STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

August 1, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Karen E. Carlson, Esq.
Assistant Counsel
NYS Department of Health
Corning Tower-Room 2429
Empire State Plaza
Albany, New York 12237

Judith M. Norman, Esq.
Nixon , Hargrave, Devans & Doyle
P.O. Box 1051
Clinton Square
Rochester, New York 14603

Kwan Ho Chung M.D.
1024 Hilton Parma Corners
P.O. Box 729
Hilton, New York 14468

RE: In the Matter of Kwan Ho Chung, M.D.

Dear Ms. Carlson, Ms. Norman and Dr. Chung:

Enclosed please find the Determination and Order (No. 95-162) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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

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

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

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

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

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

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw
Enclosure

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

IN THE MATTER

OF

KWAN HO CHUNG, M.D.

DETERMINATION

AND

ORDER

BPMC-95-162

THERESE G. LYNCH, M.D., Chairperson, **MARGARET H. McALOON, M.D.**, and **GEORGE S. SIMMONS, Ed. D**, 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) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **JERRY JASINSKI, ESQ.** , Acting General Counsel, **KAREN E. CARLSON, ESQ.**, Assistant Counsel of Counsel. The Respondent appeared by **NIXON, HARGRAVE , DEVANS & DOYLE, JUDITH M. NORMAN, ESQ.** of 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 submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged nine specifications of professional misconduct, including allegations of conduct evidencing moral unfitness, willful, physical and

verbal abuse of a patient, practicing the profession fraudulently, negligence on more than one occasion and inadequate record keeping.

The charges are more specifically set forth in the Statement of Charges, with letter of amendment dated May 25, 1995, a copy of which is attached as Appendix I hereto and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	December 28, 1994
Amendment to Statement of Charges Dated:	May 25, 1995
Pre-Hearing Conference:	January 23, 1995
Hearing Dates:	February 1, 1995 February 2, 1995 April 7, 1995 April 14, 1995 April 18, 1995 April 25, 1995 May 10, 1995 May 17, 1995
Received Petitioner's Proposed Findings of Fact, Conclusions of Law:	June 1, 1995
Received Respondent's Proposed Findings of Fact, Conclusions of Law:	June 1, 1995
Deliberation Date:	June 5, 1995
Place of Hearing:	Alliance Shorthand Reporters, Inc. 183 Main Street East Rochester, New York

WITNESSES

For the Petitioner:

" K. B."
Joyce Mole, RN
Jacalyn Hunter
Robert C. Tatelbaum, M.D.
Thomas Letourneau, M.D.

For the Respondent:

Kwan Ho Chung, M.D.
Deborah Arend
Paul A. Rapoza, M.D.
Frank J. Chafel, M.D.
Harold A. Stopp, M.D.
Teresa R. Miller, M.D.

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits, and they denote evidence that the Hearing Committee found persuasive in determining a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited.

GENERAL FINDINGS OF FACT

1. Respondent is licensed to practice medicine in the State of New York and is currently registered with the New York State Education Department. (Pet. Ex. 3)

2. Patient A received medical care from Respondent specifically on December 2, 1992, December 9, 1992 and December 30, 1992 for treatment of infected sores on different

parts of her body resulting from nervousness and anxiety. (T. 53, 64, 81)

3. Patient A's husband, during this same time period, was also being treated by Respondent for terminal cancer and was at home in the hospice program, being cared for primarily by Patient A. (T. 43)

4. Patient A was also at the same time under the care of a psychiatrist, Dr. Thomas Letourneau. Patient A had been treated by Dr. Letourneau for a mental illness diagnosed as borderline personality disorder and had been under his care for an approximate eight (8) year period. (T. 45) Dr. Letourneau summarized Patient A's condition in a letter to Blue Choice, dated September 8, 1993. (Pet. Ex. 1, p. 00108)

5. Respondent had been the primary care physician of both Patient A and her husband since 1988. (Pet. Ex. 5)

6. On December 2, 1992, Patient A had an appointment with Respondent made largely upon advice from Joyce Mole, RN, the hospice nurse working with Patient A and her family as a result of her husband's terminal condition. Joyce Mole advised Patient A that her skin condition was worsening and she needed to be seen by a doctor. (T. 200 - 201) Patient A was reluctant to go anywhere at that time as she did not want to leave her husband in the event that he should die before she returned and, resultingly, he would die alone. Nurse Mole assured her that his condition was such that Patient A could go to the office visit on December 2 and Nurse Mole drove Patient A to the office. (T. 50 - 53, 202)

7. Joyce Mole testified that on December 2, 1992 Patient A was nervous, shaking, and sleep deprived. (T. 52, 204, 225) Patient A waited alone in the examining room for Respondent. She remained fully clothed. (T. 55 - 56)

8. Joyce Mole testified that Patient A had open sores on her face, knee and near her right eye, some of which looked infected. (T. 200) Patient A stated that she had sores on her face, chest, breast and leg, but denied having any sores on her buttocks. (T. 55, 142, 203) Mrs. Mole, however, requested that Respondent examine Patient A's buttocks for lesions pursuant to information she had received from Patient A's mother-in-law. (T. 203)

9. Patient A testified that when Respondent entered the room, she showed Respondent the skin lesions on her leg. (T.56) He next examined the lesions on her face, and th Patient A unbuttoned her blouse to show Respondent the lesions on her chest and breasts. (T. 57) Respondent told Patient A that he needed to check her bottom for sores, so Respondent told Patient A to lie down on her right side. Respondent was continually talking about Patient A's husband and her care of him. (T. 58 - 60) Patient A lowered her pants and underwear to her thighs as she lay on her side with Respondent facing her back.

10. Patient A testified that Respondent then pressed on Patient A's rectal area with his fingers and let up. After touching Patient A's rectal area Respondent asked if she felt more relaxed. Although Patient A responded yes, she testified that in reality she did not. (T. 59 - 61) Respondent then ended the examination and began to discuss medications with Patient A. (T. 61-62) Among other drugs, he prescribed Ceclor, Buspar, Atarax and he continued her Lasix and Zoloft prescriptions. (T. 902-905, 1087, Pet. Ex. 5 and Resp. N)

11. At that point Joyce Mole came into the examination room area to join in on the conversation concerning medications Respondent was prescribing for Patient A. (T. 61,

205)

12. Patient A told Joyce Mole on the way home from the office how Respondent had pressed on her rectal area and Joyce Mole responded that she must have misunderstood, that he must have been looking at a sore there. Patient A felt embarrassed for this misunderstanding and told Joyce Mole that. (T. 63 - 64)

13. Patient A testified that upon returning home, she contacted Dr. Letourneau for an appointment. (T. 227)

14. Respondent testified that following the "December 2nd visit, he called Dr. Letourneau to discuss Patient A's medication." (T. 904, Resp. Ex. E, p. 00141)

15. Dr. Letourneau testified that he spoke to Respondent about Patient A. (T. 554)

16. Patient A returned to Respondent's office one week later on December 9, 1992, again with Joyce Mole. (T. 64)

17. Patient A was feeling better on December 9th than the previous week and had been taking the medication prescribed for her. She was more relaxed, sleeping better and the itching was improved. (T. 65, 209 - 210)

18. Joyce Mole testified that she offered to accompany Patient A into the examining room but Patient A responded by saying that she felt stupid about last week's misunderstanding and that she could do it alone. (T. 66 - 67, 209)

19. Patient A testified that she waited for Respondent to come into the examination room and she was fully clothed while she waited. Respondent came into the room and asked Patient A if she was having any trouble with the medication he had given her. Patient A replied no. (T. 68)

20. Patient A testified that Respondent asked her to put a gown on so that he could examine her chest. Respondent asked Patient A to put the gown on with the opening in the front so that he could examine her breasts. (T.69)

21. Patient A testified that Respondent then pinched the nipple of her breast and asked if that stimulated her. (T. 70)

22. Patient A testified that Respondent then had her lie back so that he could do a breast exam. While examining Patient A's breasts Respondent asked her what type of birth control she used. (T. 70 - 71) Patient A responded by crying and telling Respondent that she and her husband had not had sex in years.

23. Patient A testified that Respondent told her that if she didn't use that organ she could have problems and that he would need to examine her. (T. 71)

24. Patient A testified that Respondent assisted her with putting her feet in the stirrups on the table. As Respondent was doing this he told Patient A that it was normal for a person of her age to have sex. (T. 73)

25. Patient A testified that she erroneously told Respondent that she had not had a pelvic

examination in nine years, when in fact she had a pelvic exam and PAP smear in Respondent's office on March 1, 1991. (T. 74, Pet. Ex. 5 and Resp. N)

26. Patient A testified that Respondent put his fingers inside her vagina while telling her that it was normal for someone her age to have sex; that she needed a sexual release; asking her if this was stimulating her; asking her if the touching gave her pleasure. Patient A also testified that Respondent rubbed her clitoris while asking her if it gave her pleasure. (T. 74 - 76)

27. Respondent testified that Patient A complained of vaginal itching. (T. 911, 914, Resp. Ex. N)

28. Respondent testified that he performed a limited pelvic examination of Patient A which was limited to the insertion of a speculum. Respondent had no plans from the beginning to do a PAP smear and he did not conduct a bi-manual examination. The only abnormality was a slight discharge. (T. 924-925)

29. Patient A testified that she was anxious and crying during this. Respondent eventually stopped touching Patient A and asked her if she felt better. (T.77)

30. Patient A testified that Respondent then put his finger inside her rectum. (T. 78)

31. Patient A testified that Respondent told her that what was happening was completely normal and strictly confidential and that she was too tense and that the massage would help her sleep. (T. 78)

32. Joyce Mole testified that Patient A left the examination room, made another appointment

and then left the office with her. When Patient A came into the waiting area within view of Joyce Mole she was trembling, pale, and could barely speak. (T. 210) Patient A testified that she told Joyce Mole in the car that Respondent touched her the way her husband would touch her. (T. 79)

33. On December 10, 1992, Patient A had an appointment with Dr. Letourneau, her psychiatrist, and told him about Respondent's conduct. (T. 553-554, Resp. Ex. E2, p. 00141)

34. On December 16, 1992, Patient A met with Jacalyn Hunter of the Office of Professional Medical Conduct in Dr. Letourneau's office for the purpose of discussing the case. Patient A insisted that Dr. Letourneau be present. (T. 555 - 556 Resp. E2, p. 00141)

35. On December 29, 1992, Respondent spoke with Patient A and told her she needed to come into his office to see him. Patient A told him she couldn't as her husband was much worse. (T. 81; Pet. Ex. 14)

36. Patient A testified that on December 30, 1992 Respondent telephoned her to say that he was coming to her home to make a house call on Patient A's husband and Patient A. (Pet. Ex. 14) Respondent arrived at the home of Patient A and examined Patient A's husband who was in a hospital bed in the living room of the house. No one else was home at the time. Respondent then asked Patient A how she was doing and looked at her face. He told her to go to her bedroom so that he could examine her. Patient A further testified that Respondent then accompanied her to her bedroom where he told her to lie down on the bed. Respondent looked at her chest and then started to lower her pants. Patient A then called for her children, who were not home at the time (and she knew so). She further stated that Respondent had his hands on her "butt" and then moved his hand in

a circular motion over her buttocks while talking to her. Respondent asked her if she was feeling better from last time and if she had any discharge after the last visit. (T. 81-85, Pet. Ex. 14))

37. After examining Patient A on December 30, 1992, Respondent stated that her lesions on her back looked better. (T. 1065-1066) He again prescribed Ceclor. (T. 1068, Resp. N)

38. On January 2, 1993, the husband of Patient A died.

39. Patient A testified that Respondent telephoned Patient A approximately one week after her husband's death to check her medication, express his condolences and discuss her insurance. (T. 87)

40. Patient A testified that Respondent telephoned her several times in early January to encourage her to make appointments with him. (T. 88, 313-314, Pet. Ex. 4A, 6)

41. On January 13, 1993 Patient A telephoned Respondent and taped the conversation with him. (Pet. Ex. 4.a & 4.b) Patient A had the assistance of Jacalyn Hunter from the Office of Professional Medical Conduct who also heard the telephone conversation between Respondent and Patient A. (T. 290 - 291)

42. Respondent then telephoned Patient A within a few minutes of ending the first telephone call on January 13, 1993. (T. 313 - 315)

43. Patient A never was treated by Respondent again and transferred her records to another physician.

44. On September 14, 1993, Respondent was interviewed by Jacalyn Hunter and Frank Coughlin, M.D. in the Rochester Office for the Office of Professional Medical Conduct along with an attorney for Respondent, Walter Marcus. Respondent was questioned about the care and treatment of Patient A during December 2, 9, and 30, 1992. (T. 317-319)

45. Respondent wrote a letter to the investigator within a few days of that interview and failed to mention any problems or concerns about the examination or diagnosis from December 9, 1992. (Resp. Ex. C)

46. Respondent testified that he has no previous charges of professional misconduct (T. 874) and that he has never been sanctioned or disciplined by any hospital, health care facility, or third party payor. (T. 873-874)

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 are sustained. The citations in parenthesis refer to the Findings of Fact which support each Factual Allegation:

Paragraph A:	(2, 3, 5)
Paragraph A.1(a):	Not sustained
Paragraph A.1(b):	(6 through 10)
Paragraph A.2:	(16)
Paragraph A.2(a):	Not sustained
Paragraph A.2(b)	(20, 21, 26, 30, 31)
Paragraph A.2(c)	(26, 30)
Paragraph A.2(d)	(26)

Paragraph A.2(e)	(21, 23, 26 ,31)
Paragraph A.3	(36)
Paragraph B:	(2, 3, 5)
Paragraph B. 1:	(9, 10, 20, 22, 36)
Paragraph B.2:	(10) (except with respect to Lasix)
Paragraph B.3:	Not sustained
Paragraph B.4:	(28) (except with respect to performance)
Paragraph B.5:	Not sustained

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

CONDUCT EVIDENCING MORAL UNFITNESS

Not Sustained (Vote 2 to 1)

WILLFUL PHYSICAL AND VERBAL ABUSE

Fourth Specification:	(Paragraphs A, A.1 and A.1(b)
Fifth Specification:	(Paragraphs A, A.2(b), A.2(c), A.2(d) and A.2(e)
Sixth Specification:	(Paragraphs A and A.3)

PRACTICING THE PROFESSION FRAUDULENTLY

Not Sustained

NEGLIGENCE ON MORE THAN ONE OCCASION

Not Sustained

INADEQUATE RECORDS

Ninth Specification: (Paragraphs B, B.1, B.2 and B.4)

The Hearing Committee further concluded that the following specifications should not be sustained:

First Specification

Second Specification

Third Specification

Seventh Specification

Eighth Specification

DISCUSSION

Respondent is charged with nine (9) 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 do 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 the 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:

Negligence is the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Fraudulent practice is the intentional misrepresentation or concealment of a known fact, made in some connection with the practice of medicine.

Using the above-referenced definitions as a framework for its deliberations, the Hearing

Committee concluded, by a preponderance of the evidence, that four (4) of the nine (9) specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset, the Hearing Committee made a determination as to the credibility of the significant witnesses presented by the parties. As the major allegation concerns willful physical and verbal abuse, the most significant witnesses are Patient A and Respondent. Notwithstanding the severe anxiety she exhibited at the hearing, the Hearing Committee found Patient A's testimony to be intelligent, consistent and logical. Patient A did not exaggerate the details of these incidents over time as one might do if they were concocting a complaint or lawsuit against a physician. She was also able to correct misstatements in her records and had very plausible explanations for any discrepancies. Examples include questions raised during cross-examination regarding misstatements that her sons were killed in auto accident, (T. 1127, 130) Dr. Letourneau's note stating she had cut her breast instead of her wrist, (T. 114) and the number of brothers who had incest with her. (T. 123-124)

The Respondent cast much dispersion upon Patient A's ability to tell the truth and posited that she could tend to misinterpret events. Dr. Letourneau, a psychiatrist who has treated Patient A for over 10 years, stated that Patient A's hallucinations were auditory, not visual in nature. Typically, they were voices telling her that she was a bad person and that she should harm or kill herself. (T. 549-550) Dr. Letourneau further stated that persons with borderline personality disorder do not generally fabricate lies (T. 674) and that he can't ever remember that she fabricated anything to him. (T.679) He further clarified that Patient A's "lies are not lies of commission. She leaves things out; she doesn't make things up." (T. 678)

The Hearing Committee finds the taped conversation (Pet. Ex. 4A) to be a very significant and persuasive factor to support the credibility of Patient A. Respondent's own words on the tape appear to confirm that he massaged her clitoris to stimulate Patient A because she was so uptight and that he would do it again to help her.

On the other hand, the Hearing Committee found that Respondent's testimony was not

straight forward and that he often hedged when answering questions. Respondent was unable to define "stimulation" in a forthright manner. (T. 1094) Respondent tried to justify his actions by explaining that what Patient A alleged as an inappropriate touching of her vagina was in fact a rarely used medical term called "ironing the perineum." (T. 923, 1186-1187) The Hearing Committee however, notes that these explanations were not brought forward during Respondent's initial interviews with OPMC. (T. 320,322,1052- 1053) Overall, Respondent's testimony was determined to be not forthright and not truthful and it was given very little credence. The Hearing Committee further finds the testimony of Joyce Mole and Jacalyn Hunter to be credible and precise as a recitation of Patient A's description of the events at the time they occurred.

Psychiatric testimony was also offered by both sides regarding the degree of Patient A's mental illness. The Department offered, Thomas Letourneau, M.D., a board certified psychiatrist who has been in private practice treating general adult psychiatry for the past 13 years and is also a Clinical Assistant Professor of Psychiatry at the University of Rochester. He has treated Patient A since 1985 and stated that he sees her on the average of every other week. (T. 545) Dr. Letourneau has no stake in the outcome of these proceedings and no motive for falsification or fabrication of his testimony was alleged or proven. Respondent argued that Dr. Letourneau's testimony should be discounted because he is an advocate for Patient A and wants to see her claims validated (T. 1462). The Hearing Committee, however, found that Dr. Letourneau was thoroughly knowledgeable of Patient A's condition, yet was quite candid regarding the ups and downs of his treatment of her. Therefore, the Hearing Committee gave his testimony great weight.

Teresa R. Miller, M.D. testified on behalf of Respondent. She is also a board certified psychiatrist, in private practice treating adults 16 or older. Dr. Miller is an Associate Clinical Professor of Psychiatry and Assistant Clinical Professor of Family Medicine at the University of Rochester. (T. 1283) Dr. Miller only met with Patient A once. She conducted a two hour interview with Patient A in the presence of both Patient A's and Respondent's personal attorneys.

She also administered a psychiatric test known as the MMP12. (Resp. Ex. U) The Hearing Committee found that the MMP12 is open to a range of interpretations when viewed against the patient's history and psychiatric evaluations. Both Dr. Miller and Dr. Letourneau offered a differing range of interpretations on the test. The Hearing Committee was not persuaded by either opinion. Thus, the Hearing Committee found the results of the MMP12 as well as Dr. Miller's one time, non-confidential interview to be inconclusive. Therefore, her testimony was given less weight.

Other significant testimony involved the adequacy of Respondent's medical records for Patient A. The Department offered the testimony of Robert C. Tatelbaum, M.D. who is board certified in the practice of obstetrics and gynecology. Dr. Tatelbaum, in addition to a private practice, is Chairman of the Obstetrical and Gynecological Department at Genesee Hospital and an Associate Professor of Obstetrics and Gynecology at the University of Rochester Medical Center. (T. 387) The Hearing Committee found Dr. Tatelbaum to be knowledgeable in his area of specialty and objective and straight forward in his testimony. Respondent offered the testimony Paul Rapoza, M.D. , who is a board certified in the American Board Family Practice. Dr. Rapoza is employed by Highland Hospital and he is also on the faculty at the University of Rochester as a Technical Assistant Professor of Family Medicine. (T. 768-769) The Hearing Committee found Dr. Rapoza to be well qualified as an expert of family medicine, but found inconsistencies in his opinion regarding Respondent's performance of a pelvic exam of Patient A. (T. 808, 811, 1131) The Hearing Committee also found that Dr. Rapoza's opinion that Respondent's records were minimally acceptable, overreached the average standard of adequate record keeping which was testified to by Dr. Tatlebaum. (T. 394) Respondent also offered the testimony of Frank J. Chafel, M.D., who has been board certified in obstetrics and gynecology since 1967. (T. 1178) The Hearing Committee found Dr. Chafel's post investigation discussion with Respondent regarding vaginismus and its possible misinterpretations by female patients as not credible and not helpful.

CHARGE A.1(a)

It is alleged that during a physical exam on December 2, 1992, Respondent fondled Patient A's anal area. Although the Hearing Committee believes that Respondent inappropriately touched Patient A's anal area, the touching did not rise to the level of "fondling." Therefore, this charge is not sustained.

CHARGE A.1(b)

This charge alleges in essence that while touching Patient A's anal area, Respondent told her to relax. The Hearing Committee sustains this charge because although not equivalent to fondling, the touching of the anal area was inappropriate according to Dr. Tatelbaum, because if the Respondent did not observe any lesions in the anal area, there was no medical justification to touch or press down there. (T. 412-413) Respondent's medical records likewise do not describe any lesions in the anal area. (Resp. Ex. N, 12/2/92 visit) Therefore, the Hearing Committee finds the use of words such as "relax" by Respondent were not medically appropriate. Therefore, the Fourth Specification of misconduct is sustained.

CHARGE A.2(a)

Patient A testified that on December 9, 1992, Respondent pinched her nipple while performing an examination of her breasts. (T. 70) The Hearing Committee believes Patient A's testimony that her breast was pinched by Respondent. However, the Hearing Committee believes that this touching, although inappropriate, does not meet the definition of "fondling" as stated in the charge. Therefore, this charge as well as the Second Specification is not sustained.

CHARGE A.2(b)

Patient A further stated that while pinching her nipple, Respondent asked her if that stimulated her. (T. 70) The Hearing Committee believes that Respondent asked Patient A if she was stimulated or words to that effect. The Hearing Committee finds that the touching and the comment were inappropriate and not medically justified. Therefore this charge and the Fifth Specification are sustained.

CHARGE A. 2(c)

This charge alleges that during the course of the December 9, 1992 exam, Respondent inserted his fingers in Patient A's vaginal and anal areas. Respondent, in his testimony before the Hearing Committee, admitted that he inserted his fingers into Patient A's vaginal area. Respondent stated that he attempted to insert the right index finger at the start of the exam, but the patient was too anxious He felt that she was too tense to insert the speculum, so he performed a "vaginal massage to widen vaginal canal digitally, from distal vaginal canal all the way to the proximal vaginal canal, a few times." (T. 923) Respondent then conducted a brief pelvic exam. (T. 925) Respondent further admitted that "whenever I do a pelvic exam, I always do a rectal exam" and that one was performed on Patient A on December 9th. (T. 1063)

Dr. Tatelbaum testified that there was no medical justification or indication for Respondent to insert his fingers into Patient A's vaginal and anal areas under these circumstances. (T. 414-415) Therefore, this charge as part of the Fifth Specification, is sustained.

CHARGE A.2(d)

Patient A testified that during the course of the aforesaid examination, Respondent rubbed her clitoris while asking her if it gave her pleasure. (T. 75) Respondent vehemently denied this allegation at the hearing (T. 934-935) However, as previously discussed, the Hearing Committee found Patient A's testimony to be credible and that it was further buttressed by the taped telephone conversation, (Pet. Ex. 4A, 4B, p.10) in which Respondent did not object to Patient A's use of the word "clitoris." Even Respondent's expert, Dr. Rapoza stated that he could think of no reason to directly stimulate the clitoris during a pelvic examination, unless it was through incidental contact through other tissues in the vaginal area. (T. 1152) Therefore, this charge as part of the Fifth Specification is sustained.

CHARGE A.2(e)

Patient A testified that Respondent put his fingers inside her vagina while telling her that it was normal for someone her age to have sex. He told her that she needed a sexual release and then asked her if this was stimulating her and if the touching gave her pleasure. (T. 74-76) Again, the Hearing Committee found Patient A's testimony to be credible and that this incident is further re-enforced by the taped conversation between Patient A and Respondent. (Pet. Ex. 4). Therefore, the charge is sustained as an act of willful abuse in support of the Fifth Specification.

CHARGE A.3

This charge alleges that during a house call on December 30, 1992, Respondent, after examining Patient A's dying husband in the living room, told Patient A to go to her bedroom so that he could examine her. Patient A testified that Respondent told her to lie down on the bed.

During this exam, Respondent lowered her bra and looked at her chest and then moved his hands on the side of her pants and began rubbing her buttocks. Patient A then faked a call to her children and the exam ended. (T. 83-84)

Respondent acknowledged that he requested to go to a room with more privacy because he felt anyone could walk into the living room from the front door. (T. 954) Respondent further stated that Patient A was not undressed during the course of his exam. (T. 955) The Hearing Committee, however, finds Respondent's testimony to be ambivalent and imprecise. His testimony that Patient A was not undressed is inconsistent with the type of exam that he documented in his records. (Resp. Ex. N, 12/30/92 note). Respondent further testified that during his December 2, 1992 exam, he found no lesions on or near her rectum (T. 894) and his records for December 30, 1992 indicate sore spots on back only. (Resp. Ex. N, 12/30/92) The Hearing Committee finds that there is no medical justification for rubbing Patient A's buttocks. Therefore , this charge is sustained as an act of willful abuse in support of the Fifth Specification.

CHARGE B.1

This charge alleges that Respondent failed to adequately record a description of the skin lesions on Patient A on December 2, 1992, December 9, 1992 and December 30, 1992. Respondent testified that when he saw Patient A on the December 2nd visit, he first noticed sores, redness and swelling on her face. He then discovered the sores on her breasts and buttocks as he proceeded with his medical exam. (T. 888-889) However, the nurse's notes for December 2nd are limited to "multiple skin scratching on face and back." (T. 1056) On the December 9th visit he wrote, "Face (right), breasts, 2 or 3 open wounds." (T. 1056-1057) On the December 30th visit he wrote only "Back sore spots." (T. 1065) By his own admission Respondent stated that he is a "lousy writer" and that on the December 2nd note he didn't write "sores" or cellulitis," but that is what he meant to write.(T. 1066-1067)

In addition, it was Dr. Tatelbaum's expert opinion that the skin lesions were not

adequately documented. (T. 391, 393,431-433) The Hearing Committee notes that lesions are mentioned nowhere in Respondent's medical records. Adequate medical records require accurate descriptions of the patient's condition for any subsequent physician who may have to cover for a physician in an emergency. Therefore, this charge and the Ninth Specification are sustained.

CHARGE B.2

This charge alleges that Respondent failed to adequately record the indication and/or amount of Ceclor and/or Lasix prescribed on December 2, 1992. Respondent testified that on the date in question he prescribed Ceclor, 250 milligrams t.i.d. (T. 902) Dr. Tatelbaum testified that in his review of the records for that date, Ceclor was prescribed without any clear indication of its intended use. (T. 391-392) The Hearing Committee agrees that the reason for prescribing Ceclor is not stated in Patient A's record. With respect to the Lasix, Respondent explained that his notes of March 17, 1992 document that Patient A complained of increased fluid retention, thus necessitating the Lasix prescription. The Hearing Committee concedes that the documentation for Lasix is adequate if the March 17th note and the December 2nd note are read in conjunction with each other. Therefore, the charge with respect to the Lasix is not sustained. However, the charge regarding the Ceclor is sustained in support of the Ninth Specification.

CHARGE B. 3

This charge alleges that on December 9, 1992, Respondent recorded that Patient A had "vaginal itching" when, in fact, Patient A had made no such complaint, had no such condition, and Respondent knew such facts. The Hearing Committee found that at no point in the record did Patient A ever state that she did not complain of vaginal itching. There is no evidence to support this allegation, therefore the charge is not sustained.

CHARGE B.4

This charge alleges that on December 9, 1992, Respondent failed to adequately perform and/or document a pelvic examination he performed on Patient A. Respondent testified that he performed the pelvic exam because he suspected that Patient A had developed a yeast infection from the Ceclor. (T. 914) He explained the extent of his pelvic exam to the Hearing Committee and stated that he did not conduct a bimanual (i. e. utilizing the left hand) exam or a PAP smear. (T. 919-925) His medical note merely states "Pelvic-slight discharge" (Resp. Ex. N)

Dr. Tatelbaum testified regarding the appropriate way to perform a pelvic exam. (T. 397-400) Dr. Tatelbaum further testified that a physician should record both normal and abnormal findings because it is helpful to keep a record of the patient's history against future changes. (T. 401) Dr. Tatelbaum was unable to render an opinion regarding the appropriateness of the pelvic exam due to the lack of adequate documentation of Respondent's record. However, Dr. Tatelbaum was of the opinion that the medical records did not meet acceptable standards of medical care because they should have included a description of the vulvar area, the vaginal area, the cervix, the uterine fundus, the adnexal area and the rectal area. (T. 407-408) Dr. Rapoza testified that the records were minimally accurate, (T. 1154) but admitted that the "slight discharge" was not described with enough specificity to identify this symptom as a yeast infection and that it could be indicative of many other things. (T. 811, 1158)

The Hearing Committee accepts the opinion of Dr. Tatelbaum that the records were not adequate and believes that Dr. Rapoza stretched his opinion of minimum standards in attempt to favor Respondent. Therefore, the charge with respect to inadequate records is sustained as part of the Ninth Specification.

CHARGE B.5

This charge alleges that Respondent at various times during the course of his treatment of Patient A, failed to adequately ascertain and/or document the treatment provided by Patient A's treating psychiatrist. The Hearing Committee found several references in the record to support the fact that Respondent was aware of Dr. Letourneau's treatment of Patient A and documented it in his records. (T. 171, 411, 554, 962, Resp. Ex. N, 12/2/92) Therefore, the Hearing Committee finds there is no proof to establish this charge and it is not sustained.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined that Respondent shall be permanently banned from performing pelvic examinations on female patients. In addition, Respondent's license to practice medicine in New York State shall be suspended for three (3) years following the effective date of this Determination and Order. The suspension shall be stayed for a period of two and one-half (2 and 1/2) years and Respondent placed on probation. The complete terms of probation are attached to this Determination and Order in Appendix II. 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 Hearing Committee truly believes that Patient A was inappropriately touched by Respondent during the course of 3 physical examinations. Respondent's comments regarding massage, stimulation and Patient A's lack of sexual activity were tantamount to verbal abuse. These inappropriate actions and words are re-confirmed by Respondent in the taped conversation with Patient A. No female patient should ever be subjected to abuse of that nature from

Respondent, therefore, Respondent is permanently banned from performing female pelvic exams in the future. In addition, Respondent's documentation of what occurred during the course of his medical examinations of Patient A and his reasons for the need for drugs like Ceclor clearly demonstrate his lack of skill in record documentation. Therefore, the Hearing Committee feels that retraining in medical record keeping is certainly warranted.

However, the Hearing Committee was convinced that the Respondent's inappropriate actions and words to Patient A were not for his own sexual gratification, but some misguided attempt to help Patient A during an extremely stressful period in her life. In addition, they found that Respondent appeared to be naive in the areas of human sexuality when answering questions posed by the Hearing Committee. (T. 1094) The Hearing Committee believes that the Respondent will be sufficiently penalized economically through the actual six (6) month suspension from a practice in which he sees 30 to 40 patients a day. (T. 869) He also is facing financial exposure from a pending civil suit filed by Patient A. Finally, Respondent has been practicing in the town of Hilton since 1976 and this is the only complaint of professional misconduct against him. For the foregoing reasons, Respondent's license should not be revoked.

Therefore, the Hearing Committee believes that under the totality of the circumstance, the permanent ban from performing female pelvic exams and a three year suspension with two and one-half years stayed probation that includes continuing education and monitoring is the appropriate sanction in this instance.

ORDER

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

1. The Fourth, Fifth, Sixth and Ninth Specifications of Professional Misconduct, as set forth in the Statement of Charges as amended by letter dated May 25, 1995 (Petitioner's Exhibit # 1 and 1A) are **SUSTAINED**; and

2. The First, Second, Third, Seventh and Eighth Specifications are **NOT SUSTAINED**; and

3. Respondent shall be **PERMANENTLY** banned from performing pelvic examinations upon female patients.

4. Respondent's license to practice medicine in New York State be and is hereby **SUSPENDED** for a period of three (3) years from the effective date of this Determination and Order. The term of the suspension shall be stayed for two and 0ne-half (2 1/2) years and Respondent shall be placed on probation in accordance with the terms of probation contained in Appendix II which is attached to this Determination and Order and incorporated herein.

DATED: Albany, New York
July 25, **1995**

Therese G. Lynch M.D.
THERESE G. LYNCH, M.D. Chairperson

MARGARET H. McALOON, M.D.
GEORGE S. SIMMONS, Ed.D

TO: Karen E. Carlson, Esq.
Assistant Counsel
NYS Department of Health
Corning Tower-Room 2429
Empire State Plaza
Albany, New York 12237

Judith M. Norman, Esq.
Nixon , Hargrave, Devans & Doyle
P.O. Box 1051
Clinton Square
Rochester, New York 14603

Kwan Ho Chung M.D.
1024 Hilton Parma Corners
P.O. Box 729
Hilton, New York 14468

APPENDIX I

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	NOTICE
OF	:	OF
KWAN HO CHUNG, M.D.	:	HEARING

----------X

TO: Kwan Ho Chung, M.D.
1024 Hilton Parma Corners
P.O. Box 729
Hilton, New York 14468

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §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 1st day of February, 1995, at 10:00 a.m. in the forenoon of that day at the Alliance Building, 183 East Main Street, Suite 1500, Rochester, New York, 14609 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 issue or 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 Section 230 (McKinney 1990 and Supp. 1994), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. 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 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 THE OTHER SANCTIONS SET OUT 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: Albany, New York
December 28, 1994

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

Karen Eileen Carlson
Assistant Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2429
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	:	STATEMENT
OF	:	OF
KWAN HO CHUNG, M.D.	:	CHARGES

KWAN HO CHUNG, M.D., the Respondent, was authorized to practice medicine in New York State on January 25, 1972 by the issuance of license number 111213 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994, from 1024 Hilton Parma Corners, P.O. Box 729, Hilton, New York 14468.

FACTUAL ALLEGATIONS

A. Respondent, at various times from January 6, 1988 through January 16, 1993, provided medical care to Patient A [patient is identified in the Appendix] at Respondent's office at 1024 Hilton Parma Corners, Hilton, New York [hereafter "Respondent's office"]. Respondent, from July 15, 1987 through January 5, 1993, also provided medical care to Patient A's terminally ill husband. Respondent engaged in physical contact and/or made remarks to Patient A which were of a sexual nature and/or were not medically justified,

including the following:

1. On or about December 2, 1992, during a physical examination at Respondent's office

   a. Respondent fondled Patient A's anal area.

   b. Respondent, while engaging in the conduct described in paragraph 1.a. above, told Patient A to relax and that he would help her to relax, or words to such effect.

2. On or about December 9, 1992, during a physical examination at Respondent's office

   a. Respondent fondled Patient A's breasts.

   b. Respondent, while engaging in the conduct described in paragraph 2.a. above, asked Patient A if she was stimulated by this contact, or words to such effect.

   c. Respondent inserted his fingers in Patient A's vaginal and anal areas.

   d. Respondent massaged Patient A's clitoris.

   e. Respondent, at various times during the

examination, asked Patient A if she was stimulated and told Patient A that she needed to be more relaxed, told Patient A she needed more stimulation, told Patient A she needed to have more sex, and told Patient A that Respondent would help her to relax, or words to such effect.

3. Respondent, on or about December 30, 1992, during a house call to Patient A's dying husband, physically examined Patient A in her bedroom. Respondent, while doing so, fondled Patient A's buttocks through her clothing.

B. Respondent, during the course of his treatment of Patient A with regard to the evaluation, treatment, and/or maintenance of records of Patient A, failed to do the following:

1. Respondent failed to adequately record a description of the skin lesions on Patient A on December 2, 1992, December 9, 1992 and December 30, 1992.

2. Respondent failed to record the indication and/or amount of Ceclor and/or Lasix prescribed on December 2, 1992.

3. Respondent, on December 9, 1992, recorded that Patient A had "vaginal itching" when, in fact, Patient A had

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

November 7, 1995

CORRECTED LETTER

Karen E. Carlson, Esq.
NYS Department of Health
Room 2429 - Corning Tower
Empire State Plaza
Albany, New York 12237

Judith M. Norman, Esq.
Nixon, Hargrave, Devans & Doyle
P.O. Box 1051
Clinton Square
Rochester, New York 14603

Kwan Ho Chung, M.D.
1024 Hilton Parma Corners
P.O. Box 729
Hilton, New York 14468

Effective Date: 11/13/95

RE: In the Matter of Kwan Ho Chung, M.D.

Dear Ms. Carlson, Ms. Norman and Dr. Chung:

Due to a wordprocessing error, the cover letter you received regarding the above referenced matter contained an error.

The first sentence of the letter dated November 6, 1995 should have read "Enclosed is the Determination and Order (95-162) of the Professional Medical Conduct Administrative Review Board in the above referenced matter."

The Determination and Order you received is not a corrected copy.

We are sorry for any inconvenience this may have caused you.

Sincerely yours,

Tyrone T. Butler, Director
Bureau of Adjudication

made no such complaint, Patient A did not have such condition, and Respondent knew such facts.

4. Respondent, on December 9, 1992, failed to adequately perform and/or document a pelvic examination he performed on Patient A.

5. Respondent, at various times during the course of his treatment of Patient A, failed to adequately ascertain and/or document the treatment provided by Patient A's treating psychiatrist.

SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

CONDUCT EVIDENCING MORAL UNFITNESS

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(20) (McKinney Supp. 1994) by reason of his conduct in the practice of medicine which evidences moral unfitness to practice medicine in that Petitioner charges:

1. The facts in Paragraphs A and A.1(a) and/or A and A.1(b).
2. The facts in Paragraphs A and A.2(a), A and A.2(b), A and A.2(c), A and A.2(d) and/or A and A.2(e).

3. The facts in Paragraphs A and A.3.

FOURTH THROUGH SIXTH SPECIFICATIONS

WILLFUL, PHYSICAL AND VERBAL ABUSE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(31) (McKinney Supp. 1994) by reason of his willful abuse of a patient, either physically or verbally, in that Petitioner charges:

4. The facts in Paragraphs A and A.1(1), A and A.1(a) and/or A and A.1(b).

5. The facts in paragraphs A and A.2(a), A and A.2(b), A and A.2(c), A and A.2(d) and/or A and A.2(e).

6. The facts in Paragraphs A and A.3.

SEVENTH SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(2) (McKinney Supp. 1994) by reason of his practicing the profession fraudulently in that Petitioner charges:

7. The facts in Paragraphs B and B.3.

EIGHTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

8. The facts in Paragraphs B and B.1, B and B.4, and/or B and B.5.

NINTH SPECIFICATION

RECORD KEEPING

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1994) by reason of his failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient in that Petitioner charges:

9. The facts in Paragraphs B and B.1, B and B.2, B and B.3, B and B.4 and/or B and B.5.

DATED: Dec. 28, 1994
Albany, New York

Peter D. Van Buren

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

APPENDIX II

TERMS OF PROBATION

1. Dr. Chung shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Dr. Chung shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Dr. Chung shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct ("OPMC"), Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, addresses, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. In the event that Dr. Chung leaves New York to reside or practice outside the State, Dr. Chung shall notify the Director of the office of Professional Medical Conduct in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. Chung's probation shall be supervised by the Office of Professional Medical Conduct.

6. For the first six (6) months of probation, Dr. Chung shall have bi-monthly, and for the remaining two years, quarterly meetings with a monitoring physician who shall review his practice. The monitoring physician shall be board certified in internal medicine, who has been in practice as such for at least five (5) years, selected by Dr. Chung and subject to the approval of the

Office of Professional Medical Conduct. This monitoring physician shall review randomly selected medical records from Dr. Chung's practice and evaluate whether Dr. Chung's medical care compares with generally accepted standards of medical practice. Dr. Chung shall not practice medicine in New York State until an acceptable monitoring physician is approved by the Office of Professional Medical Conduct.

7. Dr. Chung shall satisfactorily complete an OPMC approved course in medical records keeping during the six (6) month period in which his license is actually suspended.

8. Dr. Chung shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the Office of Professional Medical Conduct at the address indicated above.

9. Dr. Chung shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Dr. Chung elects not to practice medicine as a physician in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

10. If there is full compliance with every term set forth herein, Dr. Chung may practice as a physician in New York State in accordance with the terms of probation; provided, however, that upon receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Dr. Chung pursuant to New York Public Health Law Section 230(19) or any other applicable laws.