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

PUBLIC

IN THE MATTER

OF

KWANG HAN PAIK

COMMISSIONER'S ORDER AND NOTICE OF HEARING

TO: **KWANG HAN PAIK, M.D.**
47 Edison Drive
Schenectady, New York 12309

The undersigned, Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner of Health, after an investigation, upon the recommendation of a Committee on Professional Medical Conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by Kwang Han Paik, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law §230(12), that effective immediately Kwang Han Paik, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law §230(12).

PLEASE TAKE NOTICE, that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230, and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on April 21, 2004, at 10:00 a.m., at Hedley Park Building, 433 River Street, 5th Floor, Troy, New York 12180-2299, and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

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. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to §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.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, and by telephone (518-402-0748), 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. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

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. Such determination may be reviewed by the administrative review board for professional medical conduct.

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

DATED: Albany, New York
April 14, 2004

ANTONIA C. NOVELLO, M.D., M.P.H., Dr.P.H.
Commissioner
New York State Health Department

Inquiries should be directed to:

Joseph H. Cahill, Esq.
Associate Counsel
N.Y.S. Department of Health
Division of Legal Affairs
Corning Tower Building, Room 2512
Empire State Plaza
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
KWANG HAN PAIK, M.D.

STATEMENT
OF
CHARGES

KWANG HAN PAIK, M.D., Respondent, was authorized to practice medicine in New York State on or about October 29, 1982, by the issuance of license number 152336 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care at Nathan Littauer Hospital, 99 East State Street, Gloversville, New York 12078 (hereafter "Nathan Littauer Hospital") to Patient A, a 74 year old male admitted on June 5, 2003. Respondent administered general anesthesia during an appendectomy performed on June 6, 2003. Respondent extubated the patient in the operating room. Respondent's care of Patient A failed to meet accepted standards of medical care in that:

1. Respondent failed to take timely measures to adequately monitor the patient in the immediate post-extubation period, including the failure to reattach the

anesthesia machine monitors or similar monitors to the patient.

2. Respondent repeatedly misrepresented the patient's status to other health care professionals present, saying "the patient is fine, the patient is breathing" or words to that effect, when the patient was, in fact, in significant cardiac and/or respiratory distress.

3. Respondent failed to timely diagnose post-operative hypoxia.

4. Respondent failed to give the patient adequate ventilation.

5. Respondent failed to timely diagnose severe hypotension in the post-operative period.

6. Respondent failed to timely treat severe hypotension in the post-operative period.

7. Respondent prevented health care professional staff from applying chest compressions to the patient when medically indicated.

8. Respondent failed to timely institute cardiac life support measures or provide cardiac resuscitation when medically indicated.

9. Respondent failed to timely diagnose and/or treat cardiovascular collapse, including pulseless electrical activity in Patient A.

10. Respondent inappropriately withheld adequate ventilation from Patient A following the conclusion of the operation.

11. Respondent's failed to appropriately manage the patient's airway post-operatively.

12. Respondent failed to adequately and/or accurately document Patient A's medical record.

B. Respondent provided medical care at Nathan Littauer Hospital to Patient B, a 25 year old male, admitted through the Emergency Department on June 27, 2002. Respondent administered general anesthesia in an open reduction internal fixation of an ankle fracture performed on that date. Respondent extubated Patient B in the operating room. Respondent's care of Patient B failed to meet accepted standards of medical care in that:

1. Respondent failed to appropriately manage the patient's airway post-operatively.

2. Respondent failed to adequately recover the patient prior to extubation.

3. Respondent inappropriately transferred the patient out of the operating room to the post-anesthesia care unit with an unstable airway.

4. Respondent failed to reintubate the patient when medically indicated and after ambubag efforts failed to move the patient into sustained acceptable oxygen saturation levels.

5. Respondent failed to adequately and/or timely treat the patient's hypoxia.

6. Respondent failed to adequately assess and/or treat the patient's symptoms of cyanosis and unresponsiveness.

7. Respondent failed to adequately and/or timely respond to the patient's respiratory failure and/or pulmonary edema.

8. Respondent ordered the administration of IV Demerol to the patient which was contra-indicated given the patient's respiratory failure and unresponsive status.

9. Respondent failed to adequately and/or accurately document Patient B's medical record.

C. Respondent provided medical care at Nathan Littauer Hospital to Patient C, a 48 year old female, on June 11, 2003. Respondent administered general anesthesia related to an elective total abdominal hysterectomy, bilateral salpingo-oophorectomy, cystoscopy and bladder suspension surgery. Respondent extubated Patient C in the operating room. Respondent's care of Patient C failed to meet accepted standards of medical care in that:

1. Respondent failed to record the time that muscle relaxant reversal agent(s) were administered.

2. Respondent failed to record the time(s) that Dopram and/or Zofram were administered.

3. Respondent failed to record specific and/or complete data related to post-extubation oxygen saturation fluctuations.

4. Respondent failed to adequately diagnose the cause of the patient's post-extubation respiratory distress.

5. Respondent inappropriately ordered the administration of IV Lasix for Patient C.

6. Respondent inappropriately ordered the administration of Versed for Patient C.

7. Respondent failed to appropriately manage the patient's airway post-operatively.

8. Respondent failed to adequately and/or accurately document Patient C's medical record.

D. Respondent provided medical care at Nathan Littauer Hospital to Patient D, a 33 year old female, on November 28, 2001. Respondent administered general anesthesia during a laparoscopic cholecystectomy surgery. Respondent extubated Patient D in the operating room. Respondent's care of Patient D failed to meet accepted standards of medical care in that:

1. Respondent failed to appropriately manage the patient's airway post-operatively.

2. Respondent inappropriately transferred the patient from the operating room to the post-anesthesia care unit with an unstable airway.

3. Respondent failed to adequately and/or accurately document Patient D's medical record.

E. Respondent provided medical care at Nathan Littauer Hospital to Patient E, a 42 year old male who was admitted on June 11, 2003 for repair of an epigastric hernia. Patient E had a history of Hepatitis C. On this date Respondent administered general anesthesia during the hernia procedure. Respondent's care of Patient E failed to meet accepted standards of medical care in that:

1. Respondent failed to record the time that muscle relaxant reversal agent(s) were administered.

2. Respondent failed to record the time that Dopram was administered.

3. Respondent failed to record low oxygen saturation readings.

4. Respondent inappropriately placed a used LMA (with oral secretions and blood) into his pocket, using his bare hands. Respondent, when confronted about this matter, placed the bloody side of the LMA back into his pocket and then sat on various chairs in the post-anesthesia care unit.

5. Respondent failed to adequately and/or accurately document Patient E's medical record.

F. Respondent provided medical care at Nathan Littauer Hospital to Patient F, a 40 year old female who was admitted on an outpatient basis on July 1, 2002 for a laparoscopic bilateral salpingo-oophorectomy. Respondent provided general anesthesia during this procedure. Respondent extubated Patient F in the operating room. Respondent's care of Patient F failed to meet accepted standards of medical care in that:

1. Respondent failed to record the doses and/or times that atropine and/or neostigmine were administered.

2. Respondent failed to appropriately manage the patient's airway post-operatively.

3. Respondent failed to adequately recover the patient prior to extubation.

4. Respondent inappropriately transferred the patient from the operating room to the post-anesthesia care unit with an unstable airway.

5. Respondent failed to adequately and/or accurately document Patient F's medical record.

G. Respondent provided medical care at Nathan Littauer Hospital to Patient G, a 58 year old female who was admitted on May 13, 2002 for a laparoscopic cholecystectomy. Respondent provided general anesthesia related to this procedure. Following the procedure, Respondent extubated Patient G in the operating room. Respondent's care of Patient G failed to meet accepted standards of medical care in that:

1. Respondent failed to appropriately manage the patient's airway post-operatively.

2. Respondent failed to adequately recover the patient prior to extubation.

3. Respondent inappropriately transferred the patient from the operating room to the post-anesthesia care unit with an unstable airway.

4. Respondent failed to adequately and/or accurately document the patient's medical record.

H. Respondent provided medical care at Nathan Littauer Hospital to Patient H, a 40 year old male who was admitted on April 16, 2002 through the Emergency Department for an acute appendix. Respondent provided general anesthesia during an appendectomy surgery performed on that date. Following the operation Respondent extubated Patient H in the operating room. Respondent's care of Patient H failed to meet accepted standards of medical care in that:

1. Respondent failed to appropriately manage the patient's airway post-operatively.

2. Respondent failed to adequately recover the patient prior to extubation.

3. Respondent inappropriately transferred the patient from the operating room to the post-anesthesia care unit with an unstable airway.

4. Respondent failed to adequately and/or accurately document the patient's medical record.

I. Respondent provided medical care at Saint Mary's Hospital, 427 Guy Park Avenue, Amsterdam, New York 12010 (hereafter "St. Mary's Hospital"), to Patient I, a 58 year old male who was admitted on November 20, 2000 for evaluation of rectal bleeding. On November 21, 2000, Respondent provided general anesthesia during a rigid proctosigmoidoscopic examination, rectal biopsies and debridement of a rectal ulcer. Following these procedures, Respondent extubated Patient I in the operating room. Respondent's care of Patient I failed to meet accepted standards of medical care in that:

1. Respondent failed to appropriately manage the patient's airway post-operatively.

2. Respondent failed to adequately recover the patient prior to extubation.

3. Respondent inappropriately transferred the patient from the operating room to the post-anesthesia care unit with an unstable airway.

4. Respondent failed to timely reintubate the patient in the face of signs of respiratory distress and/or cardiac decompensation.

5. Respondent failed to adequately and/or timely secure the patient's airway after the patient suffered a cardiac arrest and a code was instituted.

6. Respondent, following reintubation, inappropriately allowed the patient to breath spontaneously, in the face of respiratory distress and/or cardiac arrest.

7. Respondent failed to adequately and/or accurately document the patient's medical record.

J. Respondent provided medical care at St. Mary's Hospital to Patient J, a 35 year old pregnant female who was admitted on November 27, 2001 in active labor. Respondent provided general anesthesia during an emergency Caesarian section performed on that date. Respondent's care of Patient J failed to meet accepted standards of medical care in that:

1. Respondent, following the inadvertent extubation of the endotracheal tube, failed to appropriately manage the patient's airway.

2. Respondent inaccurately documented in the patient's record that laryngospasm was the cause of an unsuccessful intubation.

3. Respondent inaccurately documented the patient's hypoxia on the anesthesia record.

4. Respondent inaccurately documented the patient's $ETCO^2$ levels on the anesthesia record.

5. Respondent failed to document the time(s) that induction agents were administered.

6. Respondent, failed to document the time that Atracurium was administered.

7. Respondent, despite the patient's respiratory distress, failed to adequately evaluate and/or treat the patient and told staff that the situation was "under control,"

or words to that effect.

8. Respondent physically interfered with a physician attempting to monitor the patient's respiratory status, when such monitoring was medically indicated.

9. Respondent failed to adequately and/or accurately document the patient's medical record.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education 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:

1. The facts in Paragraphs A and A1, A and A2, A and A3, A and A4, A and A5, A and A6, A and A7, A and A8, A and A9, A and A10, A and A11, A and A12; B and B1, B and B2, B and B3, B and B4, B and B5, B and B6, B and B7, B and B8, B and B9; C and C1, C and C2, C and C3, C and C4, C and C5, C and C6, C and C7, C and C8; D and D1, D and D2, D and D3; E and E1, E and E2, E and E3, E and E4, E and E5; F and F1, F and F2, F and F3, F and F4, F and F5; G and G1, G and G2, G and G3, G and G4; H and H1, H and H2, H and H3, H and H4; I and I1, I and I2, I and I3, I and I4, I and I5, I and I6, I and I7; J and J1, J and J2, J and J3, J and J4, J and J5, J and J6, J and J7, J and J8, J and J9.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in New York Education 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:

2. The facts in Paragraphs A and A1, A and A2, A and A3, A and A4, A and A5, A and A6, A and A7, A and A8, A and A9, A and A10, A and A11, A and A12; B and B1, B and B2, B and B3, B and B4, B and B5, B and B6, B and B7, B and B8, B and B9; C and C1, C and C2, C and C3, C and C4, C and C5, C and C6, C and C7, C and C8; D and D1, D and D2, D and D3; E and E1, E and E2, E and E3, E and E4, E and E5; F and F1, F and F2, F and F3, F and F4, F and F5; G and G1, G and G2, G and G3, G and G4; H and H1, H and H2, H and H3, H and H4; I and I1, I and I2, I and I3, I and I4, I and I5, I and I6, I and I7; J and J1, J and J2, J and J3, J and J4, J and J5, J and J6, J and J7, J and J8, J and J9.

THIRD THROUGH ELEVENTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(4) by practicing the profession of medicine with gross negligence

as alleged in the facts of the following:

3. The facts in Paragraph A and A1, A and A2, A and A3, A and A4, A and A6, A and A7, A and A8, A and A9, A and A10, A and A11, A and A12.
4. The facts in Paragraph B and B1, B and B2, B and B3, B and B4, B and B5, B and B6, B and B7 and/or B and B8.
5. The facts in Paragraph C and C4 and/or C and C6.
6. The facts in Paragraph D and D1 and/or D and D2.
7. The facts in Paragraph F and F2, F and F3 and/or F and F4.
8. The facts in Paragraph G and G1, G and G2 and/or G and G3.
9. The facts in Paragraph H and H1 and/or H and H2.
10. The facts in Paragraph I and I1, I and I2, I and I3, I and I4, I and I5 and/or I and I6.
11. The facts in Paragraph J and J1, J and J7 and/or J and J8.

TWELFTH THROUGH TWENTIETH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

12. The facts in Paragraph A and A1, A and A2, A and A3, A and A4, A and A6, A and A7, A and A8, A and A9, A and

A10, A and A11, A and A12.

13. The facts in Paragraph B and B1, B and B2, B and B3, B and B4, B and B5, B and B6, B and B7 and/or B and B8.
14. The facts in Paragraph C and C4 and/or C and C6.
15. The facts in Paragraph D and D1 and/or D and D2.
16. The facts in Paragraph F and F2, F and F3 and/or F and F4.
17. The facts in Paragraph G and G1, G and G2 and/or G and G3.
18. The facts in Paragraph H and H1 and/or H and H2.
19. The facts in Paragraph I and I1, I and I2, I and I3, I and I4, I and I5 and/or I and I6.
20. The facts in Paragraph J and J1, J and J2, J and J7 and/or J and J8.

TWENTY-FIRST THROUGH THIRTIETH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in New York Education 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:

21. The facts in Paragraph A and A12.
22. The facts in Paragraph B and B9.
23. The facts in Paragraph C and C1, C and C2, C and C3 and/or C and C8.
24. The facts in Paragraph D and D3.

25. The facts in Paragraph E and E1, and E and E.2, E and E3 and/or E and E5.

26. The facts in Paragraph F and F1 and F and F5.

27. The facts in Paragraph G and G4.

28. The facts in Paragraph H and H4.

29. The facts in Paragraph I and I7.

30. The facts in Paragraph J and J2, J and J3, J and J4, J and J5, J and J6 and/or J and J9.

THIRTY-FIRST SPECIFICATION

INFECTION CONTROL VIOLATION

Respondent is charged with committing professional misconduct as defined in New York Education Law § 6530(47) by failing to use scientifically accepted barrier precautions and infection control practices as established by the Department of Health pursuant to § 230(a) of the Public Health Law as alleged in the facts of the following:

31. The facts in Paragraph E and E4.

DATED: April 14, 2004
Albany, New York

Peter D. Van Buren

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