# 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*

June 12, 1996

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Mao-Hsung Tseng, M.D.
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123 Shin Ted Road
Perkang Yun Lin
TAIWAN

Mao-Hsung Tseng, M.D.
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Chia Yi City
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Mao-Hsung Tseng, M.D.
8945 Woodside Drive
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Timothy J. Mahar, Esq.
Assistant Counsel,
New York State Department of Health
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower Building, Room 2429
Albany, NY 12237-0032

Effective Date: 06/19/96

RE: In the Matter of Mao-Hsung Tseng, M.D.

Dear Dr. Tseng and Mr. Mahar :

Enclosed please find the Determination and Order (No. 96-144) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

bcc: Dr. Vacanti
Ms. Riser
Ms. Bohenek
Ms. Saile
Mr. Osten
Mr. Horan
Mr. Kelleher (w/AOS)
SAPA File
Case File
Reading File

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.

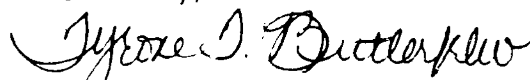
The notice of review served on the Administrative Review Board should be forwarded to:

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,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

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

COPY

| IN THE MATTER<br>OF<br>MAO H. TSENG, M.D. | DETERMINATION<br>AND<br>ORDER<br>BPMC-96-144 |
|---|---|

**ROGER M. OSKVIG, M.D.**, (Chair), **PAUL M. DE LUCA, M.D.** and **GEORGE M. SIMMONS, Ed. D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10) of the Public Health Law.

**MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE**, (**ALJ**") served as the Administrative Officer.

The Department of Health appeared by **TIMOTHY J. MAHAR, ESQ.**, Assistant Counsel.

Respondent, **MAO H. TSENG, M.D.**, did not appeared personally and was not represented by counsel.

Evidence was received and examined, including witnesses who were sworn or affirmed. Transcripts of the proceeding were made. After consideration of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

## PROCEDURAL HISTORY

| | |
|---|---|
| Date of Statement of Charges & Notice of Hearing: | February 1, 1996 |
| Date of Service of Notice of Hearing: | March 22 & April 11, 1996 |
| Date of Service of Statement of Charges: | March 22 & April 11, 1996 |
| Answer to Statement of Charges: | None Filed |
| Pre-Hearing Conference Held: | NONE |
| Hearing Held: | May 3, 1996 |
| Witnesses called by the Petitioner, Department of Health: | Jeffrey F. Torsell<br>Patient B's Husband<br>Raymond J. Lanzafame, M.D. |
| Witnesses called by the Respondent, Mao H. Tseng: | NONE |

## STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York (§ 230 et seq. of the Public Health Law of the State of New York [hereinafter "**P.H.L.**"]).

This case was brought by the New York State Department of Health, Bureau of Professional Medical Conduct ("**Petitioner**") pursuant to § 230 of the P.H.L.

MAO H. TSENG, M.D., ("**Respondent**") (also known as "Mao-Hsung Tseng") is charged with: five (5) specifications of professional misconduct, as delineated in § 6530 of the Education Law of the State of New York ("**Education Law**").

Respondent is charged with: (1) professional misconduct by reason of practicing the profession with gross negligence[1]; (2) professional misconduct by reason of practicing the profession with gross incompetence[2]; (3) professional misconduct by reason of practicing the profession with negligence on more than one occasion[3]; (4) professional misconduct by reason of practicing the profession with incompetence on more than one occasion[4] and (5) performing professional services which have not been duly authorized by the patient or her legal representative (lack of informed consent)[5]

The charges concern the medical care, treatment and services provided by Respondent to four (4) patients (A, B, C & D)[6]. A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

## FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Unless otherwise noted, all Findings and Conclusions herein were unanimous.

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[1] Education Law §6530(4) and First Specification of Petitioner's Exhibit # 1.

[2] Education Law §6530(6) and Second Specification of Petitioner's Exhibit # 1.

[3] Education Law §6530(3) and Third Specification of Petitioner's Exhibit # 1.

[4] Education Law §6530(5) and Fourth Specification of Petitioner's Exhibit #1.

[5] Education Law §6530(26) and Fifth Specification of Petitioner's Exhibit #1.

[6] Patients are identified in an Appendix to the Statement of Charges, Petitioner's Exhibit # 1.

The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was authorized to practice medicine in New York State on September 17, 1984 by the issuance of license number 160199 by the New York State Education Department (Petitioner's Exhibits # 1 & # 2)[7].

2. Raymond J. Lanzafame, M.D., graduated from George Washington University Medical School, in Washington, D.C. in 1978. Dr. Lanzafame became board certified in Surgery in 1984 (recertified in 1995) and in Laser Surgery in 1988. He is presently an Associate Professor of Surgery at the University of Rochester. Dr Lanzafame currently performs surgery on 400 to 500 patients per year. Dr. Lanzafame testified as the State's expert witness (Petitioner's Exhibit # 3); [T-35-134][8].

**PATIENT A**

3. From July 16, 1992 through July 31, 1992, Respondent provided medical care to Patient A at the Tri-County Memorial Hospital, Gowanda, New York, ("**Tri-County**") including a surgical decompression of her colon and a sigmoid colostomy procedure for bowel obstruction, constipation, severe colon dilation and colonic carcinoma, among other conditions (Petitioner's Exhibit # 5); [T-39-88].

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[7] Refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit) (no exhibits were submitted by Respondent).

[8] Numbers in brackets refer to transcript page numbers [T- ].

4. Respondent prescribed laxatives (magnesium citrate and mineral oil) to Patient A at various times which were contraindicated in circumstances in which the patient had colonic distention and partial bowel obstruction (Petitioner's Exhibit # 5); [T-40-45, 79-80, 85-87].

5. Respondent's use of a 14 gauge catheter to decompress Patient A's colon was contraindicated (Petitioner's Exhibit # 5); [T-50-54,73-75].

6. Respondent failed to appropriately decompress Patient A's colon (Petitioner's Exhibit # 5); [T-53-63].

**PATIENT B**

7. From April 4, 1990 to May 20, 1990, Respondent provided medical care to Patient B (37 year old female) at Tri-County, including, during one surgery, the following procedures: a subtotal gastrectomy, partial colectomy, hysterectomy and cholecystectomy, among other surgical procedures, for recurrent intra-abdominal colon cancer, pelvic pain, and multiple metastatic lesions, among other conditions (Petitioner's Exhibit # 6); [T-89-116].

8. On April 5, 1990, Respondent subjected Patient B to nine hours of surgery which was not indicated in circumstances in which the patient had advanced metastatic cancer (Petitioner's Exhibit # 6); [T-97-102].

9. The surgery performed on April 5, 1990 was to treat multiple metastatic lesions and cholelithiasis (Petitioner's Exhibit # 6); [T-91-92].

10. Patient B and her husband understood that the April 5, 1990 proposed surgery was to be extensive (Petitioner's Exhibit # 6 at p. 110, 181, 222); [T-26-34, 108, 113-114].

11. Patient B was in incapacitating pain and was in distress [T-116].

**PATIENT C**

12. On April 27, 1989, Respondent attempted to perform a sigmoidoscopy and gastroscopy procedure on Patient C (93 year old female) at Tri-County in circumstances in which the patient had a history of "tarry stools", among other conditions (Petitioner's Exhibit # 7); [T-117-126].

13. The purpose of the procedures was to identify the potential source of bleeding [T-118].

14. The sigmoidoscopy procedure was terminated because of the presence of stool [T-118].

15. Respondent prescribed excessive amounts of Demerol and Valium intravenously to Patient C prior to the endoscopy procedure [T-118-123, 126].

**PATIENT D**

16. On April 28, 1989, Respondent attempted to perform a esophago-gastroscopy on Patient D (86 year old female) for gastrointestinal bleeding and diverticular disease (Petitioner's Exhibit # 8); [T-127-134].

17. Respondent prescribed excessive amounts of Demerol and intravenous Valium to Patient D prior to the endoscopy procedure (Petitioner's Exhibit # 8); [T-128-133].

## CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the February 1, 1996, Statement of Charges, are **SUSTAINED:**[9]

| | | |
|---|---|---|
| Paragraph A. | : | ( 3 ) |
| Paragraph A.1. | : | ( 4 ) |
| Paragraph A.2. | : | ( 5 ) |
| Paragraph A.3. | : | ( 6 ) |
| Paragraph B. | : | ( 7 ) |
| Paragraph B.1. | : | ( 8 - 9 ) sustained in part |
| Paragraph C. | : | ( 12 ) |
| Paragraph C.1. | : | ( 13 - 15 ) |
| Paragraph D. | .: | ( 16 ) |
| Paragraph D.1. | : | ( 17 ) |

The Hearing Committee concludes that the following Factual Allegations, from the February 1, 1996 Statement of Charges, are **NOT SUSTAINED:**

| | | |
|---|---|---|
| Paragraph B.1 | : | ( 11 ) not sustained in part |
| Paragraph B.2 | : | ( 10 ) |

[9] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation contained in the Statement of Charges.

Based on the above, the complete Findings of Fact and the entire record, the Hearing Committee concludes that the following Specifications of Charges are **SUSTAINED:**[10]

| | |
|---|---|
| FIRST SPECIFICATION: | (Paragraphs: A., A.2, A.3 and B.1) |
| SECOND SPECIFICATION: | (Paragraphs: A. and A.2.) |
| THIRD SPECIFICATION: | (Paragraphs: A., A.1, A.2, A.3, B., B.1, C., C.1., D. and D.1.) |
| FOURTH SPECIFICATION: | (Paragraphs: A., A.1, A.2, A.3, B., and B.1.) |

Based on the above and the complete Findings of Fact the Hearing Committee concludes that the following Specification of Charge is **NOT SUSTAINED:**

FIFTH SPECIFICATION: (Paragraphs: B. and B.2.)

## DISCUSSION

Respondent is charged with five specifications alleging professional misconduct within the meaning of § 6530 of the Education Law. § 6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitute professional misconduct. However § 6530 of the Education Law does not provide definitions or explanations of the types of misconduct charged in this matter, except for the informed consent specification.

[10] The citations in parentheses refer to the Factual Allegations which support each Specification.

The Administrative Law Judge ("**ALJ**") issued instructions to the Hearing Committee regarding the definitions of medical misconduct as alleged in this proceeding. These definitions were obtained from a memorandum, prepared by Henry M. Greenberg, General Counsel for the New York State Department of Health, dated January 9, 1996. This document, entitled: Definitions of Professional Misconduct under the New York Education Law, ("**Misconduct Memo**"), sets forth suggested definitions of practicing the profession: (1) fraudulently; (2) with negligence on more than one occasion; (3) with gross negligence; (4) with incompetence on more than one occasion and (5) with gross incompetence.

During the course of its deliberations on these charges, the Hearing Committee consulted the relevant definitions contained in the Misconduct Memo.

The Hearing Committee was told that the term "egregious" means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

The Hearing Committee was instructed by the ALJ to use ordinary English usage and understanding for all other terms, allegations and charges.

With regard to the testimony presented herein, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to their training, experience, credentials, demeanor and credibility.

Dr. Raymond Lanzafame, as the State's expert, had no professional association with Respondent. The Hearing Committee determined that Dr. Lanzafame presented a very credible and thorough review of the documents and questions posed. All of the State's witnesses presented credible, direct and forthright testimony. They did not appear to have had a stake in the outcome of these proceedings and no motive for falsification or fabrication of their testimony was alleged or shown.

Respondent failed to appear and therefore did not offer any testimony.

Using the above understanding, the Hearing Committee unanimously concludes that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State, as set forth above. The Department of Health has met its burden of proof as to four of the five specifications of misconduct contained in the February 1, 1996 Statement of Charges.

The rationale for the Hearing Committee's conclusions is set forth below.

**PATIENT A**

**I. Gross Negligence** (First Specification)

Respondent's use of a 14 gauge catheter to decompress Patient A's colon exposed Patient A to predictable and unnecessary harm with no chance of relief or improvement. The description of the procedure by Respondent is that of a distended fluid-filled or stool-filled bowel which is likely to be very pasty and as a result of that, it would not be expected to be able to be aspirated by such a small caliber instrument as a 14 gauge catheter. Respondent, after being unsuccessful with the 14 gauge catheter at the mid descending colon, also attempted it at the cecum, which was unsuccessful as well. Respondent created, in essence, iatrogenic perforations of bowel in bowel that is unprepared and already dilated and potentially compromised that would increase the possibility of leakage or infection.

Respondent's actions were extreme deviations from accepted standards of care because of the risks and because of the ineffectiveness of the procedure per se. The simplest and least risky decompression would have been to perform a loop colostomy at the transverse colon level. All attempts at other procedures by

Respondent, other than the loop had the potential to harm the patient with no benefit. In addition, by subjecting the patient to a number of attempts at decompressing the colon, Respondent exposed the patient to excessive anesthesia.

In summary, the Hearing Committee determines that Respondent's care, management and treatment of Patient A was well below minimally accepted standards of practice and was egregious

Respondent was grossly negligent in the care and treatment he provided to Patient A.

The charge of practicing the profession with gross negligence, within the meaning of § 6530(4) is sustained.

**II. Gross Incompetence** (Second Specification)

As to Patient A, with regard to the accusation of gross incompetence, there is evidence that Respondent has a complete lack of ability or a total and flagrant lack of necessary knowledge or ability to practice medicine.

A reasonably competent surgeon would be aware of the shortfalls of attempting decompression by the means attempted by Respondent. One would expect that a surgeon would gain such knowledge in his or her training early on but certainly by the time he has reached senior resident level. Somewhat to Respondent's credit, when he was attempting the 14-gauge needle decompression of the colon, he anticipated some of the risk by using purse-string sutures. This indicates that Respondent was attempting to control the puncture site. However, Respondent should have known that a loop transverse colostomy was the apparent or appropriate option in the circumstances of Patient A.

Respondent was grossly incompetent in his care and treatment of Patient A. The charge of practicing the profession with gross incompetence, within the meaning of § 6530(6) is sustained.

**III. Negligence** (Third Specification)

Having found that Respondent was grossly negligent in the care and treatment he provided to Patient A, the Hearing Committee concludes that Respondent was negligent for the same reasons stated above. In addition, Respondent was negligent in continuing to prescribe the laxatives magnesium citrate and mineral oil to Patient A in circumstances in which the patient had colonic distention and partial bowel obstruction.

The Hearing Committee determines that Respondent's care, management and treatment of Patient A was below minimally accepted standards of practice.

Respondent was negligent in the care and treatment he provided to Patient A.

**IV. Incompetence** (Fourth Specification)

Having found that Respondent was grossly incompetent in the care and treatment he provided to Patient A, the Hearing Committee concludes that Respondent was incompetent for the same reasons stated above. The Hearing Committee finds that Respondent had a lack of understanding regarding the decompression procedure. This leads the Hearing Committee to conclude that Respondent lacked the knowledge, under these circumstances, that a first year resident would have.

Respondent was incompetent in the care and treatment he provided to Patient A.

**Patient B**

**V. Gross Negligence** (First Specification)

The Hearing Committee concludes that the surgery of April 5, 1990 had no possible benefit for the patient. There was no possibility of cure or life extension.

The risks of surgery were not warranted. The surgery performed by Respondent was not consistent with acceptable care and could be characterized at best as exceeding heroics. Given the degree of involvement of organ systems and blood supply in this patient, it was foolish at best to conceive that surgical resection would eradicate tumors and it exposed the patient to additional risk vis-a-vis multiple resections and anastomosis, protracted procedure with their attendant potential for complications, protracted hospitalization, without any real benefit from the perspective of making her a candidate for other measures such as chemotherapy or radiation.

Patient B was subjected to an extreme amount of surgical intervention, which was undertaken for non beneficial reasons. Nine (9) hours of surgery was grossly excessive and egregious for this patient. The risks that Respondent subjected Patient B to, included, infection, bleeding, perforation, leakage and post-surgical infections developing in wounds that have been open for that length of time.

In summary, the Hearing Committee determines that Respondent's care, management and treatment of Patient B was well below minimally accepted standards of practice.

Respondent was grossly negligent in the care and treatment he provided to Patient B. The charge of practicing the profession with gross negligence, within the meaning of §6530(4) is sustained.

**VI.** **Gross Incompetence** (Second Specification)

As to Patient B, with regard to the accusation of gross incompetence, there was no evidence that Respondent had a complete lack of ability or a total and flagrant lack of necessary knowledge or ability to practice medicine.

The Hearing Committee sees Respondent's treatment of Patient B as a triumph of technique over reason. In other words, the surgery itself was not deficient in how it was done. The Hearing Committee believes however, that there was no reason to be so extensive and therefore the why it was done is suspect. It certainly was not for the benefit of the patient.

The Hearing Committee can not find that Respondent was grossly incompetent in his care and treatment of Patient B. The charge of practicing the profession with gross incompetence, within the meaning of § 6530(6) is not sustained.

**VII.** **Negligence** (Third Specification)

Having found that Respondent was grossly negligent in the care and treatment he provided to Patient B, the Hearing Committee concludes that Respondent was a fortiori negligent for the same reasons stated above.

The Hearing Committee determines that Respondent's care, management and treatment of Patient B was below minimally accepted standards of practice.

Respondent was negligent in the care and treatment he provided to Patient B.

## VIII. Incompetence (Fourth Specification)

There is evidence that Respondent's actions showed a lack of knowledge in regards to the appropriateness of performing such extensive and intrusive surgery on Patient B. The type of surgery that was performed on Patient B was of a kind not done by a reasonably prudent competent surgeon.

This leads the Hearing Committee to conclude that Respondent lacked the knowledge, under these circumstances, that a competent surgeon would have.

Respondent was incompetent in the care and treatment he provided to Patient B.

## IX. Informed Consent (Fifth Specification)

Although the State was not able to find an informed consent form in the medical records, the Hearing Committee can not sustain this Charge. There is indications in the hospital records of Patient B that the Preoperative Teaching Nurses Notes, which indicates what the nurse would be describing to the patient, provide information to the patient about the proposed procedure. The Notes state "Exlap, subtotal gastrectomy, partial, with small bowel resection, partial colectomy, partial resection abdominal wall and omentum, left and right oophorectomy, cholecystectomy, resection pelvic wall nodules, bilateral salpingectomy, abdominal hysterectomy, excision of mass at surface of right kidney." The nurse's notes seem consistent with what was done in surgery by Respondent.

In addition, Patient B's husband indicated that he understood that extensive surgery was being proposed. As Patient B's husband testified "It was an expression of Dr. Tseng's to eradicate the disease and using that right hand kind of sweeping motion to cut it out."

Therefore the Hearing Committee can not find that Respondent performed professional services, on Patient B, which were not duly authorized by the patient or her duly authorized representative.

**Patient C**

**X. Negligence** (Third Specification)

It is common to give agents such as, Demerol and Valium, in the type of procedure undergone by Patient C. Demerol and Valium are given for some degree of sedation and for reduction or elimination of discomfort related to the procedure. However, Demerol 50 milligrams plus 5 milligrams of Valium is not consistent with accepted standards of medical care where it is given intravenously, relatively rapidly, in succession with one another and in a frail patient such as Patient C. The Hearing Committee believes that the prudent course of action would have been first of all to determine what a reasonable dose might be for the particular medications to be used. Then one should proceed with incremental dosing and allow a sick patient an amount of time to elapse to observe the effect prior to giving the patient additional medications. This is particularly true since the object of giving the medications was to sedate the patient somewhat, so the end point that you were looking for was someone who was less agitated and comfortable in order to allow the procedure to proceed. Respondent failed to follow the prudent course of action.

The risks in administering that volume of medication (Demerol 50 milligrams plus 5 milligrams of Valium) to Patient C, under the circumstances included: profound respiratory depression; the Valium can precipitate respiratory arrest and profound hypotension which could lead to cardiac arrest.

The amount of Demerol and the amount of Valium administered was excessive, particularly by the route and in the time frame administered. The physician in attendance (Respondent) is the person responsible whether that person de facto administers the drug himself or not.

The Hearing Committee determines that Respondent's care, management and treatment of Patient C was below minimally accepted standards of practice.

Respondent was negligent in the care and treatment he provided to Patient C.

**XI.** **Incompetence** (Fourth Specification)

There is insufficient evidence for the Hearing Committee to determine that Respondent's actions showed a lack of knowledge or skill in regards to the administration of the Demerol and Valium. Patient C's respiratory arrest was appropriately treated and the effects of the drugs were reversed with Narcan.

The Hearing Committee cannot conclude that Respondent lacked the knowledge or skill, under these circumstances, that a competent surgeon would have.

Respondent was not incompetent in the care and treatment he provided to Patient C.

**Patient D**

**XII.** **Negligence** (Third Specification)

The circumstances of Patient C and Patient D are very similar and in fact occurred on successive dates. The Hearing Committee concludes and determines that Respondent was negligent in the care, management and treatment of Patient D for the same reasons set forth in the discussion of Patient C. Respondents medical practice was below minimally accepted standards of practice.

Respondent was negligent in the care and treatment he provided to Patient D.

**XIII. Incompetence** (Fourth Specification)

The Hearing Committee cannot conclude that Respondent lacked the knowledge or skill, under these circumstances, that a competent surgeon should have (see discussion of Patient C above).

Respondent was not incompetent in the care and treatment he provided to Patient D.

## DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, unanimously determines that Respondent is guilty of professional misconduct under the definitions of § 6530 of the Education Law and under § 230 of the P.H.L. The Hearing Committee unanimously determines that Respondent's license to practice medicine in New York State should be REVOKED.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. §230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service and (10) probation.

The record establishes that Respondent committed professional misconduct by practicing the profession with gross negligence as to Patients A and B; gross incompetence as to Patient A; practicing with negligence on more than one occasion (Patients A, B, C & D); and practicing with incompetence on more than one occasion (Patients A & B).

Respondent, not having attended the Hearing, presented no mitigation for his actions.

The Hearing Committee considers Respondent's misconduct to be very serious. With a concern for the health and welfare of patients in New York State, the Hearing Committee determines that revocation of Respondent's license is the appropriate sanction to impose under the circumstances.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of these proceedings.

## ORDER

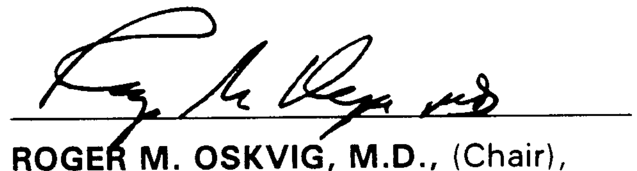
Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First, Second, Third and Fourth Specifications of professional misconduct from the Statement of Charges (Petitioner's Exhibit # 1) are **SUSTAINED**, and

2. The Fifth Specification of professional misconduct from the Statement of Charges (Petitioner's Exhibit # 1) is **NOT SUSTAINED**, and

3. Respondent's license to practice medicine in the State of New York is hereby **REVOKED.**

**DATED: Albany, New York**
**June 7 , 1996**



**ROGER M. OSKVIG, M.D.**, (Chair),

**PAUL M. DE LUCA, M.D.**
**GEORGE M. SIMMONS, Ed. D.**

TO:

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# APPENDIX I

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

---------------------------------------X

| IN THE MATTER | : STATEMENT |
|---|---|
| OF | : OF |
| MAO H. TSENG, M.D. | : CHARGES |

---------------------------------------X

MAO H. TSENG, M.D., the Respondent, was authorized to practice medicine in New York State on September 17, 1984 by the issuance of license number 160199 by the New York State Education Department.

**FACTUAL ALLEGATIONS**

A. From July 16, 1992 through July 31, 1992, Respondent provided medical care to Patient A (Patients are identified in Appendix A hereto) at the Tri-County Memorial Hospital, Gowanda, New York, including a surgical decompression of her colon and a sigmoid colostomy procedure for bowel obstruction, constipation, severe colon dilation and colonic carcinoma, among other conditions. Respondent's medical care of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent prescribed laxatives to Patient A at various times which were contraindicated in circumstances in which the patient had colonic distention and partial bowel obstruction.

2. Respondent's use of a 14 gauge catheter to decompress Patient A's colon was contraindicated.

3. Respondent failed to appropriately decompress Patient A's colon.

B. From April 4, 1990 to May 20, 1990, Respondent provided medical care to Patient B at the Tri-County Memorial Hospital, including during one surgery, the following procedures: a subtotal gastrectomy, partial colectomy, hysterectomy and cholecystectomy, among other surgical procedures, for recurrent intra-abdominal colon cancer, pelvic pain, and multiple metastatic lesions, among other conditions. Dr. Tseng's medical care of Patient B deviated from accepted standards of medical care in the following respects:

1. On April 5, 1990, Respondent subjected Patient B to nine hours of surgery for multiple metastatic lesions and cholelithiasis which was not indicated in circumstances in which the patient had advanced metastatic cancer and was in no acute distress.

2. Respondent failed to advise Patient B or her representative as to the extent of the April 5, 1990 surgery prior to and/or during the procedure, and failed to obtain her informed consent to the same.

MPZ
5/3/96

C. On April 27, 1989, Respondent performed a gastroscopy procedure on Patient C at the Tri-County Memorial Hospital in circumstances in which the patient had a history of "tarry stools", among other conditions. Respondent's medical care of Patient C deviated from accepted standards of medical care in the following respects:

1. Respondent prescribed excessive amounts of Demerol and intravenous Valium to Patient C prior to the endoscopy procedure.

D. On April 28, 1989, Respondent attempted to perform a esophagogastroscopy on Patient D for gastrointestinal bleeding and diverticular disease. Respondent's medical care of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent prescribed excessive amounts of Demerol and intravenous Valium to Patient D prior to the endoscopy procedure.

## SPECIFICATION OF CHARGES

## FIRST SPECIFICATION

### PRACTICING WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4)(McKinney Supp. 1996) by reason of his practicing the profession of medicine with gross negligence on a particular occasion in that Petitioner charges the following:

1. The facts in paragraphs A and A(2), A and A(3), B and B(1), and/or B and B(2).

## SECOND SPECIFICATION

PRACTICING THE PROFESSION
WITH GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6)(McKinney Supp. 1996) by reason of his practicing the profession of medicine with gross incompetence, in that Petitioner charges the following:

2. The facts in paragraphs A and A(2), A and A(3), B and B(1), and/or B and B(2).

## THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE
ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3)(McKinney Supp. 1996) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

3. The facts in paragraphs A and A(1), A and A(2), A and A(3), B and B(1), B and B(2), C and C(1), and/or D and D(1).

## FOURTH SPECIFICATION

### PRACTICING WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(5)(McKinney Supp. 1996) by reason of his practicing the profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

4. The facts in paragraphs A and A(1), A and A(2), A and A(3), B and B(1), B and B(2), C and C(1), and/or D and D(1).

## FIFTH SPECIFICATION

### INFORMED CONSENT

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(26) (McKinney Supp. 1996) by reason of his performing professional services which have not been duly authorized by the patient or his or her legal representative, in that the Petitioner charges the following:

5. The facts in paragraph B and B(2).

DATED: February 1, 1995
Albany, New York

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct