STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 1, 2003

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Pi Ju Tang, M.D.
150 Boulder Road
Manhasset, New York 11030

Michael P. Barnes, Esq.
10 West Railroad Avenue, Suite 200
Tenafly, New Jersey 07670

Terrence J. Sheehan, Esq.
NYS Department of Health
5 Penn Plaza – 6th Floor
New York, New York 10001

RE: In the Matter of Pi Ju Tang, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-84) 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.

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.

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.

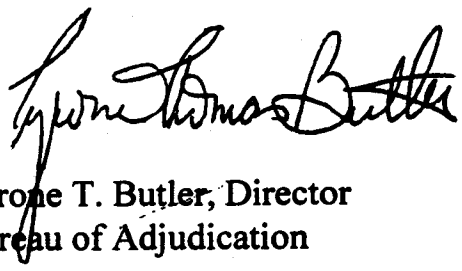
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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:cah
Enclosure

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

IN THE MATTER

OF

PI JU TANG, M.D.

DETERMINATION

AND

ORDER

BPMC #03-84

COPY

ADEL ABADIR, M.D., Chairperson, **AIRLIE CAMERON, M.D.**, and **MS. DEBORAH A. GRAY**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10)(e) of the Public Health Law ["PHL"]. **DENNIS T. BERNSTEIN, ESQ., ADMINISTRATIVE LAW JUDGE**, served as Administrative Officer for the Hearing Committee.

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

STATEMENT OF CHARGES

The Statement of Charges charges the Respondent with professional misconduct by practicing the profession of medicine with gross negligence on a particular occasion (two specifications) and with gross incompetence (two specifications), by practicing the profession of medicine with negligence on more than one occasion (one specification) and with incompetence on more than one occasion (one specification), and by failing to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient (six specifications).

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to this Determination and Order as Appendix I.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges Dated:	July 11, 2002[1]
Answer to Charges Dated:	September 17, 2002
Prehearing Conference Date:	September 25, 2002
Hearing Dates:	September 30, 2002 October 16, 2002 October 30, 2002 November 27, 2002 December 11, 2002
Deliberation Date:	January 15, 2003
Place of Hearing:	NYS Department of Health 5 Penn Plaza, 6th Floor New York, New York
Petitioner Appeared By:	Terrence J. Sheehan, Esq. Associate Counsel NYS Department of Health, Bureau of Professional Medical Conduct
Respondent Appeared By:	Michael P. Barnes, Esq. 10 West Railroad Avenue, Suite 200 Tenafly, N.J. 07670

[1] During the Prehearing Conference the parties stipulated that service of the Notice of Hearing and Statement of Charges upon the Respondent was effected (Prehearing Conference Tr. 36-37).

WITNESSES

For the Petitioner:

James N. Koppel, M.D.
Mark W. Dobriner, M.D.

For the Respondent:

Pi Ju Tang, M.D.
Jack Soterakis, M.D.
Pat J. Martin, M.D.

FINDINGS OF FACT

Numbers preceded by "Tr." in parenthesis refer to hearing transcript page numbers. Numbers or letters preceded by "Ex." in parenthesis refer to specific exhibits. These citations denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS AS TO THE RESPONDENT

1. Pi Ju Tang, M.D. ["the Respondent"] was authorized to practice medicine in New York State on or about October 17, 1968 by the issuance of license number 102647 by the New York State Education Department (Tr. 60-62).
2. The Respondent, who was born in China, graduated from the National Medical College of Shanghai, China, in 1959. From 1959 to 1962 the Respondent did a surgical residency in Shanghai. (Tr. 390-391; Ex. E).

3. In 1962 the Respondent came to the United States, studied English and worked as a surgical assistant at Parsons Hospital in Queens, New York. The Respondent passed her ECFMG (Education Consult of Foreign Medical Graduates) in 1965. (Tr. 391-392).

4. From 1965 to 1966 the Respondent did a rotating internship at St. Francis General Hospital in Pittsburgh, Pennsylvania and from 1966 to 1968 the Respondent did an anesthesiology residency at the University of Pittsburgh Health Center in Pittsburgh, Pennsylvania (Tr. 392-395; Ex. E).

5. Following the completion of her residency the Respondent worked for a short period of time as a staff anesthesiologist at St. Francis General Hospital in Pittsburgh, Pennsylvania. The Respondent then moved to New York and from 1969 to 1972 the Respondent worked as a staff anesthesiologist at St. Francis Hospital in Poughkeepsie, New York. (Tr. 396-397; Ex. E).

6. In 1973 the Respondent secured a staff anesthesiologist position at St. Francis Hospital in Roslyn, New York ("St. Francis"), where she has been employed until 2001 (Tr. 397; Ex. E).

7. The Respondent has been board certified in anesthesia since 1973 and has extensive experience in many types of procedures, including open heart surgery as well as outpatient surgery (Tr. 397-399; Ex. E).

8. In addition, the Respondent has administered anesthesia in approximately 5,000 endoscopic procedures performed at St. Francis prior to her involvement with the cases that are the subject of this hearing (Tr. 400).

GENERAL FINDINGS AS TO MEDICAL ISSUES

St. Francis Hospital Endoscopy Unit

9. Approximately three years ago a separate Endoscopy Unit was set up at St. Francis, which was designed to handle a large volume of cases (Tr. 399, 410-422 and 620-622; Ex. G).

10. The Respondent was the anesthesiologist assigned to the St. Francis Endoscopy Unit (Tr. 399).

11. A system was in place at the St. Francis Endoscopy Unit for screening and evaluating patients before their endoscopic procedures (Tr. 464-465 and 622-625).

12. Prior to the day of the procedure and again on the day of the procedure, the patient is seen and evaluated by the gastroenterologist (Tr. 622-624).

13. In addition, prior to the procedure the gastroenterologist completes a "Physicians Pre-Sedation Evaluation Certification" and certifies in writing that "The Patient has been re-evaluated just prior to the start of the procedure, and it is appropriate to proceed with the planned procedure and sedation I requested." (Tr. 625-626 and 631-632; Ex. 2, p. 23; Ex. 3, p. 8; Ex. 4, p. 12; Ex. 5, p. 13; Ex. 6, p. 11; and Ex. 7, p. 11).

14. The patient, upon arrival at the Endoscopy Unit, is also assessed by a nurse (Tr. 414, 464-465, 567 and 623). The nursing staff completes an "Interdisciplinary Patient Admission Screen/Assessment Record" which contains an extensive history of the patient (Ex. 2, pp. 24-25; Ex. 3, pp. 9-10; Ex. 4, pp. 13-14; Ex. 5, pp. 14-15; Ex. 6, pp. 14-15; and Ex.7, pp. 12-13). Vital signs, including temperature, blood pressure, respiratory rate and heart rate, are taken and noted by the nurse on this form (Tr. 414-416 and 567).

The Respondent's Pre-Operative Procedures

15. After the patient is interviewed and assessed by the nursing staff, the patient's medical record is given to the Respondent. The Respondent then reviews the medical record (which includes the "Short Stay Record" with the "Physicians Pre-Sedation Evaluation Certification" and the completed "Interdisciplinary Patient Admission Screen/Assessment Record") and interviews the patient. (Tr. 567-568 and 684-685).

16. The Respondent assigns the patient an ASA level which the Respondent notes in the "Pre-Anesthesia Note" included in the patient's medical record (Tr. 569-570 and 716-717; Ex. 2, pp. 49-50; Ex. 3, pp. 16-17; Ex. 4, pp. 20-21; Ex. 5, pp. 23-24; and Ex. 6, pp. 28-29).[2]

17. In each of the six cases in question the Respondent, following the standard procedure of the Endoscopy Unit, reviewed the medical record and interviewed and examined the patient (which includes an airway evaluation).[3]

18. Following the Respondent's review of the medical record and interview and assessment of the patient, the patient is prepped for the procedure by the insertion of an IV line, the attachment of monitoring devices such as EKG, blood pressure cuff and oximeter, and the placement of a nasal oxygen cannula (Tr. 571-572).

Intraoperative Monitoring of Patient by the Respondent

19. The Respondent monitors the patient's status during the procedure, which is reflected in the "Anesthesia Record" (Tr. 594-598; Ex. 2, pp. 51-52; Ex. 3, pp. 18-19; Ex. 4, pp. 22-23; Ex. 5, pp. 25-26; Ex. 6, pp. 30-31; and Ex. 7, pp. 19-20).

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[2] The ASA level is noted on the "Pre-Anesthesia Note" for each of the patients who are the subject of this hearing, except Patient F (Ex. 7, p. 18; Ex. 7A; and Ex. 7B).

[3] The Respondent testified that in each of the six cases she reviewed the medical record and interviewed and examined the patient. This testimony has not been contradicted by the Petitioner to the satisfaction of the Hearing

Drugs Administered by the Respondent

20. In the six cases in question the Respondent used a combination of drugs - Versed, Propofol and Sublimaze – all of which were used within the recommended doses (Tr. 400-403; Exs. A, B and C).

21. In all six patients, upon arrival at the Post Anesthesia Care Unit ("PACU"), the "Post Anesthesia Recovery Room Score" was 9 or 10 (10 being the highest and 1 being the lowest). (Tr. 757-758; Ex. 2, p. 56; Ex. 3, p. 23; Ex. 4, p. 27; Ex. 5, p. 30; Ex. 6, p. 32; and Ex. 7, p. 24).

SPECIFIC FINDINGS AS TO EACH PATIENT

Patient A

22. On or about February 7, 2001 the Respondent provided anesthesiological services to Patient A in connection with an endoscopic procedure at St. Francis (Tr. 62-64).

23. Specifically, on February 7, 2001 Patient A, a 70 year old obese male with a history of coronary artery bypass surgery five years earlier and valvular replacement, presented at the Endoscopy Unit at St. Francis for a colonoscopy (Ex. 2, pp. 1, 22, 24-25 and 49-50). During the procedure performed by Mark W. Dobriner, M.D., the patient had respiratory distress requiring intubation and mechanical ventilation. The procedure was then aborted. The patient was subsequently found to have a left upper lobe infiltrate and was admitted to the hospital for observation and treatment of aspiration pneumonia. The patient remained in the hospital overnight, was placed on intravenous antibiotics and improved. On February 8, 2001 the patient was discharged in good condition. (Ex. 2, pp.

3-4, 26-27 and 46).

24. The pre-operative history taken and the physical examination performed, including an airway evaluation, in connection with the patient's admission to the Endoscopy Unit was adequate. (Tr. 424-426 and 763-765; Ex. 2, pp. 23-25 and 49-50; See findings 11 through 17, *supra*).

25. There is no documentation appearing in the medical record that Patient A had a known hiatal hernia (Ex. 2).

26. The anesthetic agents administered by the Respondent were used within the recommended doses and not excessive. (Tr. 755-758; Ex. 2, p. 51; See finding 20, *supra*).

27. The airway obstruction encountered during the procedure was not caused by the excessive use of anesthetic agents (See finding 26, *supra*). Additionally, the airway obstruction was appropriately managed by the Respondent (Tr. 758-763; Ex. 2, p. 46).

28. The drop in the patient's systolic blood pressure and heart rate during the procedure was also properly managed by the Respondent (Tr. 758 and 773-774; Ex. 2, p. 51).

29. The Respondent adequately documented pre-operative history, level of sedation or mental status during the procedure and upon transfer to the recovery area, administration of supplemental oxygen and mode of ventilation, and EKG monitoring (Tr. 763-770; Ex. 2, pp. 51-52).

30. However, the Respondent failed to adequately document pre-operative physical, description of intraoperative complication, and description of treatment provided. The documentation of these items is inadequate for the following reasons:

a. Pertinent physical findings regarding the patient's airway and dentures should have been noted in the pre-operative physical (Tr. 837-838).

b. The Respondent should have elaborated more on hypoxia, bradycardia and hypotension in the description of the intraoperative complication (Tr. 806-809 and 858-859; Ex. 2, p. 51).

c. The Respondent should have noted that she administered Narcan in the description of the treatment provided (Tr. 822-823).

Patient B

31. On or about December 13, 2000 the Respondent provided anesthesiological services to Patient B in connection with an endoscopic procedure at St. Francis (Tr. 187-188; Ex. 3, p. 18).

32. Specifically, on December 13, 2000 Patient B, a 60 year old female with a history of reflux, asthma and a family history of colon cancer, was admitted to the Endoscopy Unit at St. Francis for a colonoscopy and a gastroscopy (Ex. 3, pp. 1, 7, 9-10 and 16-17). The procedures were performed by Stephen R. Siegel, M.D.. Dr. Siegel's assessment was "normal colonoscopy" and a "hiatal hernia", which he noted during the gastroscopy. The patient tolerated both procedures well and was transferred to PACU. (Ex. 3, pp. 12-13 and 21). The Patient arrived at PACU at 3:30 P.M. and was discharged at 4:30 P.M. (Ex. 3, pp. 23-24).

33. The pre-operative history taken and the physical examination performed, including an airway evaluation, in connection with the patient's admission to the Endoscopy Unit was adequate. (Tr. 565-571 and 763-765; Ex. 3, pp. 8-10 and 16-17; See findings 11 through 17, *supra*).

34. During the procedures the Respondent monitored the EKG (Tr. 594-597; Ex. 3, p. 18).

35. The Respondent adequately documented pre-operative history, level of sedation or mental status during the procedure and upon transfer to the recovery area, administration of supplemental oxygen and mode of ventilation, EKG monitoring, fluid administration, and time of induction of anesthesia and duration of anesthesia (Tr. 763-770; Ex. 3, pp. 18-19).

36. However, the Respondent failed to adequately document pre-operative physical. The documentation of this item is inadequate since pertinent physical findings regarding the patient's airway and dentures should have been noted (Tr. 837-838).

Patient C

37. On or about March 14, 2001 the Respondent provided anesthesiological services to Patient C in connection with an endoscopic procedure at St. Francis (Tr. 220-221).

38. Specifically, on March 14, 2001 Patient C, a 58 year old female with a family history of colonic carcinoma and polyps, was admitted to the Endoscopy Unit at St. Francis for a colonoscopy (Tr. 221 and 629; Ex. 4, pp. 1, 11, 13-14 and 20-21). The procedure, a colonoscopy to the cecum with polypectomy and ileoscopy, was performed by Jack Soterakis, M.D.. Dr. Soterakis' postoperative diagnosis was "colonic polyp and diverticulosis coli". The patient tolerated the procedure well and was transferred to PACU in good condition. (Ex. 4, pp. 16-17 and 25). The Patient arrived at PACU at 10:40 A.M. and was discharged at 11:30 A.M. (Ex. 4, pp. 27-28).

39. The pre-operative history taken and the physical examination performed, including an airway evaluation, in connection with the patient's admission to the Endoscopy Unit was adequate. (Tr. 625-630, 647-650 and 763-765; Ex. 4, pp. 11-14 and 20-21; See findings

11 through 17, *supra*).

40. The anesthetic agents administered by the Respondent were used within the recommended doses and not excessive. (Tr. 755-758; Ex. 4, p. 22; See finding 20, *supra*).

41. The Respondent's postoperative order for oxygen was appropriate (Tr. 765-767; Ex. 4, p. 3). However, the appropriateness of the Respondent's postoperative order for fluids is questionable (Tr. 242-245 and 765-767; Ex. 4, p. 3).[4]

42. The Respondent adequately documented pre-operative history, level of sedation or mental status during the procedure and upon transfer to the recovery area, administration of supplemental oxygen and mode of ventilation, EKG monitoring, fluid administration, and time of induction of anesthesia and duration of anesthesia (Tr. 763-770; Ex. 4, pp. 22-23).

43. However, the Respondent failed to adequately document pre-operative physical. The documentation of this item is inadequate since pertinent physical findings regarding the patient's airway and dentures should have been noted (Tr. 837-838).

Patient D

44. On or about March 21, 2001 the Respondent provided anesthesiological services to Patient D in connection with an endoscopic procedure at St. Francis (Tr. 257).

45. Specifically, on March 21, 2001 Patient D, an 81 year old female with a history of mastectomy 27 years earlier, was admitted to the Endoscopy Unit at St. Francis for a colonoscopy (Tr. 663; Ex. 5, pp. 1, 12, 14-15 and 23-24). The procedure, a colonoscopy to the cecum with ileoscopy, was performed by Jack Soterakis, M.D.. Dr. Soterakis'

[4] While recognizing that the appropriateness of the postoperative order for fluids is questionable, the Hearing Committee finds that the Petitioner failed to prove that this order was below such minimum acceptable medical

postoperative diagnosis was "diverticulosis coli". The patient tolerated the procedure well and was transferred to PACU in good condition. (Ex. 5, pp. 19-20). The Patient arrived at PACU at 12:40 P.M. and was discharged at 1:30 P.M. (Ex. 5, pp. 30-31).

46. The pre-operative history taken and the physical examination performed, including an airway evaluation, in connection with the patient's admission to the Endoscopy Unit was adequate. (Tr. 631-632, 663-666 and 763-765; Ex. 5, pp. 13-15 and 23-24; See findings 11 through 17, *supra*).

47. There is no specific requirement for a pre-operative EKG. While most hospitals require a pre-operative EKG, some do not. (Tr. 259).

48. During the procedure the Respondent monitored the EKG (Tr. 594 and 668-669; Ex. 5, p. 25).

49. The anesthetic Sublimaze administered by the Respondent was used within the recommended dose and not excessive. (Tr. 755-758; Ex. 5, p. 25; Ex. A; See finding 20, *supra*).

50. The Respondent's postoperative order for oxygen was appropriate (Tr. 765-767; Ex. 5, p. 4).

51. The Respondent adequately documented pre-operative history, level of sedation or mental status during the procedure and upon transfer to the recovery area, administration of supplemental oxygen and mode of ventilation, and monitoring of intraoperative EKG (Tr. 763-770; Ex. 5, pp. 25-26).

52. However, the Respondent failed to adequately document pre-operative physical. The documentation of this item is inadequate since pertinent physical findings regarding the patient's airway and dentures should have been noted (Tr. 837-838).

Patient E

53. On or about February 2, 2000 the Respondent provided anesthesiological services to Patient E in connection with an endoscopic procedure at St. Francis (Tr. 284).

54. Specifically, on February 2, 2000 Patient E, a 55 year old male with a history of asthma and chronic obstructive pulmonary disease, was admitted to the Endoscopy Unit at St. Francis for a colonoscopy (Tr. 285-286 and 683-684; Ex. 6, pp. 1, 10, 14-15 and 28-29). The procedure, a colonoscopy to the cecum, was performed by Jack Soterakis, M.D.. Dr. Soterakis' postoperative diagnosis was "diverticulosis coli". The patient tolerated the procedure well and was transferred to PACU in good condition. (Ex. 6, pp. 24-25 and 35). The Patient arrived at PACU at 11:15 A.M. and was discharged at 12:30 P.M. (Ex. 6, pp. 32-33).

55. The pre-operative history taken and the physical examination performed, including an airway evaluation, in connection with the patient's admission to the Endoscopy Unit was adequate. (Tr. 632, 683-685 and 763-765; Ex. 6, pp. 11, 14-15 and 28-29; See findings 11 through 17, *supra*).

56. The anesthetic agents administered by the Respondent were used within the recommended doses and not excessive. (Tr. 755-758; Ex. 6, p. 30; See finding 20, *supra*).

57. The Respondent adequately documented pre-operative history, level of sedation or mental status during the procedure and upon transfer to the recovery area, administration of supplemental oxygen and mode of ventilation, EKG monitoring, fluid administration, and time of induction of anesthesia and duration of anesthesia (Tr. 763-770; Ex. 6, pp. 30-31).

58. However, the Respondent failed to adequately document pre-operative physical. The documentation of this item is inadequate since pertinent physical findings regarding the patient's airway and dentures should have been noted (Tr. 837-838).

Patient F

59. On or about March 14, 2001 the Respondent provided anesthesiological services to Patient F in connection with an endoscopic procedure at St. Francis (Tr. 322-323).

60. Specifically, on March 14, 2001 Patient F, an 80 year old male with a history of emphysema and bilateral collapsed lungs in 1942, was admitted to the Endoscopy Unit at St. Francis for a colonoscopy (Tr. 323-324 and 712; Ex. 7, pp. 1, 10, 12-13 and 18). The procedure, a colonoscopy, was performed by Stephen R. Siegel, M.D.. Dr. Siegel's assessment was "normal surveillance colonoscopy". The patient tolerated the procedure well and was transferred to PACU. (Ex. 7, pp. 15 and 22). The Patient arrived at PACU at 2:30 P.M. and was discharged at 3:10 P.M. (Ex. 7, pp. 24-25).

61. The pre-operative history taken and the physical examination performed, including an airway evaluation, in connection with the patient's admission to the Endoscopy Unit was adequate. (Tr. 712-714 and 763-765; Ex. 7, pp. 11-13 and 18; See findings 11 through 17, *supra*).

62. The anesthetic agents administered by the Respondent were used within the recommended doses and not excessive. (Tr. 755-758; Ex. 7, p. 19; See finding 20, *supra*).

63. The Respondent adequately documented pre-operative history, level of sedation or mental status during the procedure and upon transfer to the recovery area, administration of supplemental oxygen and mode of ventilation, and monitoring of intraoperative EKG

(Tr. 763-770; Ex. 7, pp. 19-20).

64. However, the Respondent failed to adequately document pre-operative physical. The documentation of this item is inadequate since pertinent physical findings regarding the patient's airway and dentures should have been noted (Tr. 837-838).

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 unless otherwise specified.

The Respondent did not practice medicine with gross negligence on a particular occasion. The Petitioner has failed to prove by a preponderance of the evidence that there was a failure by the Respondent in connection with the Respondent's treatment of Patients A and/or B, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

The Respondent did not practice medicine with gross incompetence. The Petitioner has failed to prove by a preponderance of the evidence that the Respondent showed a total and flagrant lack of the necessary knowledge, skill or ability to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A and/or B.

The Respondent did not practice medicine with negligence on more than one occasion. The Petitioner has failed to prove by a preponderance of the evidence that on more than one occasion there was a failure by the Respondent in connection with the Respondent's

treatment of Patients A, B, C, D, E and/or F, to exercise the care that would be exercised by a reasonably prudent physician under the circumstances.

The Respondent did not practice medicine with incompetence on more than one occasion. The Petitioner has failed to prove by a preponderance of the evidence that on more than one occasion the Respondent lacked the requisite skill or knowledge necessary to perform an act in connection with the practice of medicine with respect to the Respondent's treatment of Patients A, B, C, D, E and/or F.

The Respondent did fail to maintain a record for a patient which accurately reflects the evaluation and treatment of the patient. The Petitioner has proved by a preponderance of the evidence that the Respondent in connection with the Respondent's treatment of Patients A, B, C, D, E and F, failed to maintain adequate records that accurately reflect the Respondent's evaluation and treatment of each of these patients.

DISCUSSION

In reaching its findings and its conclusions derived therefrom, the Hearing Committee conducted a thorough evaluation of the testimony of each of the witnesses who testified at the hearing and an extensive review of the documents admitted into evidence. With regard to the testimony presented, the witnesses were assessed according to their training, experience, credentials, demeanor and credibility. In its evaluation of the testimony of each witness, the Hearing Committee considered the possible bias or motive of the witness as well as whether the testimony of the witness was supported or contradicted by other independent objective evidence.

Discussion of the Witnesses

The Petitioner relies primarily upon the medical testimony of James N. Koppel, M.D., and the factual testimony of Mark W. Dobriner, M.D., in its efforts to establish its case against the Respondent. While Dr. Koppel testified with regard to the Respondent's medical care and treatment of the various patients listed in the Statement of Charges, Dr. Dobriner testified about the various events which occurred during the procedure that he performed on Patient A.

James N. Koppel, M.D., was the only witness presented by the Petitioner in support of its direct case. Dr. Koppel, who was presented as an expert in the field of anesthesiology, is a board certified anesthesiologist with over 20 years of clinical experience. He has served as Director of the Ambulatory Surgery Unit at South Nassau Communities Hospital in Oceanside, New York; Director of the Department of Anesthesiology at Community Hospital of Western Suffolk in Smithtown, New York; Director of the Division of Geriatric Anesthesia at the Mount Sinai Medical Center in New York, New York; Clinical Director of Anesthesiology and Head of the Section of Office-Based Anesthesia at Long Island Jewish Medical Center in New Hyde Park, New York; and, Medical Director and Anesthesiologist-in-Chief at Hillside SurgiCare Ambulatory Surgery Center in Hollis, New York. He has also served as Clinical Instructor in Medicine at the Health Sciences Center of the State University of New York at Stony Brook, New York; Assistant Clinical Professor of Anesthesiology at the Mount Sinai School of Medicine in New York, New York; and, Assistant Professor of Anesthesiology at Albert Einstein College of Medicine in Bronx, New York. Dr. Koppel is presently in private practice as an office-based anesthesiologist, performing anesthesia for plastic surgery and gastrointestinal procedures. (Tr. 41-42; Ex. 8).

While the Hearing Committee found that Dr. Koppel has an impressive medical background, the Hearing Committee was not impressed with Dr. Koppel's testimony. Dr. Koppel was frequently dogmatic and, at times, his testimony was inconsistent. In addition, he lacked objectivity and did not appear to be impartial.

Following the completion of the Respondent's direct case, the Petitioner presented Mark W. Dobriner, M.D., as a rebuttal witness. Dr. Dobriner is board certified in both general surgery and in colon and rectal surgery. After completing a 5 year residency in general surgery and a 1 year fellowship in colon and rectal surgery, Dr. Dobriner went into private practice. His present practice is limited to colon and rectal surgery procedures. He currently practices at St. Francis, at North Shore University Hospital in Manhasset, New York, and at North Shore University Hospital at Plainview in Plainview, New York. (Tr. 849-850).

The Hearing Committee found that Dr. Dobriner has a good medical background. However, the Hearing Committee had various concerns about his credibility. The Hearing Committee noted that his testimony that was critical of the Respondent's management of the patient's airway obstruction conflicts with his Operative Report (Tr. 854-866; Ex. 2, p. 46). The Operative Report clearly states that the Respondent took appropriate measures to maintain the patient's airway. In addition, the Hearing Committee has reservations about Dr. Dobriner's objectivity.

The Respondent's case relies primarily upon the medical testimony of Pat J. Martin, M.D., the factual testimony of Jack Soterakis, M.D., and the medical and factual testimony of the Respondent. While Dr. Martin and the Respondent testified with regard to the Respondent's medical care and treatment of the various patients listed in the Statement of Charges, Dr. Soterakis testified about the St. Francis Endoscopy Unit and the treatment of

Patients C, D and E.

Pat J. Martin, M.D., was presented as an expert in the field of anesthesiology. Dr. Martin is a board certified anesthesiologist with over 20 years of clinical experience. She has served as Site Director of Anesthesia at Montefiore Medical Center in Bronx, New York; Associate Professor of Anesthesiology as well as Assistant Professor of Anesthesiology at the College of Physicians & Surgeons at Columbia University in New York, New York; Associate Attending Anesthesiologist as well as Assistant Attending Anesthesiologist at Presbyterian Hospital in New York, New York; and, Medical Director of the Post Anesthesia Care Unit, Director Quality Assurance of the Department of Anesthesiology and Clinical Coordinator of the Department of Anesthesiology, at Columbia-Presbyterian Medical Center in New York, New York. (Tr. 747-750; Ex. F). Dr. Martin is currently retired. She retired two years ago. (Tr. 776).

The Hearing Committee found Dr. Martin to be a very convincing and highly credible witness. She was straightforward, non-evasive, extremely knowledgeable and her testimony was balanced and unbiased. Her credentials were quite impressive and she demonstrated a far-reaching command of the field of anesthesiology. Additionally, her service for 13 years as Director of Quality Assurance of the Anesthesiology Department at Columbia-Presbyterian Medical Center makes her uniquely qualified to assess the quality of the anesthesiological services provided by the Respondent. Furthermore, the Hearing Committee noted that Dr. Martin has authored various medical articles, four of which are relevant to the issues presented at this hearing (Ex. F, p. 3).

Jack Soterakis, M.D., is the gastroenterologist who performed the endoscopic procedures on Patients C, D and E. He was essentially called as a factual witness by the Respondent to describe the pre-operative procedures employed at the St. Francis Endoscopy Unit and to explain various notations appearing in the medical records of the three patients.

Dr. Soterakis is a gastroenterologist in private practice in Manhasset, New York. He is board certified in internal medicine as well as gastroenterology. He has been in private practice since 1979 and has served as an attending physician at St. Francis. In 1991 Dr. Soterakis was appointed Assistant Director of Medicine at St. Francis and in 1999 he was appointed Director of Medicine. He performs approximately 1,000 endoscopic procedures a year at St. Francis. (Tr. 618-620).

The Hearing Committee found Dr. Soterakis to be a credible witness with a solid medical background. He was straightforward and non-evasive and he appeared unbiased and objective.

The third witness who testified in support of the Respondent's case, was the Respondent herself. The Respondent is a board certified anesthesiologist with extensive experience in many types of procedures, including open heart surgery. Between 1973 and 2001 the Respondent has served as a staff anesthesiologist at St. Francis. The Respondent was the anesthesiologist assigned to the St. Francis Endoscopy Unit which opened approximately three years ago. While at St. Francis the Respondent administered anesthesia in approximately 5,000 endoscopic procedures. (See findings 6 through 10, *supra*).

The Hearing Committee found the Respondent to be a presentable witness with an adequate medical background. She was credible and objective during most of her testimony, although at times she became vague and evasive and her testimony was self-serving. However, when pressed she did provide objective testimony, even when such testimony did not support her position at the hearing. Although the Respondent is fluent in English, the Hearing Committee observed that at times she appeared to have difficulty comprehending questions and articulating answers. She testified in English, not her native language, which may account for some of the problems that arose during her testimony.

Discussion of the Charges

In order to resolve the negligence and incompetence issues, which include ordinary and gross negligence and ordinary and gross incompetence, it was necessary to evaluate the medical testimony and medical records relating to each of the particular patients.

The resolution of the recordkeeping issues required an examination of the medical records for each patient as well as an evaluation of the medical testimony relating to the adequacy of each of these medical records.

Discussion of the Treatment of the Patients

The Hearing Committee found that the Respondent's primary shortcoming was in the area of medical recordkeeping. However, the Respondent's failure to adequately document the care and treatment that she provided to each of the patients, although constituting a violation of § 6530(32) of the Education Law, did not constitute negligence since such failure did not adversely affect patient treatment.

In fact, the Hearing Committee found that the Respondent appropriately managed each of the patients who were the subject of this hearing. The Hearing Committee noted that

none of the patients experienced any complications other than Patient A, and that the Respondent's management of Patient A's complication was appropriate. Additionally, all patients arrived at PACU in stable condition, with vital signs within normal limits. Other than routine oxygen administered in PACU, none of the patients required any further treatment or assistance. Even Patient A had a Post Anesthesia Recovery Room Score of 9, indicating almost full recovery. All patients were discharged the same day of the procedure, except Patient A who was admitted to the hospital that day and discharged the following day.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise specified)

Factual Allegations

Factual Allegations relating to the treatment of Patient A

Sustained: A and A6[5]

Not Sustained: A1, A2, A3, A4 and A5

Factual Allegations relating to the treatment of Patient B

Sustained: B and B4[6]

Not Sustained: B1 and B2

Withdrawn: B3

Factual Allegations relating to the treatment of Patient C

Sustained: C and C4[7]

[5] Factual allegation A6 is sustained only to the extent that the Respondent failed to adequately document pre-operative physical, description of intraoperative complication, and description of treatment provided.
[6] Factual allegation B4 is sustained only to the extent that the Respondent failed to adequately document pre-operative physical.

Not Sustained: C1, C2 and C3[8]

Factual Allegations relating to the treatment of Patient D

Sustained: D and D5[9]

Not Sustained: D1, D2, D3 and D4

Factual Allegations relating to the treatment of Patient E

Sustained: E and E3[10]

Not Sustained: E1 and E2

Factual Allegations relating to the treatment of Patient F

Sustained: F and F3[11]

Not Sustained: F1 and F2

Specifications

Gross Negligence

1st Specification	(Treatment of Patient A)	Not Sustained
2nd Specification	(Treatment of Patient B)	Not Sustained

Gross Incompetence

3rd Specification	(Treatment of Patient A)	Not Sustained
4th Specification	(Treatment of Patient B)	Not Sustained

[7] Factual allegation C4 is sustained only to the extent that the Respondent failed to adequately document pre-operative physical.

[8] Although factual allegation C3 has not been sustained, the Hearing Committee found the appropriateness of the postoperative order for fluids questionable (See finding 41, *supra*).

[9] Factual allegation D5 is sustained only to the extent that the Respondent failed to adequately document pre-operative physical.

[10] Factual allegation E3 is sustained only to the extent that the Respondent failed to adequately document pre-operative physical.

[11] Factual allegation F3 is sustained only to the extent that the Respondent failed to adequately document pre-operative physical.

Negligence on More than One Occasion

5th Specification	(Treatment of Patients A, B, C, D, E and F)	Not Sustained

Incompetence on More than One Occasion

6th Specification	(Treatment of Patients A, B, C, D, E and F)	Not Sustained

Failure to Maintain a Patient Record

7th Specification	(Medical Record of Patient A)	Sustained

Sustained Factual Allegations in Support of the 7th Specification: A and A6

8th Specification	(Medical Record of Patient B)	Sustained

Sustained Factual Allegations in Support of the 8th Specification: B and B4

9th Specification	(Medical Record of Patient C)	Sustained

Sustained Factual Allegations in Support of the 9th Specification: C and C4

10th Specification	(Medical Record of Patient D)	Sustained

Sustained Factual Allegations in Support of the 10th Specification: D and D5

11th Specification	(Medical Record of Patient E)	Sustained

Sustained Factual Allegations in Support of the 11th Specification: E and E3

12th Specification	(Medical Record of Patient F)	Sustained

Sustained Factual Allegations in Support of the 12th Specification: F and F3

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that the Respondent should receive a penalty of censure and reprimand. In addition, the Respondent should be required to enroll in and complete a

continuing medical education program in the area of medical recordkeeping.

This determination was reached after due and careful consideration of the full spectrum of penalties available pursuant to PHL § 230-a, including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties. The Hearing Committee's selection of a specific penalty was made after a thorough evaluation of the underlying acts of misconduct and the question of whether the public is placed at risk by the Respondent. The Hearing Committee also conducted a thorough examination of the Respondent's testimony and demeanor during the hearing.

The Hearing Committee observed that most of the misconduct charges were not substantiated and those misconduct charges that were substantiated had little or no impact on patient care. The Hearing Committee also noted that all of the sustained misconduct charges related to inadequate recordkeeping. Since the Respondent's primary deficiency is connected to her failure to maintain adequate patient records, supplemental training in medical recordkeeping would enable the Respondent to overcome her shortcomings in recordkeeping.

Given the totality of the circumstances regarding this matter and the fact that the ordinary and gross negligence and the ordinary and gross incompetence charges were not proven, the Hearing Committee believes that neither revocation, suspension nor probation is warranted.

Finally, the Hearing Committee believes that in view of all the circumstances, a censure and reprimand together with a requirement for supplemental training in medical recordkeeping, is an appropriate penalty commensurate with the seriousness of the proven misconduct.

ORDER

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

1. The 7th, 8th, 9th, 10th, 11th and 12th Specifications of professional misconduct, as set forth in the Statement of Charges (Appendix I), are **SUSTAINED**; and

2. The 1st, 2nd, 3rd, 4th, 5th and 6th Specifications of professional misconduct contained within the Statement of Charges (Appendix I) are **DISMISSED**; and

3. The Respondent is hereby **CENSURED and REPRIMANDED**; and

4. The Respondent shall enroll in and complete a **CONTINUING MEDICAL EDUCATION PROGRAM** in the area of Medical Recordkeeping ("the CME Program"); the CME Program shall be subject to the prior written approval of the Director of the Office of Professional Medical Conduct ("the Director") who has offices at Hedley Park Place, 433 River Street, Suite 303, Troy, New York 12180; and, the CME Program shall be completed within ninety (90) days of the effective date of this Order, unless the Director approves an extension in writing; and

5. This **ORDER** shall be effective upon service on the Respondent which shall be either by certified mail at the Respondent's last known address (to be effective upon receipt or seven days after mailing, whichever is earlier) or by personal service (to be effective upon receipt).

Dated: New York, New York
3 March 28, 2003

ADEL ABADIR, M.D.
Chairperson

AIRLIE CAMERON, M.D.
DEBORAH A. GRAY

TO: PI JU TANG, M.D.
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APPENDIX 1

APPENDIX I

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

IN THE MATTER OF PI JU TANG, M.D.	STATEMENT OF CHARGES

PI JU TANG, M.D., the Respondent, was authorized to practice medicine in New York State on or about October 17, 1968, by the issuance of license number 102647 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about February 7, 2001, Respondent provided anesthesiological services to Patient A in connection with an endoscopic procedure at St. Francis Hospital, Roslyn, New York. (The names of patients are contained in the attached Appendix) Respondent's care deviated from acceptable standards in the following respects:

1. Respondent failed to take and perform an adequate preoperative history and physical examination, including an airway evaluation.

2. Respondent failed to provide medication prophylaxis for a known hiatal hernia.

3. Respondent administered excessive amounts of anesthetic agents.

4. The excessive anesthetic administration caused airway obstruction. Respondent failed to properly correct the airway obstruction.

5. Intra operatively, Patient A experienced a precipitous drop in systolic blood pressure and heart rate. Respondent failed to properly manage these events.

6. Respondent failed to maintain a record for Patient A which accurately reflect the evaluation and treatment he provided including preoperative history and physical, documentation of level of sedation or mental status during the procedure and upon transfer to recovery area, documentation of administration of supplemental oxygen and mode of ventilation, EKG monitoring and description of intraoperative complication and treatment provided.

B. On or about December 12, 2000, Respondent provided anesthesiological services to Patient B in connection with an endoscopic procedure at St. Francis Hospital. Respondent's care deviated from acceptable standards in the following respects:

1. Respondent failed to take and perform an adequate preoperative history and physical examination, including an airway evaluation.

2. Respondent ~~failed to obtain and review a preoperative EKG and~~ failed to monitor the intraoperative EKG.

* Withdrawn by Petitioner 9/30/02 DZA ALJ

Withdrawn by Petitioner DFB MLJ 9/30/02

3. * ~~Respondent administered an excessive dose of the anesthetic agent Sublimaze.~~

4. Respondent failed to maintain a record for Patient B which accurately reflects the evaluation and treatment he provided including preoperative history and physical, documentation of level of sedation or mental status during the procedure and upon transfer to recovery area, documentation of administration of supplemental oxygen and mode of ventilation, EKG monitoring, charting of fluid administration and accurate recording of time of induction of anesthesia and duration of anesthesia.

C. On or about March 14, 2001, Respondent provided anesthesiological services to Patient C in connection with an endoscopic procedure at St. Francis Hospital. Respondent's care deviated from acceptable standards in the following respects:

1. Respondent failed to take and perform an adequate preoperative history and physical examination, including an airway evaluation.

2. Respondent administered excessive amounts of anesthetic agents.

3. Respondent's postoperative orders for oxygen and fluids are inappropriate and/or excessive.

4. Respondent failed to maintain a record for Patient C which accurately reflects the evaluation and treatment he provided including preoperative history and physical, documentation of level of sedation or mental status during the procedure and upon transfer to recovery area, documentation of administration of supplemental oxygen and mode of ventilation, EKG monitoring, charting of fluid administration and accurate recording of time of induction of anesthesia and duration of anesthesia.

D. On or about March 21, 2001, Respondent provided anesthesiological services to Patient D in connection with an endoscopic procedure at St. Francis Hospital. Respondent's care deviated from acceptable standards in the following respects:

1. Respondent failed to take an perform an adequate preoperative history and physical examination, including an airway evaluation.

2. Respondent failed to obtain and review a preoperative EKG and failed to monitor the intraoperative EKG.

3. Respondent administered an excessive dose of the anesthetic Sublimaze.

4. Respondent's postoperative order for oxygen is inappropriate and fails to specify parameters for institution of therapy or proper flow rate.

5. Respondent failed to maintain a record for Patient D which accurately reflects the evaluation and treatment he provided including preoperative history and physical, documentation of level of sedation or mental status during the procedure and upon transfer to recovery area, documentation of administration of supplemental oxygen and mode of ventilation and monitoring of intra operative EKG.

E. On or about February 02, 2000, Respondent provided anesthesiological services to Patient E in connection with an endoscopic procedure at St. Francis Hospital. Respondent's care deviated from acceptable standards in the following respects

1. Respondent failed to take and perform an adequate preoperative history and physical examination, including an airway evaluation.

2. Respondent administered excessive amounts of anaesthetic agents.

3. Respondent failed to maintain a record for Patient E which accurately reflects the evaluation and treatment he provided including preoperative history and physical, documentation of level of sedation or mental status during the procedure and upon transfer to recovery area, documentation of administration of supplemental oxygen and mode of ventilation, EKG monitoring, charting of fluid administration and accurate recording of time of

induction of anesthesia and duration of anesthesia.

F. On or about March 14, 2001, Respondent provided anesthesiological services to Patient F in connection with an endoscopic procedure at St. Francis Hospital. Respondent's care deviated from acceptable standards in the following respects:

1. Respondent failed to take and perform an adequate preoperative history and physical examination, including an airway evaluation.

2. Respondent administered excessive amounts of anesthetic agents.

3. Respondent failed to maintain a record for Patient F which accurately reflects the evaluation and treatment he provided including preoperative history and physical, documentation of level of sedation or mental status during the procedure and upon transfer to recovery area, documentation of administration of supplemental oxygen and mode of ventilation, and monitoring of intraoperative EKG.

SPECIFICATION OF CHARGES

FIRST AND SECOND SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following paragraphs:

1. A and A(1) - A(6).
2. B and B(1) - B(4).

THIRD AND FOURTH SPECIFICATIONS
GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following paragraphs:

3. A and A(1) - A(6).
4. B and B(1) - B(4).

FIFTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

5. A and A(1) - A(6), B and B(1)-B(4), C and C(1)-C(4), D and D(1)-D(5), E and E(1)-E(3) and F and F(1)-F(3).

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following paragraphs:

6. A and A(1) - A(6), B and B(1)-B(4), C and C(1)-C(4), D and D(1)-D(5), E and E(1)-E(3) and F and F(1)-F(3).

SEVENTH THROUGH TWELFTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of the following paragraphs:

7. A and A(6).
8. B and B(4).
9. C and C(4),.
10. D and D(5).
11. E and E(3).
12. F and F(3).

DATED: July 11, 2002
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct