NEW YORK
state department of
HEALTH

Public

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

August 17, 2011

**CERTIFIED MAIL - RETURN RECEIPT REQUESTED**

Tae Kyu Park, M.D.
724 Eighth Avenue
Brooklyn, New York 11215-4204

Joseph C. Schioppi, Esq.
123-35 82nd Road, Suite 2L
Kew Gardens, New York 11415

Claudia Morales Bloch, Esq.
NYS Department of Health
145 Huguenot Street
New Rochelle, New York 10801

**RE: In the Matter of Tae Kyu Park, M.D.**

Dear Parties:

Enclosed please find the Determination and Order (No. 11-203) 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 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
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

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), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "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 penalties other than suspension or revocation 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
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

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

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

Sincerely,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH: nm
Enclosure

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

COPY

| IN THE MATTER OF TAE KYU PARK, M.D. | DETERMINATION AND ORDER |
|---|---|

BPMC-11-203

A Notice of Hearing, and Amended Statement of Charges dated October 22, 2010 and November 22, 2010 were served upon the Respondent **TAE KYU PARK M.D.** **JACQUELINE H. GROGAN Ed.D., Chair, DAVID HARRIS M.D., M.P.H.** and **RALPH W. LIEBLING M.D.** duly designated members of the State Board of Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Administrative Law Judge **KIMBERLY A. O'BRIEN ESQ.** served as the Administrative Officer.

The Department of Health appeared by JAMES E. DERING ESQ., General Counsel, by **CLAUDIA MORALES BLOCH ESQ.**, of Counsel. The Respondent, **TAE KYU PARK M.D.** appeared in person and by Counsel **JOSEPH C. SCHIOPPI ESQ.**

Evidence was received and argument heard, and transcripts of these proceedings were made.

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

## PROCEDURAL HISTORY

| | |
|---|---|
| Notice of Hearing & Amended Statement of Charges | October 22, 2010 & November 22, 2010 |
| Respondent's Answer | November 12, 2010 |
| Hearing Location & Dates | 90 Church Street, New York, New York November 22, 2011; December 22, 2010; February 7, 2011; and March 16, 2011 |
| Witnesses for Petitioner | Lewis Bass D.O. |
| Witnesses for Respondent | Tae Kyu Park M.D. |
| Final Hearing Transcript Received | April 1, 2011 |
| Parties Briefs | April 22, 2011 |
| Deliberations Date | June 17, 2011 |

## STATEMENT OF THE CASE

The State Board of Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York pursuant to Section 230 et seq. of the Public Health Law of New York. This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to Section 230 of the Public Health Law. Tae Kyu Park, M.D. (hereinafter "Respondent") is charged with nine specifications of misconduct involving the care and treatment of five patients. The Respondent is charged with negligence on more than one occasion, incompetence on more than one occasion, gross negligence, gross incompetence, and failing to maintain patient records as set forth in Section 6530 of the Education Law of the State of New York (hereinafter "Education Law"). The Respondent admits that he provided care to Patients A-E, however, Respondent denies all the factual allegations and nine specifications of misconduct set forth in the Notice of Hearing and

Amended Statement of Charges, attached hereto and made part of this Decision and Order, and marked as Appendix 1.

## FINDING OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("Tr."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard argument and considered the documentary evidence presented, the Hearing Committee hereby makes the following findings of fact:

1. On or about December 10, 1982, Tae Kyu Park M.D., Respondent, was authorized to practice medicine in New York State by the issuance of license number 152709 (Ex. 2).
2. Respondent maintains a "walk in" medical practice at 724 Eighth Avenue, Brooklyn, New York ("office") and the majority of his practice is internal medicine, with twenty to thirty percent of his practice dedicated to weight management (Tr. 399, 401, 426-429).
3. Respondent views weight management as a "social" problem (Tr. 436, 513-515).
4. Body Mass Index (BMI) is a number based on a calculation using a person's height and weight, the number is used to gauge a person's weight within the ranges of normal, overweight, and obese (Ex. 10; Tr. 31 – 33).
5. Phentermine may be prescribed for weight reduction and has numerous side effects including rapid heartbeat, nausea, vomiting, diarrhea, and with long term use a significant

risk of the patient forming a physical and/or psychological dependence on the drug. (Tr. 29-34, 38-39). Phentermine is prescribed for short term use by patients who are extremely obese and its use is contraindicated for any patient with cardiac conditions, metabolic conditions, liver problems and/or kidney problems (Tr. 28-29, 33-34, 37; Ex.10).

6. Hydrochlorothiazide and Furosemide are diuretics prescribed to address weight gain associated with water retention and treat hypertension (Tr. 36-41, 54 – 58).

7. Vicodin, Vicodin ES, Vicoprofen, Tylenol IV and Percocet are drugs prescribed for pain relief, and these drugs are often abused and can be habit forming (Tr. 226-229).

8. All physicians licensed in New York State shall: maintain a medical record that accurately reflects the care and treatment for each patient: obtain complete medical history, perform physicals, order basic laboratory studies, rule out underlying disorders, diagnose conditions, make a treatment plan, and justify prescribing (Education Law Section 6530; Tr. 15-382).

**Patient A**

9. Respondent began treating Patient A for weight management on or about 1990 through on or about June 23, 2008 (Ex. 3A, 3B & 3C; Tr. 19-20, 395-396).

10. While Respondent treated Patient A. the patient's weight ranged from normal to slightly overweight (Ex. 3A, 3B & 3C, Ex.10; Tr. 31-32). Respondent continuously prescribed and maintained Patient A on Phentermine over a period of several years, and also prescribed Hydrochlorothiazide and Furosemide for weight management associated with fluid retention without indication that Patient A was retaining fluid and/or experienced hypertension (Ex.3A, 3B &3C, Tr. 31-37, 54-58, 431-433).

11. Respondent did not: obtain an adequate medical history, regularly perform physicals or weigh the patient, evaluate or note psychological condition, order laboratory studies and blood work, rule out underlying disorders, diagnose conditions, establish a treatment plan, and/or provide justification for prescribing Phentermine, Hydrochlorothiazide, and Furosemide for Patient A (Ex. 3A, 3B & 3C; Tr. 30-34, 39-41, 46-47, 49-51, 54-58, 65, 407-411, 420-421, 430-433).

**Patient B**

12. Respondent began treating Patient B on or before March 22, 1989 through on or about December 3, 2008 (Ex. 4; Tr. 100 – 103).

13. Respondent failed to assess and follow up on abnormal laboratory results including Patient B's elevated blood glucose levels and cholesterol triglycerides (Ex. 4; Tr. 126-127, 154-155, 164, 170 – 172, 216-217).

14. Respondent prescribed Vicodin, Percocet, Tylenol IV, Viagra, Levitra, and Zocor to Patient B often for extensive periods of time and without: obtaining an adequate medical history, indication and/or justification for prescribing, performing a physical examination, ordering or noting diagnostic testing, considering underlying disorders, a treatment plan, maintaining a medical record that accurately reflects the care and treatment of the patient, noting overlapping prescribing of Vicodin and Percocet to Patient B's spouse (Patient C) and/or determining whether Patient B may be abusing or addicted to these medications (Ex. 4, Ex. 5 & Ex. 8; Tr. 103-106, 115-116, 122, 126-127, 129-130, 132, 134 - 135, 164, 170- 172, 174- 176, 182-183, 187, 218-219, 230, 288 – 289, 311).

## Patient C

15. Respondent treated Patient C from on or about January 30, 1990 through on or about December 8, 2008 and during this time he failed to: maintain a medical record that accurately reflects the care and treatment of Patient C, obtain a medical history, perform or note appropriate physical examinations, order and/or follow-up on laboratory studies/ bloodwork, rule out underlying disorders, diagnose conditions, establish a treatment plan, and justify prescribing of various medications including Vicodin, Percocet, and Lidoderm Patch (Ex. 5; Tr. 230, 293- 298, 303-305, 307-308, 311-315, 336-337).

16. Respondent prescribed and maintained Patient C on medications including Vicodin and Percocet without indication and/or justification, while simultaneously prescribing these same medications to Patient C's spouse (Patient B) and failed to assess and evaluate whether Patient C was abusing and/or addicted to these medications (Ex. 4, Ex.5 & Ex.8; Tr. 230, 313-314).

## Patient D

17. The Respondent treated Patient D from on or about March 2, 1998 through February 2, 2009. During this time the Respondent failed to: maintain a medical record that accurately reflects the care and treatment of Patient D, obtain or note complete medical history or physical examinations, obtain or follow-up on abnormal laboratory and test results and findings of consulting physicians, rule out underlying disorders, diagnose conditions, establish a treatment plan, and provide indication and/or justification for prescribing and maintaining Patient D on Vicoprofen, Lorazepam and Ativan (Ex. 6; Tr. 252, 339-341, 349-353, 355-356, 360, 370, 374 ).

## Patient E

18. The Respondent treated Patient E from on or about June 8, 2001 through on or about December 22, 2008 (Ex. 7). During this time the Respondent failed to: maintain a medical record that accurately reflects the care and treatment of Patient F, obtain appropriate medical history and physical examinations, diagnose a condition, rule out underlying disorders, establish a treatment plan, and provide justification for prescribing Vicoprofen, Vicodin ES, Xanax, Valium, Fioricet, Ambien, Paxil and Robaxin (Ex. 7; Tr. 367-369, 373-377).

## DISCUSSION & CONCLUSIONS

The Hearing Committee ("Hearing Committee" or "Committee") conclusions were unanimous and based on the entire record including testimony of the Department's witness Dr. Lewis Bass and Respondent himself, and the documentary evidence introduced at the hearing. The Committee found that both witnesses were highly credible and the Respondent's records for Patients A-E are an indicative sample of Respondent's overall practice.

### Testimony of Department's Witness Dr. Lewis Bass

Dr. Bass provided credible and detailed testimony about the standard of care, using the patient records to show the multitude of ways the Respondent failed to meet the standard of care for each of the Patients A-E. Throughout his testimony, it was clear to the Committee that Dr. Bass gave Respondent the benefit of the doubt when assessing Respondent's care of these patients. The Committee noted that in many instances Dr. Bass assumed Respondent had obtained more complete medical histories or performed examinations even when there was little or no evidence in a patient record to support the assumption. Overall the Committee found Dr.

Bass's balanced and restrained testimony about the repeated and serious deviations from the standard of care very powerful. Despite the many favorable assumptions Dr. Bass made about the care Respondent provided, the patient records clearly show that Respondent consistently failed to: maintain records that reflect the care and treatment provided to his patients, obtain adequate medical histories, order and assess diagnostic tests, perform physicals, rule out underlying medical issues and causes of symptoms, make a diagnosis, develop treatment plans, and/or justify prescribing.

Dr. Bass's testimony about Respondent's treatment of Patient A for weight management revealed serious acts of misconduct including Respondent's ongoing failure to address what underlying medical disorder could be causing the patient to be overweight. Patient A was not obese and regardless Respondent maintained the patient on phentermine for years and wrote prescriptions without: seeing the patient , determining if its use was contraindicated, ordering blood work to monitor adverse effects of the drug, and regularly weighing the patient to determine if the treatment was effective.

The Respondent's records for Patients A-E contain little evidence that Respondent ordered blood work or other diagnostic tests. Dr. Bass found it curious that Respondent ordered blood work for Patient B on a number of occasions over the years, and while the reports consistently showed elevated cholesterol triglycerides and blood glucose levels, which could be indications of heart disease and/or diabetes, Respondent did nothing to act or follow up on this information.

Dr. Bass testified that Respondent's prescribing practices including maintaining his patients on potentially habit forming pain medications such as Vicodin and Percocet with little or no justification for prescribing the medications constitute significant deviations from

acceptable standards of medical care. Respondent treated both Patient B and Patient B's spouse (hereinafter "Patient C") for twenty years or more, and he maintained Patient B on pain medications for years merely because he was a truck driver who complained of back pain. There is no indication that Respondent ever attempted to diagnose the cause of the pain or identify alternative treatments. Further, at times Respondent simultaneously prescribed the same pain medications to Patient C without seeing the patient, and upon the patient's specific request for the medications and combined only with vague complaints of pain related to strain while doing household chores. Similarly, Respondent's prescribing of pain medications including Vicoprofen and Vicodin ES for Patient D and Patient E without medical indication, justification, diagnosis, and/or ruling out underlying disorders fell well below acceptable medical standards in the treatment of a patient.

Testimony of Respondent Dr. Tae Kyu Park

The Committee found Respondent testified honestly and sincerely about the care and treatment he provided to his patients. It was clear to the Committee that Respondent is a person who is genuinely interested in his patients. Respondent has treated many of his patients for a period of twenty years or more. He testified about his commitment to providing a walk-in service for patients who have limited or no insurance, and because of his patients' lack of insurance coverage he avoids ordering what he believes to be unnecessary tests and procedures.

Unfortunately, Respondent's testimony also revealed to the Committee that he has little understanding or training in the area of weight management and a shallow depth of knowledge in the practice of internal medicine. Respondent testified that while weight

management constitutes twenty percent or more of his practice, he believes weight management is a social problem not a medical issue. He typically provides his weight management patients with a diet plan and prescribes weight loss medications without: a full review of systems, ordering preliminary or follow up diagnostic testing to rule out underlying causes for obesity, identifying preexisting or emerging conditions and/or co morbidities that would require treatment and/or contraindicate use of the prescribed medications or diet plan. Respondent also testified that he does not regularly weigh his weight management patients, however, he said he can get an idea about how much they weigh by looking at them. No meaningful explanation was provided to the Committee about how from visit to visit, month to month or year to year Respondent could determine whether a patient's weight management plan was appropriate and/ or whether there were any underlying medical issues.

The Committee also found that Respondent was uninformed about the use of and contraindications for many of the medications he prescribed, and/or the ramifications of prescribing these medications for long term use. Further, while Respondent admitted that he was aware that some of the medications he prescribed are subject to abuse and can be habit forming, he prescribed these medications over extended periods of time without a diagnosis or a treatment plan. Respondent also testified that as a convenience to his patients he often wrote prescriptions for amphetamines and/or pain medications for multiple refills and replacement prescriptions for "lost" or "destroyed" prescriptions without seeing the patient. The Committee found Respondent to be naïve about his patients' drug seeking behavior, earnestly believing that he could tell whether his patients were abusing and/ or addicted to the medications he prescribed for them. Respondent himself provided strong evidence that these patients were seeing him only to obtain drugs. He told the Committee that when he became

aware that he was under investigation by the Department he stopped prescribing pain medications to these patients. Respondent admitted that immediately after he stopped writing prescriptions, these patients who had been with him for many years stopped coming to see him.

While Respondent acknowledged that there were deficiencies in his record keeping practices, he showed little awareness of his repeated and significant deviations from acceptable standards of medical care and/or the potentially grave consequences of his clinical, diagnostic, prescribing, and record keeping practices. The Hearing Committee concluded Respondent has fundamental weaknesses in his understanding of the practice of medicine and has failed to keep his training current in the practice internal medicine. Respondent's care and treatment of Patients A-E constitutes repeated and significant deviations from acceptable medical standards and the Committee found that the breadth and scope of Respondent's deviations from acceptable medical standards present the risk of potentially grave consequences to his patients , and based on a preponderance of the evidence sustained the First, Third and Fifth through Ninth Specifications of misconduct finding Respondent guilty of negligence on more than one occasion, gross negligence, and failure to maintain medical records that accurately reflect the care and treatment of a patient (Education Law Section 6530(3), 6530(4) & 6530 (32); See Ex. ALJ 1A "Definitions of Professional Misconduct-Greenberg Memorandum").

The Hearing Committee did not sustain the Factual Allegations as charged in paragraphs A3 & A9, B7, C9, E10 & E11, as they were not fully supported by the record. These factual allegations relate to Respondent's failure to note, refer, and/ or follow up on patient consultations with other providers. Given the state of the patient records, it was not clear to the Committee whether or when the Respondent knew or should have known a consultation was required and/or whether or when he

had sufficient knowledge to act on procedures, tests and/ or consultations his patients had with other providers. The Second and Fourth Specifications set forth in the Amended Statement of Charges that specifically relate to incompetence on more than one occasion and gross incompetence pursuant to Education Law Sections 6530(5)&(6) (Ex.1A) were also not sustained by the Committee. In order to sustain allegations of incompetence and /or gross incompetence the Hearing Committee would be required to find that the Respondent lacks the requisite skill or knowledge necessary to practice the profession (Ex. ALJ 1A; Education Law Section 6530(5) & 6530(6)). The Hearing Committee concluded that in limited instances during Respondent's treatment of Patients A- E, he did provide acceptable medical treatment. Based on the foregoing, the Hearing Committee concludes that there is insufficient credible evidence that the Respondent was incapable of meeting accepted professional medical standards, and thus did not sustain the allegations of incompetence or gross incompetence.

## PENALTY DETERMINATION

After due and careful consideration of the penalties available pursuant to Public Health Law Section 230-a, the Hearing Committee has determined that in order to protect the public the Respondent's medical license shall be ***REVOKED***.

## ORDER

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

1. The Factual Allegations set forth in Paragraph A, A1, A2, A4, A5(a) –(c) , A6, A7, A8, A10 ; B, B1, B2, B3 (a) - (f), B4, B5, B6, B8, B9, B10, B11 ; C, C1, C2, C3 (a) –(c), C4, C5, C6 ,C7, C8, C10; D, D1, D2, D3 (a)-(c), D4, D5, D6, D7; E, E1, E2, E3, E4 (a) –(h), E5, E6, E7,

E8, E9 & E12 and the First, Third & Fifth through Ninth Specifications of misconduct as set forth in the Amended Statement of Charges (Ex. 1A) are **SUSTAINED;**

2. The Factual Allegations in Paragraph A3 & A9, B7, C9, E10 & E11, and the Second & Fourth Specifications of misconduct as set forth in the Amended Statement of Charges (Ex. 1A) are **NOT SUSTAINED;**

3. The Respondent's license to practice medicine in New York State is hereby **REVOKED;**

4. This **ORDER** shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

, New York
DATED: 06/16/11 ,2011

REDACTED

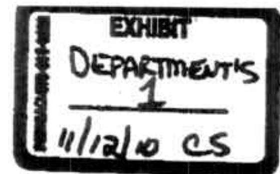
BY:______________________
**JACQUELINE H. GROGAN, Ed.D., Chairperson**
**DAVID HARRIS, M.D., M.P.H.**
**RALPH W. LIEBLING, M.D.**

To: Tae Kyu Park M.D.
724 Eighth Avenue,
Brooklyn, New York 11215-4204

Joseph C. Schioppi,Esq.
123-35 82nd Road Suite 2L
Kew Gardens, New York 11415

Claudia Morales Bloch, Esq.
NYSDOH -Bureau of Professional Medical Conduct
145 Huguenot Street
New Rochelle, NY 10801

# APPENDIX 1




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

| IN THE MATTER OF TAE KYU PARK, M.D. | NOTICE OF HEARING |
|---|---|

TO: TAE KYU PARK. M.D.

REDACTED

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on November 22, 2010, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, New York 10007, 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 who shall be an attorney admitted to practice in New York state. 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.

**YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.**

Department attorney: Initial here ________

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 New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. JAMES HORAN, ACTING DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. 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 §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be

photocopied.

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 OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New Rochelle, New York
October 22, 2010

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: CLAUDIA MORALES BLOCH
Associate Counsel
Bureau of Professional Medical Conduct
145 Huguenot Street, Rm. 601
New Rochelle, N.Y. 10801
914-654-7047

PETITIONER'S
EXHIBIT
1A
11/22/10

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

| IN THE MATTER OF TAE KYU PARK, M.D. | AMENDED STATEMENT OF CHARGES |
|---|---|

TAE KYU PARK, M.D., the Respondent, was authorized to practice medicine in New York State on or about December 10, 1982, by the issuance of license number 152709 by the New York State Education Department.

## FACTUAL ALLEGATIONS

A. Respondent, at his office, located at 724 Eighth Avenue, Brooklyn, N.Y. 11215 ("his office"), undertook the care and treatment of Patient A (the identity of all patients is set forth in the annexed Appendix) from on or about some unknown date in 1990 through on or about June 23, 2008. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient A;
2. Failed to perform and/or note complete and appropriate physical examinations of Patient A;
3. Failed to consult and/or note a consultation with prior and/or concurrent treating physicians regarding Patient A's care and treatment;
4. Failed to evaluate and/or note the psychological condition of Patient A;
5. Inappropriately and without accepted medical indication and/or

justification prescribed, dispensed and/or maintained Patient A on various medications, to wit:

a. Phentermine

b. Flurosemide

c. Hydrochlorothiazide

6. Continued to prescribe, dispense and/or maintain Patient A on the medications set forth in paragraph 5.a - 5.c, supra, without seeing the patient;

7. Failed to obtain and/or note appropriate and medically indicated laboratory studies and diagnostic studies on Patient A;

8. Failed to properly diagnosis and/or note a diagnosis for Patient A's condition(s) and/or rule out underlying disorders;

9. Failed to determine and/or note a treatment plan for Patient A;

10. Failed to maintain a medical record for Patient A in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

B. Respondent, at his office, undertook the care and treatment of Patient B from on or about March 22, 1989 through on or about December 3, 2008. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient B;

2. Failed to perform and/or note complete and appropriate physical examinations of Patient B;

3. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient B on various medications, to wit:

a. Vicodin

b. Percocet

c. Tylenol #4

d. Viagra

e. Levitra

f. Zocor

4. Continued to prescribe, Vicodin, Percocet and Tylenol #4 without accepted medical indication and/or justification, and without evaluating and/or noting an evaluation as to whether Patient B was addicted to and/or abusing said medications. Additionally, Respondent failed to evaluate and/or assess the overlap in prescribing of these medications with his prescribing the same medications to Patient C, Patient B's spouse, over the same time period;

5. Failed to properly diagnosis and/or note a diagnosis for Patient B's condition(s) and/or rule out underlying disorders;

6. Failed to follow-up on and/or note a follow-up of Patient B's consultation with other specialists, to wit: urologist and endocrinologist, and failed to coordinate the care of Patient B with said consultant;

7. Failed to refer and/or note a referral for Patient B to a cardiologist, neurologist, and/or orthopedist;

8. Failed to order and/or note an order for appropriate diagnostic testing, to wit: x-rays, MRIs, EKG, blood sugar;

9. Failed to determine and/or note an appropriate treatment plan for Patient B;

10. Failed to follow-up on and/or note a follow-up of abnormal laboratory results;

11. Failed to maintain a medical record for Patient B in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

C. Respondent, at his office, undertook the care and treatment of Patient C from on or about January 30, 1990 through on or about December 8, 2008. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient C;
2. Failed to perform and/or note complete and appropriate physical examinations of Patient C;
3. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient C on various medications, to wit:
    a. Vicodin
    b. Perocet
    c. Lidoderm patch
4. Continued to prescribe, Vicodin and Percocet without accepted medical indication and/or justification, and without evaluating and/or noting an evaluation as to whether Patient C was addicted to and/or abusing said medications. Additionally, Respondent failed to evaluate and/or assess the overlap in prescribing of these medications with his prescribing the same medications to Patient B, Patient C's spouse, over the same time period;
5. Failed to properly diagnosis and/or note a diagnosis for Patient C's condition(s) and/or rule out underlying disorders;
6. Failed to determine and/or note a treatment plan for Patient C;

7. Failed to follow-up on and/or note a follow-up of abnormal laboratory results;

8. Failed to order and/or note an order for appropriate diagnostic testing regarding Patient C's chronic lower back pain, to wit: x-rays and/or MRIs;

9. Failed to refer and/or note a referral for Patient C for appropriate consultation with a specialist, to wit: neurologist, pain management, and/or physical therapist;

10. Failed to maintain a medical record for Patient C in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

D. Respondent, at his office, undertook the care and treatment of Patient D from on or about March 2,1998 through on or about February 2, 2009. Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient D;

2. Failed to perform and/or note complete and appropriate physical examinations of Patient D;

3. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient D on various medications, to wit:

   a. Vicoprofen

   b. Lorazapam

   c. Ativan

4. Failed to properly diagnosis and/or note a diagnosis for Patient D's condition(s) and/or rule out underlying disorders;

5. Failed to determine and/or note a treatment plan for Patient D;

6. Failed to follow-up on and/or note a follow-up of abnormal laboratory and test results and the findings of consultations with other physicians;

7. Failed to maintain a medical record for Patient D in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

E. Respondent, at his office, undertook the care and treatment of Patient E from on or about June 8, 2001 through on or about December 22, 2008, Respondent:

1. Failed to obtain and/or note an adequate and complete medical history, and/or history of current complaints from Patient E;

2. Failed to perform and/or note complete and appropriate physical examinations of Patient E;

3. Failed to evaluate and/or note the psychological condition of Patient E and/or turn over Patient E's care to a psychiatrist;

4. Inappropriately and without accepted medical indication and/or justification prescribed and/or maintained Patient E on various medications, to wit:

   a. Vicoprofen
   b. Vicodin ES
   c. Xanax
   d. Valium
   e. Fioricet
   f. Ambien
   g. Paxil
   h. Robaxin

5. Continued to prescribe the medications set forth in paragraphs

4.a through 4.h, supra, without evaluating and/or noting an evaluation as to whether Patient E was addicted to and/or abusing said medications;

6. Failed to properly diagnosis and/or note a diagnosis for Patient E's condition(s) and/or rule out underlying disorders;
7. Failed to determine and/or note a treatment plan for Patient E;
8. Failed to order and/or note an order for appropriate diagnostic testing, to wit: MRI, EMG testing and/or other related modalities;
9. Failed to order and/or note any laboratory testing;
10. Failed to follow-up on and/or note a follow-up on referrals to a gynecologist, orthopedist and psychiatrist;
11. Failed to refer and/or note a referral for Patient E for appropriate consultation with a specialist, to wit: neurologist, pain management, and/or physical therapist;
12. Failed to maintain a medical record for Patient E in accordance with accepted medical standards and in a manner which accurately reflects his care and treatment of the patient.

## SPECIFICATION OF CHARGES

### FIRST SPECIFICATION

### NEGLIGENCE ON MORE THAN ONE OCCASION

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

1. The facts of paragraphs A, A.1 - A.4, A.5, A.5a - A.5c, A.6 - A.10, B, B.1, B.2, B.3, B.3a - B.3f, B.4 - B.11, C., C.1, C.2, C.3,

C.3a - C.3c, C.4 - C.10, D, D.1, D.2, D.3, D.3a - D.3c, D.4 - D.7, E, E.1 - E.3, E.4, E.4a - E.4h, E.5 - E.12.

## SECOND SPECIFICATION

## INCOMPETENCE ON MORE THAN ONE OCCASION

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

2. The facts of paragraphs A, A.1 - A.4, A.5, A.5a - A.5c, A.6 - A.10, B, B.1, B.2, B.3, B.3a - B.3f, B.4 - B.11, C., C.1, C.2, C.3, C.3a - C.3c, C.4 - C.10, D, D.1, D.2, D.3, D.3a - D.3c, D.4 - D.7, E, E.1 - E.3, E.4, E.4a - E.4h, E.5 - E.12.

## THIRD SPECIFICATION

## GROSS NEGLIGENCE

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

3. The facts of paragraphs A, A.1 - A.4, A.5, A.5a - A.5c, A.6 - A.10, B, B.1, B.2, B.3, B.3a - B.3f, B.4 - B.11, C., C.1, C.2, C.3, C.3a - C.3c, C.4 - C.10, D, D.1, D.2, D.3, D.3a - D.3c, D.4 - D.7, E, E.1 - E.3, E.4, E.4a - E.4h, E.5 - E.12.

## FOURTH SPECIFICATION

## GROSS INCOMPETENCE

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

incompetence as alleged in the facts of the following:

4. The facts of paragraphs A, A.1 - A.4, A.5, A.5a - A.5c, A.6 - A.10, B, B.1, B.2, B.3, B.3a - B.3f, B.4 - B.11, C., C.1, C.2, C.3, C.3a - C.3c, C.4 - C.10, D, D.1, D.2, D.3, D.3a - D.3c, D.4 - D.7, E, E.1 - E.3, E.4, E.4a - E.4h, E.5 - E.12.

## FIFTH THROUGH NINTH SPECIFICATION

## FAILURE TO MAINTAIN RECORDS

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

5. The facts of paragraphs A.1 - A.4, A.7 - A.10,
6. The facts of paragraphs B.1, B.2, B.4 - B.11,
7. The facts of paragraphs C.1, C.2, C.4 - C.10,
8. The facts of paragraphs D.1, D.2, D.4 - D.7,
9. The facts of paragraphs E.1 - E.3, E.5 - E.12,

DATE: November 22, 2010
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct