STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

September 26, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ralph J. Bavaro, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Young Ho Kwon, M.D.
12 Lyons Court
Wodcliff Lake, New Jersey 07675

Arnold Marshall, Esq.
Frederick C. Stern, Esq.
50 East 42nd Street
New York, New York 10017

RE: In the Matter of Young Ho Kwon, M.D.

Dear Mr. Bavaro, Mr. Marshall and Dr. Kwon :

Enclosed please find the Determination and Order (No. 94-188) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public health Law §230, subdivision 10,

paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

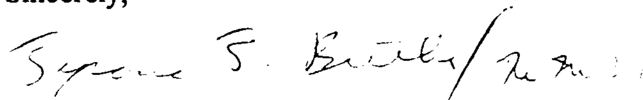
The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

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

Sincerely,



Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER OF YOUNG HO KWON, M.D.	DETERMINATION AND ORDER

NO. BPMC-94-188

Robert S. Bernstein, M.D., Chairman, Milton O.C. Haynes, M.D., and **Anthony Santiago**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230 (1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. **Jane B. Levin, Esq.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

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

SUMMARY OF THE PROCEEDINGS

Commissioner's Order and Notice of Hearing dated:	May 26, 1994
Statement of Charges dated:	May 26, 1994
Hearing dates:	June 3, 1994 June 8, 1994 June 13, 1994 July 19, 1994 July 20, 1994 July 26, 1994
Deliberation Date:	August 15, 1994

Interim Report Summary Suspension:	August 19, 1994
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, N.Y.
Petitioner appeared by:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Ralph J. Bavaro, Esq. Associate Counsel
Respondent appeared by:	Arnold Marshall, Esq. Frederick C. Stern, Esq. 50 East 42nd Street New York, N.Y. 10017

WITNESSES

For the Petitioner:

1) Alice Clark, R.N.
2) Kathy Ericsen, R.N.
3) Hilda Gomez
4) Jackie Bonilla
5) Nayda Ruiz
6) Jessica Baez
7) Mary McCloud, M.D.
8) Regina McQueen
9) David Gandell, M.D.
10) Dwight Howes
11) Joanne Heath, R.N.
12) Montoya Daniels, R.N.

For the Respondent:

1) Young Ho Kwon, M.D. (Respondent)
2) Martin Weisberg, M.D.
3) Ruth Brayer

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of practicing the profession of medicine with negligence and gross negligence, incompetence and

gross incompetence; practicing the profession fraudulently; failing to maintain adequate records; wilfully making a false statement; failing to use appropriate barrier precautions and infection control practices and failing to comply with state law governing the practice of medicine.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part hereof.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers of exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

FINDINGS OF FACT

1. Young Ho Kwon, M.D. the Respondent, was authorized to practice medicine in New York State by the issuance of license number 146249 by the New York State Education Department on June 12, 1981. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 (Pet. Ex. 2).

2. Respondent treated Patients 1-20 at his office located at 9 West 31st Street, New York City, between June 1 and September 28,

1993. Respondent performed vacuum abortions on each patient (Pet. Ex. 5).

3. The patient records provided by Respondent in these proceedings consist of the following pages:

a) medical history

b) patient chart, containing chief complaint, present illness, etc.

c) physical examination/operative note

d) ancillary lab/pathology reports

e) post-operative note

(Pet. Exs. 5, 13, 14; Resp. Ex. A).

4. On February 28, 1994 three representatives of the Department of Social Services (DSS) held a conference with Respondent in his office. Prior to that conference, Respondent had been informed verbally and in writing that his practice as a Medicaid provider was being audited by DSS and that patient records might be requested and photocopied on that date (Pet. Ex. 3).

5. At the conference, Respondent was asked to provide a sample of his Medicaid patient records. Respondent provided records for six patients (not named in this proceeding). Each record consisted of only two pages, a medical history and a physical examination/operative note (T. 32, 45-50, 107-09).

6. In a letter dated March 11, 1994, and hand delivered to Respondent on March 14, 1994, DSS requested records for Patients 1-20 herein. Attached to that letter was a list of the patient's names, dates of service, Medicaid ID numbers and dates of birth (T. 44-45; Pet. Ex. 4).

7. In response to that letter, on March 17, 1994, Respondent provided the 20 patient records with the following certification: "I acknowledge that the record submitted to the Department of Social Services (DSS) are the patients' total and complete medical records which support fully the nature and extent of all services rendered and ordered by me." (Pet. Ex. 5).

8. The records provided on March 17, 1994 consisted of only three pages: medical history, patient chart and physical examination/operative note (Pet. Ex. 5).

9. Dr. Kwon checked the "no" box on the certification page, in answer to the question whether "all ancillary documents and materials" were included (Pet. Ex. 5).

10. By letter dated April 28, 1994, delivered to Respondent on May 4, 1994, DSS informed Respondent of his exclusion from the Medicaid program. That letter listed the findings of the DSS audit, which included findings that Respondent's records lacked laboratory reports, pathology reports, and follow-up/discharge notes (Pet. Ex. 6).

11. Subsequently, on May 11, 1994, pursuant to a New York State Department of Health (DOH) request, Respondent for the first time produced two additional pages for each patient consisting of ancillary lab/pathology reports and post operative notes. Dr. Kwon testified that the additional pages of each patient's record were stored in his garage when he moved his office (T. 535, 547, 950-52; Resp. Ex. A).

12. Prior to the time that DSS began its review of Respondent's practice, Respondent's receptionists were only aware

of a one page record for each patient, consisting of the medical history form, which was filled in by patients upon entry to Respondent's office. Respondent's employees then entered information regarding the method and amount of billing (T. 161, 170-73, 199-200, 234, 259, 265, 272).

13. After DSS began requesting records, Respondent handed approximately 700 completed medical history forms to his employees Hilda Gomez and an employee identified only as "Josie" and instructed them to "white-out" the billing information. Respondent also provided these employees with two additional pages, a blank "patient chart" and a blank physical examination/operative note, and instructed them to staple the two additional pages onto the medical history form (T. 200-203, 234-5).

14. In May 1994, Respondent instructed his employee Ms. Bonilla, with the assistance of another employee, Ms. Ruiz, to fill in blood pressure and temperatures on physical examination/operative notes (T. 293-301, 367-68, 387, 389-95). Respondent also provided Ms. Bonilla and Ms. Ruiz with blank ancillary lab/pathology reports and post-operative notes and instructed them to fill in patient names, dates of service, vital signs and other random information regarding "language," "patient discharge," and "patient accompanied by" etc. Ms. Bonilla and Ms. Ruiz entered this information on more than 200 records (T. 302, 306, 368-71, 396-98, 403-05).

15. The records for Patients 1-20 are all similar. The physical examination sections are virtually identical in all 20 records, except for "weeks gestation." There is little variation

in the patients' temperatures. All patients had temperatures of either 97, 97.5, or 98 degrees. According to the records, all patients refused pap smears, and all patients had hematocrits in the 36-41 range, with 15 patients being in the 38-40 range (T. 431-32, 515-516, Pet. Ex. 5, Resp. Ex. A).

16. The medical history forms for Patients 1-20 contained in Pet. Ex. 5 appear to have "probable common authorship" rather than having been individually filled in by each patient (T. 1388-1393, 1400-01).

17. Respondents' former employees, Ms. Gomez, Ms. Bonilla, and Ms. Baez, testified that no blood was drawn from patients in Respondent's office (T. 174, 265, 670, 693, 705). Patient M.D. also testified that she had no blood drawn (T. 1414, 1446).

18. Respondent told representatives of DSS and DOH that he did not test for Rh type (T. 39, 105, 537; Resp. Ex. A).

19. On May 6, 1994, DOH investigators Mary McLeod and Regina McQueen visited Respondent's office to request additional medical records. Ms. McLeod and Ms. McQueen asked the receptionist, Ms. Baez, for blank physical examination/operative note forms utilized by the Respondent. Ms. Baez provided them with a group of identical preprinted forms with preprinted findings (T. 543, 624-31, 715-16, 722-23, 728-29; Pet. Ex. 13).

20. The preprinted findings consisted of check marks next to the following words: IV barbiturate intermittent dripping; uterus mid; dilated with no. 6; embryo none; perforation no; tissue volume moderate; villi seen yes; molar degeneration no (Pet. Ex. 13).

21. Ms. Bonilla testified that for approximately two weeks

immediately prior to Respondent's summary suspension, Respondent did not document his evaluation and treatment of non-English speaking patients (T. 291-2, 357-8).

22. Dr. Kwon prepared a question and suggested answer sheet for his employees to use at the hearing (Pet. Ex. 9).

23. The intake procedure at Respondent's office is for all patients to pay the receptionist for an abortion procedure before entering the inner office, finding out the results of the urine pregnancy test, being examined or talking to Respondent (T. 383, 665, 1173, 1408).

24. Respondent testified several times that his practice consists exclusively of performing vacuum suction abortions (T. 848-50, 863). He also testified that patients with any type of abnormal physical finding or condition are not accepted for the abortion procedure, but are referred to their own private gynecologist or elsewhere (T. 994). Respondent at first testified that he rejected 1% of patients (T. 996), but later stated this number was 30% (T. 1174-76, 1213-1216).

25. Ms. Bonilla, to whom Respondent had taught a urine testing technique, testified that on two or three occasions she had observed negative results from urine pregnancy tests. Under instructions from Respondent, those patients were told that they had tested positive, and Respondent performed the same vacuum suction procedure on those patients as he did on pregnant patients (T. 263-65, 354-57, 371-73).

26. On several occasions, Ms. Gomez and Ms. Bonilla, who had witnessed Respondent perform many vacuum suction procedures,

observed that the vacuum suction procedure did not produce any material into the specimen jar (T. 186-87, 274, 281-82). On at least one such occasion Respondent stated to Ms. Bonilla that he had made a mistake and the patient was not pregnant (T. 281-82, 381-82).

27. On another such occasion between January and March 1994, with respect to Patient 24, Respondent took a specimen from another patient's abortion, placed Patient 24's name on it, and sent it for pathology testing as if it were that of Patient 24 (T. 187-89).

28. Respondent testified that he performed vacuum suction procedures on non-pregnant women, but stated that they were intended as "menstrual extractions" for the purpose of regulating patients' periods and alleviating patients' anxiety (T. 943-47).

29. The performance of a vacuum suction procedure as a means of regulating menstrual periods does not conform to current acceptable medical standards, since a HCG blood test is readily available and can detect the presence or absence of a pregnancy prior to a patient missing her period (T. 1319).

30. With respect to Patients 21, 22, and 23, "post-abortion" pathology reports from National Health Laboratories were negative for products of conception (T. 458-62; Pet. Ex. 12). Respondent testified that he performed menstrual extractions, rather than abortions on these patients (T. 972). However no office records were produced to substantiate that testimony.

31. Respondent submitted bills to Medicaid for abortions performed on Patients 21 and 23 (T. 736-40, Pet. Ex. 15).

32. There is no evidence that Respondent attempted to contact

Patients 21 and 23 after receiving the negative pathology reports.

33. It is important that post-abortion patients with negative pathology reports be contacted on an emergency basis for evaluation and possible treatment of an ectopic pregnancy (T. 513-515).

34. Respondent testified that since 1981, when he began performing abortions, he has routinely administered Brevital intravenously as an anesthetic (T. 876-79). His procedure is to administer 10 drops of Brevital initially, wait approximately 1/2 to 2 minutes and administer another 10 drops, and if necessary, wait another minute or two and administer 10 more drops. Respondent approximated that each 10 drops of Brevital was the equivalent of 8 mgs., for a total dose of 16 to 24 mgs. per patient (T. 1028-33).

35. Respondent determines the dosage for each patient by his assessment of individual response and does not use body weight and height as a criteria (T.880-81, 1037).

36. Respondent advertises that he administers general anesthesia (T. 1071). His medical records reflect the use of general anesthesia (Pet. Ex. 5). Respondent also told DSS investigators on February 28, 1994 that he administers general anesthesia, specifically Brevital, by intermittent drip in Ringers solution (T. 35, 106).

37. Respondent testified that he administers only enough Brevital to keep patients in a drowsy state (T. 876). Other witnesses testified that while some patients were merely drowsy, others were rendered unconscious after the administration of the anesthetic (T. 278, 283, 363, 673-74, 1412, 1439-40).

38. Post-operatively, some patients had to be physically moved from the operating table to another stretcher by Respondent and one of his assistants (T. 193, 281, 680, 897).

39. Respondent stated to nurse McLeod that he monitored patients until they were "awake" (T. 546). on May 26, 1994, two post-operative abortion patients were found by nurse investigators in Respondent's recovery room asleep and in a condition described as "out" (T. 600).

40. Patients under general anesthesia, i.e. unresponsive to painful stimuli, are at risk for losing their airway. It is important that such patients be monitored by an appropriately trained person, other than the operating surgeon. It is essential to monitor vital signs. There must be emergency resuscitative equipment immediately available for possible cardiac arrest (T. 435-37).

41. Brevital tends to increase salivation, hiccuping, nausea and vomiting, which pose additional risks to the patency of the patient's airway (T. 438-40, 1085-87).

42. The above described indications also apply when patients are anesthetized only to the extent of drowsiness, because individual responses to Brevital can vary from patient to patient, depending upon body size and weight. A general anesthetic state and the complications attendant thereto can occur unexpectedly (T. 440-41, 1187-89).

43. Respondent does not have trained personnel assisting him to monitor patients under the effects of Brevital (T. 175-76, 277, 364, 537, 673, 678-79, 907, 1016, 1086), nor did Respondent's

office contain appropriate emergency equipment (T. 33-34, 232-33, 555-56, 558, 907).

44. Respondent told DSS nurse investigators on February 28, 1994 that after the abortion procedure, patients are placed in a recovery room. Respondent testified that he observes the patients through an open door from the operating room (T. 38, 105, 534).

45. The testimony of Ms. Gomez, Ms. Bonilla and Ms. Baez, as well as that of Patient M.D., was that Respondent does not attend to patients in the recovery room. Patients in recovery are checked for vomiting periodically by Respondent's employees. Vital signs are not taken. The determination as to when patients may leave the recovery room is left up to the patients themselves and/or the Respondent's employees (T. 194-96, 283-84, 365-66, 680-81, 716-18, 909).

46. In the postoperative period, it is important that abortion patients be monitored to check for excessive vaginal bleeding and for recovery from anesthesia. Patients must be watched closely to guard against the substantial risk of nausea and vomiting (T. 441-42).

47. The records for Patients 1, 3, 5, 8, 16, 18 and 20 contained in Pet. Ex. 5 reflect that Respondent did not record in-office pregnancy test results to confirm patient reports of positive home pregnancy tests. Those results were recorded in Resp. Ex. A.

48. Respondent's employees testified that the office routine was to collect a urine sample and perform a pregnancy test on all patients (T. 170, 262, 383, 669-70).

49. The records for Patients 1-20 contained in Pet. Ex. 5 reflect that patients were asked their Rh type on the medical history form. There is no documentation in Pet. Ex. 5 that Respondent himself performed Rh blood typing. Respondent told DSS and DOH investigators that he does not take Rh type, but instead relies on patients to provide that information (T. 39, 105, 537).

50. At least 10 patients indicated "+/?" in response to the medical history question regarding Rh type (Pet. Exs. 5, 11). The ancillary reports, contained in Resp. Ex. A, reflect that Respondent noted a test for Rh type.

51. Rh typing for pregnant women, particularly those about to undergo abortions, is essential. In the event a woman is Rh negative, she will require administration of RhoGAM. RhoGAM is required to prevent erythroblastosis fetalis (T. 423).

52. The records for Patients 2 and 16, contained in Pet. Ex. 5, reflect that they reported themselves as Rh negative. The administration of RhoGAM is reported in Resp. Ex. A (T. 422, 425; Pet. Ex. 5, Resp. Ex. A).

53. Respondent did not obtain cervical cytology on Patients 1-20. Only Patient 20 reported having had a pap smear in the past. Performance of cervical cytology is indicated as part of a thorough pelvic examination, even for women presenting only for an abortion (T. 425-27, 429, 515-16).

54. There was no evidence of weights or heights measured for Patients 1-20. Patient M.D. testified that her weight and height were not taken when she presented to Respondent's office (T. 1413-14).

55. The physical examinations of ear, nose and throat, neck, heart, breast, abdomen, vagina, cervix and uterus were all recorded in identical lanruage. Temperatures were recorded as 97 degrees for 7 patients, 97.5 for three patients and 98 for 10 patients (T. 431-32; Pet. Ex. 5, Resp. Ex. A).

56. The records for Patients 1-20 do not reflect that informed consent was obtained (T. 432-434). There are no written informed consent forms, nor documentation reflecting verbal informed consent. Patient M.D. testified that she was not informed about the nature or risks of the abortion procedure or the anesthesia (T. 1414-15, 1441).

57. The records for Patients 1-20 reflect that general anesthesia was administered for performance of the vacuum abortions. There is no documentation of the name of the anesthetic agent, dosage, blood pressure, pulse, or oxygen saturation at any time during the anesthetic process (T. 437, Pet. Ex. 5).

58. The records for Patients 1-20 contained in Pet. Ex. 5 do not reflect adequate post operative monitoring or any indication that patients had recovered from anesthesia and were ready for discharge (T. 444, Pet. Ex. 5). Resp. Ex. A does contain indications of post operative blood pressure readings, appearance of the patient, and progress of recovery (Resp. Ex. A).

59. Subsequent to an abortion, it is absolutely necessary to confirm that removal of the pregnancy was accomplished. Such confirmation is necessary to determine whether the patient was pregnant or had a false pregnancy; whether the pregnancy was missed and might still remain in the cornua of the uterus; or whether the

pregnancy was ectopic (T. 445-450).

60. The records for Patient 9, 13, 16, and 19 reflect that each patient was at 5 weeks gestation when their abortions took place (Pet. Exs. 5, 11).

61. At five weeks gestation, it is virtually impossible to visually determine that pregnancy tissue (i.e. villi) as opposed to decidua, has been obtained. Therefore, specimens from 5 week abortions must be sent for pathological testing. Respondent testified that he visually inspected the specimens for these patients and that villi were present (T. 445-50, 509).

62. The procedure in Respondent's office with respect to cleaning of surgical instruments was as follows: all surgical instruments were washed in either soapy water or Clorox and water. After being washed, all surgical instruments, except specula, were placed, unwrapped, in an autoclave machine. Following autoclaving, surgical instruments were left in the autoclave (T. 191-93, 272-74, 363, 388-89, 659-60, 690-91, 702-03). Respondent stated to DOH nurse investigator McLEod that such instruments were sterile (T. 557).

63. The Respondent testified that he has two autoclaves, and that the specula are sterilized in the wet autoclave, which he alone operates for safety reasons. The other surgical instruments are sterilized in a dry autoclave which is kept on until the instruments are used (T. 925-28).

64. Surgical instruments which are to be used invasively must be sterilized. Proper sterilization requires that instruments first be cleansed to remove dry blood and other material, then

wrapped and autoclaved, and then be maintained in a wrapped condition until utilized in a surgical procedure (T. 450-453).

65. Specula must, at a minimum, be cleansed and undergo a high level disinfectant process. Such a process involves the use of a chloride solution. Clorox is not acceptable as a disinfectant (T 454-455, 512).

66. The products of conception obtained by Respondent's suction procedures were deposited by the suction tubing into glass jars. Products of conception from the glass jars were regularly disposed of in the sink (T. 190-91, 283, 362, 664-665). On other occasions specimens were disposed of in ordinary trash cans (T. 188, 190).

67. The large collection tube of the suction machine, to which disposable suction tips were attached, was not changed between procedures (T. 1127-28).

68. Respondent performed vacuum abortions without wearing a protective mask or clothing (T. 175, 635, 675, 694, 1169-70).

69. On a visit to Respondent's office in May 1994 DOH nurse investigator McLeod observed the following conditions:

a) Butterfly needles, I.V. tubing, and suction catheters covered with blood and greenish material were contained in ordinary uncovered waste baskets (T. 556, 615-20). Red bags were present, but there was no receptacle for "sharps" (T. 633-34).

b) Blood and/or used Betadine was splattered on the wall near the operating table (T. 556, 589-90, 615-20, 663, 935-936).

c) Disposable surgical tips were standing in a jar of water, rather than being disposed of in red bags (T. 66-62, 692, 1124-27).

CONCLUSIONS OF LAW

1. Respondent's practice of medicine was negligent within the meaning of N.Y. Education Law 6530(3) in that it did not conform to the standards of a reasonably prudent physician under the same circumstances.

2. Respondent's practice of medicine was incompetent within the meaning of N.Y. Education Law 6305(5) in that it demonstrated a lack of requisite skill and knowledge.

3. Respondent's practice of medicine was grossly negligent within the meaning of N.Y. Education Law 6530(4) in that it did not conform to the standards of a reasonably prudent physician under the same circumstances, and was characterized by conduct which was egregiously and conspicuously bad.

4. Respondent's practice of medicine was not grossly incompetent within the meaning of N.Y. Education Law 6530(6).

5. Respondent's practice of medicine was fraudulent within the meaning of N.Y. Education Law 6530(20) in that he intentionally misrepresented and concealed known facts.

6. Respondent failed to maintain records for patients which accurately reflected their evaluation and treatment within the meaning of N.Y. Education Law 6530(32).

7. Respondent wilfully made false reports within the meaning of N.Y. Education Law Section 6530(21).

8. Respondent failed to use scientifically accepted barrier precaution and infection control practices within the meaning of

N.Y. Education Law 6530(47).

9. Respondent wilfully and with gross negligence failed to comply with substantial provisions of state rules and regulations within the meaning of N.Y. Education Law Section 6530(16), specifically 10 NYCRR Part 92 in that he failed to use sterile surgical instruments, although the evidence did not support a failure by the Respondent to adequately dispose of infectious waste.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous.)

FIRST SPECIFICATION:
(Practicing with negligence on more than one occasion)

SUSTAINED as to Paragraphs A and A1, A2, A4-8, A9 as to failure to record the results of in-office pregnancy tests, A11; B; C; D; E and E1; F; G; H; J; K and L.

NOT SUSTAINED as to Paragraph A3, A9 as to failure to perform in-office tests to confirm pregnancy, A10; E2, and I.

SECOND SPECIFICATION:
(Practicing with incompetence on more than one occasion)

SUSTAINED as to Paragraphs A and A1, A2, A4-8, A9 as to failure to record the results of in-office pregnancy tests, A11; B; C; D; E ; F; G; H; J; K and L.

NOT SUSTAINED as to Paragraph A3, A9 as to failure to perform in-office tests to confirm pregnancy, A10; and I.

THIRD SPECIFICATION:
(Practicing with gross negligence)

SUSTAINED as to Paragraphs A and A1, A2, A4-8, A9 as to failure to record the results of in-office pregnancy tests, A11; B; C; D; E ; F; G; H; J; K and L.

NOT SUSTAINED as to Paragraph A3, A9 as to failure to perform in-office tests to confirm pregnancy, A10; and I.

FOURTH SPECIFICATION:
(Practicing with gross incompetence)

NOT SUSTAINED.

FIFTH SPECIFICATION:
(Practicing the profession fraudulently)

SUSTAINED as to Paragraphs B; J; and K.

NOT SUSTAINED as to Paragraph I.

SIXTH SPECIFICATION:
(Failure to maintain adequate records)

SUSTAINED as to Paragraphs A and A11, J, K and L.

NOT SUSTAINED as to Paragraph I.

SEVENTH SPECIFICATION:
(Willfully making a false statement)

SUSTAINED as to Paragraphs A and A11, J and K.

NOT SUSTAINED as to Paragraph I.

EIGHTH SPECIFICATION:
(Failure to use scientifically accepted barrier precautions and infection control practices)

SUSTAINED as to Paragraphs E and E1.

NOT SUSTAINED as to Paragraph E2.

NINTH SPECIFICATION:
(Failure to comply with rules and regulations)

SUSTAINED as to Paragraphs E and E1.

NOT SUSTAINED as to Paragraph E2.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee felt that Dr. Kwon's testimony contained gross inconsistencies that undermined his credibility, and assertions that were totally implausible. For example:

- He testified to the Panel that he could not find a pathologist in New York willing to do reports on his specimens, yet he told his own expert that he stopped sending pathology samples because he was getting back negative results on what he knew were positive samples. Even his own expert found that statement hard to believe.
- Dr. Kwon testified that he had used Brevital and had stopped using local anesthesia; he told Ms. McKeon from DOH that he only used local anesthesia; in the prepared script for his employees' testimony, he stated that he gave Brevital to one of every three or four patients.
- He stated that he charted "pink" cervices when he really meant "blue."
- During his testimony he changed the number of patients rejected as unsuitable for the procedure from 1% to 30%.
- He testified, incredibly, that he could visibly detect villi of a five week pregnancy.

His credibility was further undermined by his attempt to influence witness testimony and by his taped telephone call (Pet. Ex. 16) to one of his employees, as well as the clear fabrication of extra pages for his patient charts after investigations were begun by DSS and DOH.

In addition, the Hearing Committee found Dr. Kwon's description of how he simultaneously performs abortion procedures and administers anesthesia demonstrated a blatant lack of concern for the welfare of his patients. His practice was substandard in many ways.

After duly considering the testimony of Respondent's expert,

there was some consideration given to imposing a penalty of suspension with retraining. However the Committee's concerns about the Respondent's ethics and deceptive practices make this an unacceptable option.

The Hearing Committee therefore unanimously votes to revoke the medical license of the Respondent.

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT

1. Respondent's license to practice medicine in the State of New York is revoked.

Dated: New York, New York
September 1994

ROBERT S. BERNSTEIN, M.D.
Chairperson

MILTON O.C. HAYNES, M.D.
ANTHONY SANTIAGO

APPENDIX I

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

IN THE MATTER OF YOUNG HO KWON, M.D.	COMMISSIONER'S ORDER AND NOTICE OF HEARING

CASE BPMC Petitioner EX 1 for ID
DATE 6-3-94
ACCU-SCRIBE REPORTING, INC. MSB

TO: YOUNG HO KWON, M.D.
12 Lyons Court
Woodcliff Lake, N.J. 07675

The undersigned, Mark R. Chassin, M.D., Commissioner of Health of the State of New York, 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 YOUNG HO KWON, 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 Section 230(12) (McKinney Supp. 1994), that effective immediately YOUNG HO KWON, 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 Section 230(12) (McKinney Supp. 1994).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994), and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 3rd day of June, 1994 at 10:00 a.m. at 5 Penn Plaza, 6th floor, New York, New York 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 Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified

interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

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 Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. 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 SECTION 230-a (McKinney Supp. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
May 26, 1994

MARK R. CHASSIN, M.D.
Commissioner of Health

Inquiries should be directed to:
Ralph J. Bavaro
Associate Counsel
N.Y.S. Department of Health
5 Penn Plaza - 6th floor
New York, New York 10001

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

IN THE MATTER	: STATEMENT
OF	: OF
YOUNG HO KWON, M.D.	: CHARGES

YOUNG HO KWON, M.D., the Respondent, was authorized to practice medicine in New York State on June 12, 1981 by the issuance of license number 146249 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 at 12 Lyons Court, Woodcliff Lake, N.J. 07675.

FACTUAL ALLEGATIONS

A. Patients 1-20 (all patients mentioned herein are more fully identified in Appendix A) presented themselves to Respondent in his office located at 9 West 31st Street, New York, New York, between approximately June 1, 1993 and September 28, 1993. Respondent performed vacuum abortions on each patient. (Dates of treatment of all patients mentioned herein are more specifically set forth in Appendix A). Office records for Patients 1-20,

subsequently provided by Respondent, reflect that Respondent:

1. Failed to perform adequate physical examinations.

2. Failed to perform Rh blood typing.

3. With respect to Patients 2 and 16, who allegedly reported themselves as Rh negative, failed to administer RhoGAM as indicated.

4. Failed to obtain cervical cytology.

5. Failed to obtain informed consent.

6. Failed to adequately monitor patients under anesthesia.

7. Failed to adequately monitor patients post-operatively.

8. With respect to Patients 9, 13, 16 and 19 failed to perform or order appropriate pathological testing of specimens post-operatively as indicated.

9. With respect to Patients 1, 3, 5, 8, 16, 18 and 20, failed to perform and/or record results of in-office

tests to confirm pregnancies reported by prior home tests.

10. With respect to Patients 9 and 10, performed abortions without confirmation of pregnancy by home or in-office testing.

11. Failed to sufficiently document evaluation and treatment.

B. Between approximately January and May 1994, Respondent performed abortions on patients despite negative in-office urine pregnancy tests. The identities of such patients are not known to the New York State Department of Health due to Respondent's fraudulent record keeping.

C. Between approximately February 10 and March 8, 1994 Respondent performed abortions on Patients 21, 22 and 23. Subsequent pathology for each patient was negative for pregnancy.

D. In approximately March 1994 Respondent performed an abortion on Patient 24 who happened to be a Medicaid patient. However, the abortion did not produce a specimen indicative of pregnancy. Respondent placed the name of Patient 24 on a specimen obtained previously from another

patient and submitted it for pathology testing as that of Patient 24.

E. In Respondent's office at 18 West 33rd Street, from its opening in January 1994 until the present, Respondent failed to maintain appropriate sanitary conditions. For example, Respondent:

1. Failed to use sterile surgical instruments.

2. Failed to properly dispose of or keep office surfaces free from infectious waste.

F. Despite the nature of Respondent's office practice (i.e. the performance of abortions under general anesthesia on a regular basis), his office at 18 West 33rd Street, from approximately January through May 1994, did not contain adequate emergency equipment, including but not limited to the following: crash cart, EKG machine, and tank oxygen with flow meter and mask.

G. In his office at 18 West 33rd Street, Respondent's practice with respect to patients undergoing abortions is to administer Brevital intravenously. Respondent performs abortions and administers anesthesia unassisted by suitably trained personnel. Respondent does not use monitoring

equipment to monitor patients under anesthesia as indicated.

H. In his office at 18 West 33rd Street, Respondent's practice with respect to patients immediately following abortion is to place them in a recovery room adjacent to the procedure room, where Respondent observes them through an open door while performing abortions on other patients. The recovery room is unattended by any suitably trained personnel.

I. With respect to Patient 25 Respondent performed vacuum abortions on April 3, 1993 and June 28, 1993, and made a separate record for each occasion. The record dated June 28, 1993 is not consistent with the record dated April 3, 1993 with respect to history and physical findings.

J. Prior to February 1994 Respondent saw patients without documenting their evaluation and treatment. In February 1994, in response to inquiries from the New York State Department of Social Services, Respondent fabricated office medical records for Medicaid patients.

K. On or about May 6, 1994 Respondent utilized pre-printed forms for physical exams and operative reports which contained pre-printed findings. He thereby fraudulently

created office medical records for patients which were not based upon actual evaluation and treatment.

L. In approximately the latter half of May 1994, Respondent saw patients without documenting their evaluation and treatment.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1994) in that Petitioner charges two or more of the following:

1. The facts contained in Paragraphs A and A1-A11, B, C, D, E and E1-E2, F, G, H, I, J, K, and/or L.

SECOND SPECIFICATION

PRACTICING WITH INCOMPETENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1994), in that Petitioner charges two or more of the following:

2. The facts contained in Paragraphs A and A1-A11, B, C, D, E, F, G, H, I, J, K. and/or L.

THIRD SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1994), in that Petitioner charges:

3. The facts contained in Paragraphs A and A1-A11, B, C, D, E, F, G, H, I, J, K, and/or L.

FOURTH SPECIFICATION

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence on more than one occasion under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1994), in that Petitioner charges:

4. The facts contained in Paragraphs A and A1-A11, B, C, D, E, F, G, H, I, J, K, and/or L.

FIFTH SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently on more than one occasion under N.Y. Educ. Law Section 6530(20)(McKinney Supp. 1994), in that Petitioner charges:

5. The facts contained in Paragraphs B, I, J, and/or K.

SIXTH SPECIFICATION

FAILURE TO MAINTAIN ADEQUATE RECORDS

Respondent is charged with professional misconduct under N.Y. Educ. Law Section 6530(32) (McKinney Supp. 1994), in that he failed to maintain records for patients which accurately reflected the evaluation and treatment of the patients. Petitioner charges:

6. The facts contained in Paragraphs A and A11, I, J, K, and/or L.

SEVENTH SPECIFICATION

WILLFULLY MAKING A FALSE STATEMENT

Respondent is charged with willfully making a false report within the meaning of N.Y. Educ. Law Section 6530(21)(McKinney Supp. 1994) in that Petitioner charges:

7. The facts contained in Paragraphs A and A11, I, J, and /or K.

EIGHTH SPECIFICATION

FAILURE TO USE SCIENTIFICALLY ACCEPTED BARRIER PRECAUTIONS AND INFECTION CONTROL PRACTICES

Respondent is charged with failing to use scientifically accepted barrier precautions and infection control practices within the meaning of N.Y. Educ. Law Section 6530(47)(McKinney Supp. 1994) in that Petitioner charges:

8. The facts contained in Paragraph E and E1-E2.

NINTH SPECIFICATION

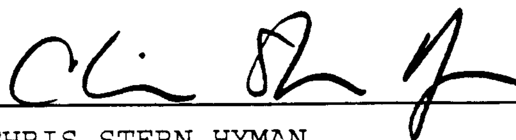
FAILURE TO COMPLY WITH RULES AND REGULATIONS

Respondent is charged with willful or grossly negligent failure to comply with substantial provisions of state rules and regulations within the meaning of New York Education Law Section

6530(16)(McKinney Supp. 1994), specifically 10 NYCRR Part 92, in that Petitioner charges:

9. The facts contained in Paragraph E and E1-E2.

DATED: New York, New York
May 26, 1994



CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical Conduct

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner
Paula Wilson
Executive Deputy Commissioner

August 24, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ralph Bavaro, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

Young Ho Kwon, M.D.
12 Lyons Court
Woodcliff Lake, N.J. 07675

Arnold Marshall, Esq.
50 East 42nd Street
New York, New York 10017

RE: In the Matter of Young Ho Kwon, M.D.

Dear Mr. Bavaro, Mr. Marshall and Dr. Kwon :

Enclosed please find the Interim Order signed be the Commissioner and the Interim Report of the Hearing Committee in the above referenced matter. Copies of this Interim Order have been sent to all other parties in this matter.

Sincerely,

Tyrone T. Butler
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER OF YOUNG HO KWON, M.D.	INTERIM ORDER

I have reviewed the Report of the Hearing Committee on the issue of Imminent Danger in this matter, the Committee's finding that Young Ho Kwon, M.D., Respondent, does present an imminent danger to the health of the people of the State of New York, and the Hearing Committee's recommended action that the Summary Order prohibiting Young Ho Kwon, M.D. from practicing medicine in the State of New York remain in effect.

Now, upon reading and filing the transcript of the hearing, the exhibits, and other evidence introduced at the hearing, the conclusions and recommendations of the Hearing Committee as set forth in the Interim Report on Summary Suspension dated August 19, 1994,

I HEREBY ORDER THAT:

The Summary Order, dated May 26, 1994, imposed upon Respondent, Young Ho Kwon, M.D., shall remain in effect, pending the final resolution of this matter.

DATED: Albany, New York
August 24, 1994

MARK R. CHASSIN, M.D.
Commissioner of Health
State of New York

TO: Ralph Bavaro, Esq.
Associate Counsel
New York State Department of Health
5 Penn Plaza, 6th Floor
New York, New York 10001

Arnold Marshall, Esq.
50 East 42nd Street
New York, New York 10017

Young Ho Kwon, M.D.
12 Lyons Court
Woodcliff Lake, N.J. 07675

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

IN THE MATTER OF YOUNG HO KWON

INTERIM REPORT
SUMMARY
SUSPENSION

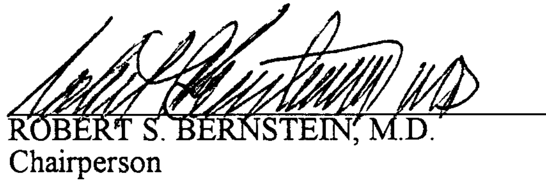
Robert S. Bernstein, M.D., Chairman, Milton O.C. Haynes, M.D. and Anthony Santiago, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230 (1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230(12) of the Public Health Law. Jane B. Levin, Esq., Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

The Committee, having considered all of the evidence in this matter, and deliberated thereon, has unanimously decided that the continued practice of medicine in the State of New York by the Respondent constitutes an imminent danger to the health of the people of this state, and therefore recommends that the ORDER of Mark R. Chassin, M.D., Commissioner of Health, dated May 26, 1994 shall remain in effect.

Based upon the foregoing, IT IS HEREBY RECOMMENDED that

1. The Order of the Commissioner of Health, dated May 26, 1994, shall remain in effect.

Dated: New York, New York
August 19, 1994



ROBERT S. BERNSTEIN, M.D.
Chairperson

MILTON O.C. HAYNES, M.D.
ANTHONY SANTIAGO