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.H.P.
Commissioner

Paula Wilson
Executive Deputy Commissioner

March 24, 1993

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Jeffrey J. Armon, Esq.
Assistant Counsel
NYS Department of Health
Empire State Plaza
Corning Tower - Room 2429

Tse Ming Cheung, M.D.
16th Floor B
11 Man Fuk Road
Kowloon, Hong Kong

Tse Ming Cheung, M.D.
PO Box 98284
Tsim Sha Tsui Post Office
Kowloon, Hong Kong

RE: In the Matter of Tse Ming Cheung, M.D.

Dear Dr. Cheung and Mr. Armon:

Enclosed please find the Determination and Order (No. 93-43) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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 than 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
Corning Tower - Room 2503
Empire State Plaza
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.

Very truly yours,

Tyrone T. Butler/crc

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:crc
Enclosure

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

IN THE MATTER	:	DETERMINATION
OF	:	AND
TSE MING CHEUNG, M.D.	:	ORDER
		ORDER NO. BPMC-93-43

A Notice of Hearing and Statement of Charges, both dated June 9, 1992, were served upon the Respondent, **Tse Ming Cheung, M.D.** **WILLIAM W. FALOON, M.D. (Chair), NANCY J. MORRISON, and JOHN P. FRAZER, M.D.**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **LARRY G. STORCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer. The Department of Health appeared by Jeffrey J. Armon, Esq., Assistant Counsel. The Respondent did not appear personally and was not represented by counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing and Statement of Charges:	June 9, 1992
Answer to Statement of Charges:	None
Pre-Hearing Conference:	None

Dates of Hearings:	August 5, 1992 August 6, 1992
Received Petitioner's Proposed Findings of Fact, Conclusions of Law and Recommendation:	September 3, 1992
Received Respondent's Proposed Findings of Fact and Conclusions of Law:	None Submitted
Witnesses for Department of Health:	Jon H. Rouch, M.D. Marie Shingler, R.N. Melvin J. Steinhart, M.D. Betty Swetz, R.N. Sharon Ann Benson, R.N.
Witnesses for Respondent:	None
Deliberations Held:	September 18, 1992

STATEMENT OF CASE

Respondent was charged with three specifications of misconduct regarding his medical care and treatment of a patient at the Gowanda Psychiatric Center on or about July 22, 1987. More specifically, Respondent was charged with gross negligence, gross incompetence, and failure to maintain accurate records. A copy of the Statement of Charges is attached to this Determination and Order in Appendix I.

JURISDICTIONAL ISSUES

Respondent failed to appear at the hearing and was not represented by counsel. On March 4, 1991, Respondent acknowledged receipt of informational charges and a proposed Notice of Hearing which were sent by certified mail. Through a series of

correspondence with counsel for the Department (See, Department's Exhibit #2), Respondent was made aware that the Petitioner intended to proceed with a hearing to be scheduled for either May 13 or May 14, 1991. During the period April 12 through April 19, 1991, a Medical Conduct Investigator from Petitioner's Buffalo Area Office attempted to personally serve Respondent with the Statement of Charges and Notice of Hearing at his Hamburg, New York residence. It was discovered that Respondent had vacated that residence and re-located to Hong Kong.

In accordance with Public Health Law Section 230.10(a), Respondent was afforded an opportunity to be interviewed to explain the issues under investigation by a letter dated August 14, 1992, sent by registered mail to his Hong Kong address. Respondent acknowledged receipt of this letter but failed to respond to it.

Petitioner subsequently attempted to personally serve the Notice of Hearing and Statement of Charges on Respondent in Hong Kong. By a letter dated July 1, 1992, an agent of an international process service company detailed his unsuccessful attempts to personally serve Respondent at his known address in Hong Kong. The agent also provided information to indicate that Respondent may have left Hong Kong for an unknown destination. Pursuant to Public Health Law Section 230.10(d), Petitioner sent copies of the Notice of Hearing and Statement of Charges by registered mail to Respondent's last known Hong Kong address on July 15, 1992. This was done more than fifteen days in advance of the hearing, as

required by statute. Petitioner also mailed a letter dated July 5, 1992 to Respondent's attorney of record in an active civil suit (Cheung, M.D. v. Surles, et. al., CIV-90-1120E) in U.S. District Court for the Western District of New York. This letter requested a current address for Respondent; however, no response was received.

Based upon the above, the Administrative Officer ruled (at pages 14-15 of the transcript) that Petitioner had demonstrated due diligence in its efforts to personally serve Respondent with notice of the hearing, as required by Public Health Law Section 230.10(d). The Administrative Officer further ruled that the Hearing Committee therefore had jurisdiction to hear the case.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered rejected in favor of the cited evidence.

1. Tse Ming Cheung, M.D. (hereinafter "Respondent"), was authorized to practice medicine in New York State on January 10, 1974 by the issuance of license number 118734 by the New York State Education Department. Respondent was registered with the New York State Education Department to practice medicine for the period

January 1, 1991 through December 31, 1992 from 6157 Wildwood Drive, Hamburg, New York 14075. (Dept. Ex. #3).

2. Patient A was a twenty-two year old male who was receiving mental health services on an outpatient basis from the Riverview Mental Health Clinic in Jamestown, New York in July, 1987. (27-28; Dept. Ex. #4, p. 4).

3. Patient A was diagnosed as having obsessive compulsive and atypical depressive disorders. (31; Dept. Ex. #4, p. 9).

4. Jon H. Rouch, M.D. was a psychiatrist employed by the Gowanda Psychiatric Center at the Riverview Clinic. He was appointed Director of Community Services and was in charge of Patient A's medical treatment. (27-28, 34).

5. The outpatient treatment of Patient A included the prescription of tricyclic anti-depressant medications, including amitriptyline, whose trade name is Elavil. (29-30, 86; Dept. Ex. #4, p.9).

6. On July 22, 1987, it was determined that in-patient hospitalization would be a more appropriate manner of treatment for the patient because he posed a risk to himself due to his gross neglect of his dietary needs and personal hygiene. (30-31; Dept. Ex. #4, pp. 8-9, 12).

7. Dr. Rouch prepared a Certificate of Examination by Director of Community Services form as well as an Application for Admission to authorize a twenty-four hour admission and diagnostic evaluation of Patient A and to obtain monitored transportation of

the patient to the Gowanda Psychiatric Center. The Application for Admission summarized the patient's history and diagnosis and indicated that the patient had "been unsuccessfully treated with BuSpar and Elavil" and that his commitment was "on grounds of extreme danger to self." (32-41; Dept. Ex. #4, pp. 6-9).

8. While waiting for the Jamestown Police to arrive at the Riverview Clinic to transport him to Gowanda, the patient fled to his apartment, which was located a few blocks away. The patient locked himself in his apartment and refused to come out for some time. (36-38; Dept. Ex. #4, pp. 12-13).

9. The patient subsequently agreed to come out from his apartment and Dr. Rouch entered it to search for any medications that may have been available to Patient A. Two medication containers that were not empty and clusters of loose pills on a counter top were located in and taken from the apartment by Dr. Rouch. (39; Dept. Ex. #4, p. 13).

10. The patient was thereafter examined by Dr. Rouch outside the apartment building to determine whether Patient A was exhibiting signs of a tricyclic overdose. (39; Dept. Ex. #4, p. 13).

11. Tachycardia and rapid pulse are symptoms of a tricyclic medication overdose. (39-41, 83).

12. Dr. Rouch determined that Patient A's pulse was fast, but regular. Patient A denied taking an overdose of medication.

It was determined that it would be appropriate for the patient to be transferred to Gowanda. (39-41; Dept. Ex. #4, p. 13).

13. Dr. Rouch gave the medication bottles he recovered from the patient's apartment and the forms for admission to a police officer accompanying Patient A to the Gowanda Psychiatric Center for the purpose of providing them to the admissions nurse. (40-41).

14. The police van left Jamestown with Patient A at approximately 5:30-6:30 p.m. The patient appeared alert and active. Dr. Rouch went to his home and promptly contacted the admissions office at the Gowanda Psychiatric Center to advise them of the imminent arrival of the patient and of the possibility that he had taken a drug overdose. He spoke with a male nurse and advised that the pill bottles recovered from Patient A's apartment were being sent with the patient and further requested that the nurse have the on-call physician telephone Dr. Rouch if there was additional information needed. Dr. Rouch did not receive a telephone call from Respondent about Patient A. (40-44, 144).

15. Marie Shingler, R.N., was the community mental health nurse assigned to the admissions room at the Gowanda Psychiatric Center on July 22, 1987. Respondent was the physician assigned to the admissions room on that evening. (48-49).

16. At approximately 8:00 p.m., a Jamestown Police officer came to the admissions room and reported that Patient A was in a police van in the facility's parking lot. The police officer gave Ms. Shingler an envelope containing the commitment papers completed

by Dr. Rouch. The officer advised Ms. Shingler that Patient A had been talkative when he entered the van. Ms. Shingler placed the medication bottles on Respondent's desk for him to examine. (50-51, 57; Dept. Ex. #4, p. 29).

17. Ms. Shingler subsequently went out to the police van and observed Patient A slumped over in the back seat. He was uncommunicative, warm to the touch , and his eyes were half-closed. Ms. Shingler returned to the admissions area, reported Patient A's condition to Respondent and requested that Respondent examine Patient A in the police van. Respondent refused to do so. (52-53; Dept. Ex. #4, pp. 29-30).

18. The patient was subsequently transferred by wheelchair from the van to the admission room with the assistance of security and nursing staff. During this transfer, a police officer gave Ms. Shingler a small bag containing the two medical bottles recovered from the patient's apartment by Dr. Rouch. (53-54, 57; Dept. Ex. #4, pp. 29-30).

19. Respondent was in the admissions room reading the admission forms prepared by Dr. Rouch when Patient A was brought there. The patient's blood pressure was recorded as being 124/86 and his pulse was recorded as "rapid 120", with his "skin dry and warm, his lips dry and cracked and his tongue puffy". Patient A's head was down and his eyes were closed, but he was capable of responding to verbal commands. (54, 109; Dept. Ex. #4, p. 30).

20. Respondent briefly examined the patient by calling his name and touching or pulling the patient's arm several times. This examination was estimated to be about five or six minutes in length. (55, 58, 112).

21. Respondent recorded his diagnostic impression as being "noncommunicable, his color was pale, pupils was [sic] moderately large. Pulse was 140/min. (See psychiatric assessment of Dr. Rouch accompanying this admission)." Respondent's initial recommendation for treatment stated that "patient was so sedated that there cannot be recommendation at this time". (Dept. Ex. #4, pp. 24-25).

22. The patient exhibited the signs and symptoms of an overdose of amitriptyline. (77, 81-82).

23. Respondent's initial examination of Patient A in the admissions room failed to meet acceptable standards of medical practice in that it was a cursory examination, with no eyewitness or written evidence to indicate that he took any action except to check the eyes and pulse of the patient. There was no attempt to determine the cause or extent of the patient's sedation. Further, Respondent failed to measure the degree of Patient A's impaired consciousness by utilizing the Glasgow coma scale - a method of measurement well-known within the medical community and easy to administer. (78-81; Dept. Ex. #7).

24. Respondent's documentation of the results of his examination of the patient in the admissions room was inadequate

and only recited that his pulse was 140 and eyes were dilated. Respondent's recommendation for treatment of the patient was not within the accepted standards of medical practice in that he failed to investigate the cause of the patient's sedation, failed to immediately draw blood or order that blood immediately be drawn for testing prior to his admission and failed to order that other appropriate tests, such as an electrocardiogram, a blood screen and a toxic screen be performed immediately. Respondent only wrote orders for routine bloodwork, a routine urinalysis, a VDRL, tetanus toxoid, diet and routine EKG. Respondent gave no indication that Patient A's presenting condition necessitated emergency treatment. (59, 83-86, 113, 125; Dept. Ex. #4, pp. 24, 45).

25. Respondent failed to meet the standards of acceptable medical care by failing to recognize that the patient's rapid pulse of 140 plus dilated pupils were signs and symptoms of anti-cholinergic intoxication caused by an overdose of tricyclic anti-depressants. (83).

26. Betty Swetz, R.N. was a nursing supervisor who assisted Ms. Shingler with the admission of Patient A to Gowanda Psychiatric Center. She observed the patient's condition and asked Respondent if the patient should be sent to the emergency room of the Tri-County Hospital in Gowanda for evaluation. Respondent said nothing about any treatment for Patient A and only indicated that Patient A's condition could be "psychiatric symptoms". Patient A was thereafter transferred by wheelchair to Ward 63, the facility's

admission ward by Ms. Shingler and Ms. Swetz. (58-59, 108-111; Dept. Ex. #4, p. 30).

27. Respondent failed to meet accepted standards of medical practice by admitting Patient A to the facility in light of his presenting condition instead of ordering the transfer of the patient to a hospital emergency room that could better and more appropriately address the patient's needs through utilization of life-support systems such as a respirator and cardiac monitoring. Prompt placement of Patient A on a respirator and cardiac monitor would have enabled him to tolerate the amitriptyline overdose by allowing the patient to metabolize the drug. Toxic effects of amitriptyline can be reversed if appropriate treatment is given. The decision as to whether to admit a patient to Gowanda Psychiatric Center or to transfer the patient to general hospital was the responsibility of the physician on call. (84-85, 97-98, 117).

28. Sharon Benson, R.N. was second in charge of Ward 63 and also had responsibility for handling the admissions room on the evening of July 22, 1987. At approximately 10:45 p.m. on that evening, Ms. Benson found Patient A on the floor in his room on Ward 63. The patient had fallen from his bed. Upon being returned to his bed, Patient A began experiencing seizure-like activity. (120-121, 127; Dept. Ex. #4, p. 33).

29. Seizures are symptoms and complications of a tricyclic anti-depressant overdose. (82, 87).

30. The patient was moved to a seclusion room on Ward 63 and his seizure activity became more frequent. Respondent was telephoned by nursing staff and advised of the patient's condition at approximately 11:00 p.m. At that time, Respondent ordered by telephone the immediate administration of Valium and immediate drawing of blood. The drawing of Patient A's blood for VDRL, blood typing, CBC and chemistry profile tests was completed by Ms. Benson during the period of 11:15-11:35 p.m., more than three hours after Patient A was admitted to the facility. (130-132, 136-137; Dept. Ex. #4, pp. 33-34, 41, 44, 46-50).

31. At about 11:15 p.m., Respondent came to Ward 63 to observe the patient, whose seizure activity was continuing. The patient was receiving oxygen at that time. Respondent ordered Valium 10 mg. intravenously, to be administered by the evening nurse supervisor on the ward. Respondent was advised that facility policy prohibited nursing staff from administering controlled substances intravenously. It is standard protocol in a New York State medical institution that a physician be required to administer intravenous Valium or to remain in attendance while it is administered because of the dangers of respiratory arrest. Respondent thereafter administered the medication himself. (76, 93, 140-141; Dept. Ex. #4, pp. 33, 41).

32. Respondent was advised during that time that Patient A should be transferred to the Tri-County Hospital emergency room for more appropriate treatment, as Ward 63 was not equipped to monitor

an administration of an intravenous solution. Tri-County Memorial Hospital is in Gowanda, approximately two miles from the Gowanda Psychiatric Center. Patients facing a medical emergency at Gowanda Psychiatric Center were often transferred to Tri-County for acute medical care. The policy at the Gowanda Psychiatric Center concerning patients diagnosed as suffering from a drug overdose called for transferring the patient to Tri-County Memorial Hospital. (67-68, 116, 142-143; Dept. Ex. #5).

33. At approximately 11:45 p.m., Respondent ordered that Patient A be transferred from Ward 63 to Ward 51, which was the facility's medical ward. Patient A's condition was described as status epilepticus with seizures occurring 1-2 times per minute, and lasting from 5-30 seconds. This condition would be considered life-threatening, and required a transfer to a hospital. Patient A's blood pressure was unattainable and Valium was administered intravenously upon his arrival at Ward 51. At that time, his rectal temperature was noted to be 104 degrees. A pulse of 96 beats per minute and respiratory rate of 28 breaths per minute were also recorded. (91-92, 143; Dept. Ex. #4, 33-34, 60).

34. Respondent thereafter ordered Valium 5 mg. to be given every thirty minutes by intravenous piggyback. At about 1:00 a.m., Respondent ordered Valium 10 mg. At approximately 1:15 a.m., Respondent's supervisor signed orders to transfer Patient A to Tri-County Memorial Hospital. The patient arrived at that facility at approximately 1:30 a.m. and died at approximately 3:45 a.m.

Subsequent laboratory results from blood drawn at both Gowanda Psychiatric Center and the Tri-County Memorial Hospital indicate that the level of amitriptyline in Patient A's blood was far in excess of a toxic level. (88-91; Dept. Ex. #4, pp. 34, 44, 55, 60; Dept. Ex. #5, pp. 4-6, 7-8).

CONCLUSIONS OF LAW

The following conclusions were made pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee unless noted otherwise.

The Hearing Committee concluded that the following Factual Allegations should be sustained. The citations in parentheses refer to the Findings of Fact which support each Factual Allegation:

Paragraph A: (1-34);

Paragraph A.1: (19-23, 25);

Paragraph A.2: (23-24);

Paragraph A.3: (19, 21-22, 25, 28-29);

Paragraph A.4: (23-24, 26-27, 32-33);

Paragraph A.5: (16, 24, 30), and

Paragraph A.6: (25-33).

The Hearing Committee further concluded that the following Specifications should be sustained. The citations in parentheses refer to the Factual Allegations which support each specification:

First Specification: (Paragraphs A and A.1-A.6);

Second Specification: (Paragraphs A and A.1-A.6), and

Third Specification: (Paragraphs A and A.2).

DISCUSSION

Respondent is charged with three specifications alleging professional misconduct within the meaning of Education Law Section 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but does not provide definitions of the various types of misconduct. During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum prepared by Peter J. Millock, Esq., General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence, and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

> **Gross Negligence** is the failure 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.
>
> **Gross Incompetence** is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing Committee unanimously concluded, by a preponderance of the evidence, that the Department has sustained its burden of proof with regard to each and every specification of misconduct. The rationale for the Committee's conclusion is set forth below.

Respondent's medical care and treatment of Patient A during the approximately five hour period of his stay at the Gowanda Psychiatric Center can only be described as both grossly negligent and grossly incompetent. His refusal to leave the building to examine the patient in the police van when advised by Ms. Shingler that the patient's appearance was poor demonstrated an indifference to Patient A's conditions that was patently egregious. Respondent's cursory examination of the patient was unreasonable under the circumstances and failed to meet acceptable standards of medical practice in that he failed to determine the extent of the patient's impaired consciousness, failed to investigate the cause for such impairment and failed to immediately order blood and drug screening tests. Respondent clearly breached his duty as the on-call physician to provide reasonable and appropriate care to persons presenting at the facility's admissions room by taking no appropriate steps to address the patient's life-threatening condition.

Furthermore, Respondent was not unaware of Patient A's recent medical history. Ms. Shingler testified that Respondent was

reading the admissions paperwork prepared by Dr. Rouch when the patient was brought to the admissions room. (See, Tr., p. 54). Indeed, Respondent referred to Dr. Rouch's assessment of the patient in the mental status commentary he prepared. (See, Dept. Ex. #4, p. 24). Dr. Rouch's note referred to the patient's "relentless self-destructive path now inexorably in process." (See, Dept. Ex. #4, p. 9).

The patient's history of treatment with tricyclic anti-depressants was clearly stated and Respondent was advised that the patient's referral for impatient treatment was based "on grounds of extreme danger to self." (See, Dept. Ex. #4, p. 9). The patient was first seen by Respondent in a semi-conscious state, pale, with a high pulse rate and dilated eyes. Nevertheless, Respondent took no appropriate steps to address these conditions and merely concluded that no recommendation for treatment could be made because the patient was so sedated. This constitutes clearly unacceptable medical practice.

Respondent was grossly negligent in failing to recognize that Patient A was exhibiting the typical symptoms of an overdose of amitriptyline. The fact that the patient was described as hot and dry, with dilated pupils and a rapid heart rate was considered by Petitioner's expert witness to be consistent with an overdose of amitriptyline. (See, Tr., p. 77). In addition, both Dr. Rouch and Dr. Steinhart stated that a physician would not need a background in psychiatry to recognize the symptoms of an overdose of tricyclic

anti-depressants. The frequency of amitriptyline overdose is very common. Based upon the information available to Respondent and considering his training as a physician, the failure to promptly and accurately diagnose and treat the patient was clearly negligent and reflected an inability to practice medicine in a safe, competent manner.

Respondent's failure to transfer Patient A to the nearby Tri-County Memorial Hospital was further evidence of both gross negligence and gross incompetence on the part of Respondent. If Respondent had undertaken an adequate examination of the patient and promptly performed appropriate diagnostic tests, he would have recognized the severity of the patient's condition. A hospital emergency room would have appropriate life-support systems available that could have enabled the patient to safely metabolize the overdose of medication. Nursing staff in both the admissions room and Ward 63 questioned Respondent as to whether Patient A should have been sent to the hospital. Respondent failed to even acknowledge these suggestions, and made no attempt to inform staff as to why the patient should not have been transferred. The patient was not ordered to be transferred to the hospital until after 1:00 a.m., by Respondent's supervisor. The failure of Respondent to promptly transfer Patient A to the hospital, given his grave condition, demonstrated an unmitigated lack of the skill and knowledge necessary to practice the profession, as well as an

egregious failure to exercise the care that a reasonably prudent physician would have exercised under the circumstances.

Based upon the foregoing, the Hearing Committee unanimously concluded that Respondent's conduct with regard to Patient A constituted both gross negligence and gross incompetence. Therefore, the Hearing Committee sustained the First and Second Specifications.

The record also established the fact that Respondent failed to maintain a record of the results of his examination of Patient A in a manner which accurately reflected his evaluation and treatment of the patient. The findings of Respondent's examination are inadequately documented, and only address the patient's pulse and dilated pupils. No diagnosis was recorded and there is no documentation of any attempts to evaluate the extent and cause of the patient's condition, nor was any recommendation for treatment made.

Based upon the above, the Hearing Committee voted to sustain the Third Specification.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determined that Respondent's license to practice medicine in New York State should be revoked. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute,

including revocation, suspension and/or probation, censure and reprimand, and the imposition of monetary penalties.

The record clearly established the fact that Respondent's medical care and treatment of Patient A constituted both gross negligence and gross incompetence. Respondent demonstrated a total lack of concern for the welfare of his patient. Further, there were no mitigating circumstances which reduce Respondent's responsibility for the ultimate demise of the patient. There was substantial information available to Respondent, in the form of partially empty medication bottles recovered from the patient's apartment, as well as the commitment papers submitted by Dr. Rouch, for him to reasonably suspect that the patient had taken a medication overdose. In addition, the patient's physical condition was such that any physician providing a reasonable standard of care would have considered the possibility of a drug overdose. Moreover, it is incomprehensible to the members of the Hearing Committee that Respondent would fail to transfer a convulsing patient to the appropriate facility for treatment.

The attitude of Respondent, both in treating the patient and in addressing the charges of misconduct brought as a result of that treatment, leads one to conclude that there are serious deficiencies in his competence and judgment that pose a substantial risk to the individuals for whom he provides care. His stubborn refusal to go outside to examine the patient in the police van, and to transfer the patient to a hospital, following repeated

suggestions by the nursing staff, demonstrate a lack of judgment that will only place future patients at risk. The correspondence included in Department's Exhibit #2 is an indication of the lengths to which Respondent has gone to avoid addressing the consequences of his treatment of Patient A.

Based upon the above, it is clear that the only appropriate penalty in this matter is the revocation of Respondent's license to practice medicine in New York State.

ORDER

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

1. The First, Second and Third Specifications of professional misconduct, as set forth in the Statement of Charges (Department's Exhibit #1) are **SUSTAINED**, and

2. Respondent's license to practice medicine in New York State is **REVOKED**.

DATED: Albany, New York
March 18, 1993

William W. Faloon M.D.

WILLIAM W. FALOON, M.D. (Chair)

NANCY J. MORRISON
JOHN P. FRAZER, M.D.

TO: Jeffrey J. Armon, Esq.
Assistant Counsel
New York State Department of Health
Corning Tower Building - Room 2429
Empire State Plaza
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Tse Ming Cheung, M.D.
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APPENDIX I

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

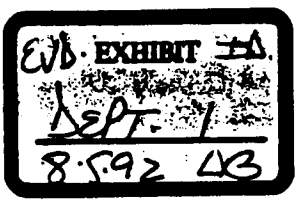
IN THE MATTER	:	
OF	:	NOTICE
TSE MING CHEUNG, M.D.	:	OF
	:	HEARING

TO: TSE MING CHEUNG, M.D.
16th Floor B
11 Man Fuk Road
Kowloon, Hong Kong

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Sec. 230 (McKinney Supp. 1992) and N.Y. State Admin. Proc. Act Secs. 301-307 (McKinney 1984 and Supp. 1992). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 5th and 6th day of August at 10:00 a.m. in the forenoon of that day at the Buffalo Regional Office, Third Floor Conference Room, 584 Delaware Avenue, Buffalo, New York and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by



counsel. You have the right to produce witnesses and evidence on your behalf, to have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Sec. 230 (McKinney Supp. 1992), you may file an answer to the Statement of Charges not less than three days prior to the date of the hearing. Pursuant to N.Y. Admin. Code Tit. 10, Sec. 51.5(c), an answer is required if there are affirmative defenses. Such answer shall be forwarded to the Attorney for the Department of Health whose name appears below.

Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a, AS ADDED BY CH. 606, LAWS OF 1991. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
June 9, 1992

Peter D. Van Buren
Deputy Counsel

Inquiries should be directed to: Jeffrey J. Armon
Assistant Counsel
Corning Tower Building, Room 2429
Empire State Plaza
Albany, New York 12237

Telephone No.: (518) 473-4282

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
TSE MING CHEUNG, M.D.	:	CHARGES

----------X

TSE MING CHEUNG, M.D., the Respondent, was authorized to practice medicine in New York State on January 10, 1974 by the issuance of license number 118734 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, 1991 through December 31, 1992 from 6157 Wildwood Drive, Hamburg, New York 14075.

FACTUAL ALLEGATIONS

A. On or about July 22, 1987, Patient A (Patient A is identified in the Appendix) was referred by the Director of Community Services for the mentally disabled for Chautauqua County to the Gowanda Psychiatic Center in Helmuth, New York for inpatient care and treatment. Patient A was transported by the Jamestown Police to Gowanda Psychiatric Center on or about the evening of July 22, 1987. The Respondent was the physician at Gowanda Psychiatric Center who examined and treated Patient A

on July 22, 1987. Respondent was informed by the application for admission form completed by the referring psychiatrist which accompanied the patient that Patient A had a history of treatment with Buspar and Elavil, tricyclic anti-depressants. The Respondent recorded in the patient's screening/ admission note that Patient A was non-communicable and appeared pale with dilated pupils and in such a sedated condition that a recommendation for treatment could not be made.

1. Respondent failed to adequately examine the patient during the initial screening/admission process to determine the cause of his condition.
2. Respondent failed to adequately document his findings in the medical record following his initial examination of the patient.
3. Respondent did not recognize the signs and symptoms of anti-cholinergic intoxication caused by an overdose of tricyclic anti-depressants.
4. Respondent wrongly admitted Patient A to the Gowanda Psychiatric Center, in light of Patient A's presenting condition.
5. Respondent did not order blood to be drawn for a toxic screen until approximately three hours after Patient A's admission.
6. Respondent failed to order a transfer of the patient to an emergency medical facility for more appropriate evaluation and treatment despite the significant deterioration of his condition during the period following his admission to the Gowanda Psychiatric Center.

SPECIFICATIONS

FIRST SPECIFICATION

PRACTICING THE PROFESSION WITH
GROSS NEGLIGENCE ON A PARTICULAR OCCASION

The Respondent is charged with practicing the profession with gross negligence on a particular occasion within the meaning of N.Y. Education Law §6530(4) (McKinney Supp. 1992); formerly §6509(2) (McKinney 1985) of the New York Education Law, in that Petitioner charges:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5 and/or A and A.6.

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH
GROSS INCOMPETENCE

The Respondent is charged with practicing the profession with gross incompetence within the meaning of N.Y. Education Law §6530(6) (McKinney Supp. 1992); formerly §6509(2) (McKinney 1985) of the New York Education Law, in that Petitioner charges:

2. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5 and/or A and A.6.

THIRD SPECIFICATION

FAILURE TO MAINTAIN ACCURATE RECORDS

The Respondent is charged with failing to maintain a patient record which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Education Law §6530(32) (McKinney Supp. 1992); (formerly §6509(9) of the N.Y. Education Law, (McKinney,1985) and 8 NYCRR §29.2(a)(3), 1987) in that Petitioner charges:

3. The facts in Paragraph A and A.2.

DATED: Albany, New York
June 9, 1992

Peter D. Van Buren

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