulatory surgery, excision of a lesion of the lower eyelid. The procedure was performed under local anesthesia. Patient B had a history of hypertension, tuberculosis, chronic pulmonary disease, and cardiac arrhythmia. Upon arrival in the the o.r. Patient B's blood pressure was 220/120. Respondent gave him Procardia 10 mgm. and Fentanyl 50 mcg. Local infiltration by the surgeon was followed by a grand mal

seizure. Respondent injected 100 mgm. Pentothal and intubated Patient B. Patient B arrested, but was successfully resuscitated by Respondent.

1. Respondent failed to adequately monitor the patient and manage ~~her~~ his airway for the first 30 minutes of the surgical procedure.

PATIENT C

C. On or about November 29, 1989, at Beekman, Patient C, a 27 year old preeclamptic woman was undergoing a Caesarean Section under epidural anesthesia with a magnesium sulfate infusion running. Patient C became progressively more obtunded during the procedure. By the completion of the procedure she was hypoventilating and unresponsive. Patient C's arterial blood gases showed ph 6.8 and pCO2 of 125. The obstetrician gave the patient calcium gluconate and she became responsive. Respondent administered calcium chloride, which resulted in Patient C's full recovery.

1. Respondent failed to adequately observe Patient C in the delivery room.

2. Respondent failed to administer the calcium chloride to Patient C in a timely fashion.

PATIENT D

D. On or about September 1, 1987, at Mid-Island Hospital, Bethpage, N.Y., Patient D, a 82 year old male, was prepped for insertion of a permanent pacemaker. Two I.V. solutions were prepared and hung; one bag contained a 5% Dextrose and Water (D&W)-500cc solution, the other bag contained a 5% (D&W) with 2 gms of Lidocaine. Respondent started the IV infusion with the Lidocaine solution, not the the solution requested by the surgeon. Patient D convulsed and was successfully resuscitated.

1. Respondent failed to identify the correct I.V. solution prior to beginning its infusion.

PATIENT E

E. On or about March 17, 1989, at Beekman, Patient E, a 44 year old morbidly obese woman was admitted for a colon resection. Preoperative evaluation showed a history of chest pain and shortness of breath after 5 blocks. A medical consultation was recommended, but never obtained. On or about March 24, 1989, a C.R.N.A. under Respondent's supervision induced Patient E with Pentothal and fentanyl. The patient was then intubated. Following intubation Patient E's ETCO2 read 10

on the capnograph. Within 10 minutes the patient had bradycardia, arrested and died.

1. Respondent administered anesthesia to Patient E without obtaining a medical consultation, or explaining in his records his reasons for for failing to obtain a medical consultation.

2. Despite all the clinical signs that Patient E was not correctly intubated, Respondent failed to ascertain that there was either a pharyngeal or esophageal intubation.

3. Respondent permitted the surgeon to begin extensive abdominal surgery without a viable airway.

SPECIFICATION OF CHARGES

FIRST THROUGH FIFTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with gross negligence within the meaning of N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1994), Petitioner charges:

4. The facts in paragraph A, A 1 and A 2.

5. The facts in paragraph B, and B 1.

6. The facts in paragraph C, C 1 and C 2.

7. The facts in paragraph D and D 1.

8. The facts in paragraph E, E 1, E 2, and E 3.

SIXTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCASSION

Respondent is charged with professional misconduct by reason of practicing the profession of medicine with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530 (3)(McKinney Supp. 1994), in that Petitioner charges that Respondent committed two or more of the following:

9. The facts in paragraphs A, A 1 and A 2; B and B 1; C, C 1 and C 2; D and D 1; and/or E, E 1, E 2, and E 3.

DATED: New York, New York
February 22, 1994

Chris Stern Hyman
Counsel
Bureau of Professional Medical
Conduct

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

IN THE MATTER OF

Sung Dam Tan, M.D. : AFFIDAVIT OF SERVICE

STATE OF NEW YORK)
COUNTY OF New York) SS:

Albert Baldassarri, being duly sworn, states:

1. I am over eighteen years of age and am not a party to the above-captioned proceeding.

2. I am employed by the New York State Department of as a Sr. Medical Conduct Investigator.

3. I served the annexed Notice Of Hearing & Statement Of Charges upon Sung Dam Tan, M.D. by going to 93 Sanford Street, Yonkers, N.Y. on February 24, 1994, at approximate 6:27PM ~~a.m.~~ p.m. and handing said person a true copy thereof.

4. A description of the person so served is as follows:
Approx. age: 53yrs; Approx. weight 170lbs; Approx. height: 5'8"
Sex Male; Skin Color: Yellow; Hair Color: Black;
Other identifying characteristics:

Albert Baldassarri
SIGNATURE

DAVID K. TRENARY
Notary Public, State of New York
No. 31-4713432
Qualified in New York County
Commission Expires May 31 1994

Sworn to before me
on this 25 day of
February, 1994

David K Trenary
NOTARY PUBLIC