STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

August 18, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Maximo Chua, M.D.
373 Route 11
Smithtown, New York 11787

James F. Farrel, Jr., Esq.
888 Veterans Memorial Highway
Hauppaugue, New York 11788-2919

Ann Hroncich, Esq.
NYS Department of Health
Metropolitan Regional Office
5 Penn Plaza - Sixth Floor
New York, New York 10001

Effective Date: November 11, 1994

RE: In the Matter of Maximo Chua, M.D.

Dear Dr. Chua, Mr. Farrel and Ms. Hroncich :

Enclosed please find the Determination and Order (No. 94-46) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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

Office of Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Corning Tower, Room 438
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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:mmn

Enclosure

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

IN THE MATTER

OF

MAXIMO CHUA, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 94-46

The Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, MARYCLAIRE B. SHERWIN, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.** held deliberations on June 24, 1994 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) March 28, 1994 Determination finding Dr. Maximo Chua (Respondent) guilty of professional misconduct, restricting his license to practice medicine in New York State and ordering that he undergo an evaluation of his skills as a physician, to determine whether he must undergo retraining. The Office of Professional Medical Conduct (Petitioner) requested the review through a Notice which the Review Board received on April 21, 1994. James F. Horan, Esq., served as Administrative Officer to the Review Board. Anne Hroncich, Esq., submitted a brief to the Review Board on the Petitioner's behalf on May 19, 1994. James F. Farrell, Jr., Esq., submitted a reply brief on the Respondent's behalf on May 26, 1994.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties

permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with negligence and incompetence on more than one occasion, gross negligence and gross incompetence. The charges involved the Respondent's intravenous administration of certain mixtures to three patients, A through C. The Petitioner began the proceeding through a Summary Order, in which the Commissioner of Health determined that the Respondent's continued practice of medicine constituted an imminent danger to the public health. The Hearing Committee issued an Interim Order on January 14, 1994, in which they recommended that the Commissioner allow the Respondent to practice acupuncture, because there were no charges concerning the Respondent's practice of acupuncture.

The Hearing Committee sustained the charge that the Respondent was guilty of gross negligence in the treatment of Patients A through C, gross negligence in the treatment of Patient A, incompetence on more than one occasion in the treatment of Patients A and B, and gross incompetence in the treatment of Patient A.

The Hearing Committee found that the Respondent had administered inappropriately a mixture of vitamins and magnesium sulfate to Patient A. The Committee found that the magnesium sulfate and one of the vitamins were expired, and that the magnesium and some of the vitamins were clearly marked to indicate that the substances were not for intravenous use. The Committee found that upon receiving the mixture, the Patient developed a severe acute allergic reaction, suffered respiratory arrest and subsequently expired. The Committee found that the Respondent, who had practiced as an Anesthesiologist from 1963 to 1983, failed to take appropriate action in response to the arrest, by failing to administer epinephrine, failing to establish a proper airway before administering oxygen or mouth to mouth, failing to use an Ambu bag, and administering oxygen by

an inappropriate means. The Committee also found that the use of vitamins intravenously was inappropriate and increased the risk of allergic reaction. The Committee found that the risk also increased in light of the Patient's allergies and asthma.

The Hearing Committee found that the Respondent inappropriately administered a mixture of vitamins and other substances to Patient B intravenously. The Committee found that the intravenous administration was an inappropriate mode, which increased the risk of allergic reaction. The Committee found that, due to Patient B having asthma, the risk to the Patient due to the inappropriate mode of administration increased. The Committee found further that the Respondent had administered streptomycin and gentamicin, separately and in combination, intramuscularly to the Patient without indication.

The Hearing Committee found that the Respondent inappropriately administered a mixture of vitamins, magnesium sulfate and potassium chloride to Patient C intravenously, inappropriately administered a combined dose of streptomycin and gentamicin to Patient C intramuscularly and inappropriately administered a dose of streptomycin to Patient C intramuscularly. The Committee found that the intravenous administration of vitamins was an inappropriate mode of administration, which unjustifiably increased the risk of an allergic reaction. The Committee found further that the treatment of the Patient with gentamicin and streptomycin was not indicated for the Patient's condition.

The Committee voted to restrict the Respondent's license to the practice of acupuncture and ordered that the Respondent undergo an evaluation of his knowledge and ability to practice medicine at the Physician Prescribed Educational Program (PPEP) at Syracuse. The Committee ordered further that , if the evaluation indicates that the Respondent can be retrained, that he undergo retraining in the PPEP. The Committee provided that if the Respondent undergoes retraining, that the restriction on his license be modified to the extent necessary for evaluation and retraining. The Committee provided further that if the Respondent completed the evaluation and retraining successfully, the Respondent would be on probation for two years.

REQUESTS FOR REVIEW

The Petitioner has asked that the Review Board review the Hearing Committee's Penalty to clarify whether the Hearing Committee intended to permanently restrict the Respondent to only the practice of acupuncture, or whether the Committee intended to limit the Respondent to the practice of acupuncture only during the time during which the Respondent undergoes PPEP Evaluation and possible retraining. The Petitioner argues that the Committee intended to limit the Respondent to the practice of acupuncture permanently, and that the Committee ordered the PPEP Evaluation and Retraining because, even if the Respondent is restricted to acupuncture, the Respondent must still continue to evaluate patients and must be able to make proper referrals to other physicians. The Petitioner argues that permanent limitation is the appropriate penalty in this case in light of the Committee's conclusions concerning the Respondent persistent and gross acts of negligence and incompetence in treating Patients A, B and C.

The Respondent argues that the Committee intended to limit the Respondent's license to acupuncture only during the period during which the Respondent undergoes PPEP Retraining.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's Determination finding the Respondent guilty of repeated and gross acts of negligence and incompetence. The Determination is consistent with the Committee's findings concerning the Respondent's treatment of patients with mixtures through improper modes, without proper indication and with substances which were past their expiration date. The Determination is also consistent with the findings concerning the allergic reaction to the mixture which Patient A suffered and with the findings and conclusions concerning the Respondent's failure to take appropriate action in response to Patient A's allergic reaction.

The Committee votes to overturn the Hearing Committee's penalty limiting the Respondent's license and ordering him to undergo an Evaluation and Retraining at the Physician

Prescribed Education Program. The Review Board finds that penalty is not consistent with the Committee's findings and conclusions concerning the extensive and serious nature of the Respondent's misconduct, that the penalty is not appropriate for the Respondent's negligent and incompetent practice and is not appropriate to protect the public from a physician who constitutes a clear danger to his patients. The penalty is also inappropriate and inconsistent in that the Hearing Committee's Determination contains no findings to demonstrate that the respondent is a fitting candidate for retraining, even if the Respondent's misconduct had not been of such a serious nature. The Review Board finds that the only appropriate penalty in this case is to revoke the Respondent's license to practice medicine in New York State.

The Respondent practiced for some time as an anesthesiologist. Any physician, but especially an anesthesiologist, must be aware of the proper mode by which to administer a substance to a patient. Any physician, but especially an anesthesiologist, should be aware of the indications and contraindications for administering medications to patients. Any physician, but especially an anesthesiologist, should be able and prepared to deal with an allergic reaction which a patient suffers to a substance which the physician administers to the patient. Any physician, but especially an anesthesiologist, should know not to administer a substance to a patient after the expiration date marked on the container for that substance.

The Respondent's acts of negligence and incompetence are not the mistakes of a physician who has failed to stay current with new trends or new information available in medicine, nor are the acts of negligence and incompetence the result of the Respondent trying procedures for which the Respondent lacks adequate training or preparation. The Respondent's acts of negligence and incompetence demonstrate such ignorance and carelessness as to prove that the Respondent lacks the requisite knowledge, skill and care to safely and effectively practice medicine.

The Review Board finds nothing in this record to indicate that the Respondent merits a second chance to continue in the practice of medicine or that the serious deficiencies in the Respondent's knowledge, skills and patterns of practice can be corrected by the course of retraining available through PPEP. A physician should not need retraining to be able to read the expiration date on a bottle, to read directions which tell the proper or improper modes for administering a drug, to

know not to give medication when there is a contraindication or to know how to deal with an allergic reaction by a patient. If the Respondent has not acquired such knowledge or skills by this time, especially after his years in practice in a specialty, anesthesiology, in which the administration of drugs is the main element of the specialty, then the Review Board does not believe that the Respondent will obtain that knowledge in the PPEP retraining.

We find further that limiting the Respondent merely to practicing acupuncture is not appropriate because of the Respondent's obvious deficiencies in knowledge and practice that the Respondent has demonstrated in his care for Patients A through C. The Respondent is not competent to practice medicine in this State, so he should not be allowed to practice acupuncture through the exemption which allows licensed physicians to practice that discipline in New York. If the Respondent is to practice acupuncture in this State, he should prove his competency in that discipline to the body responsible for certifying those who practice acupuncture.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board **sustains** the Hearing Committee on Professional Medical Conduct's Determination finding Dr. Maximo Chua guilty of professional misconduct.

2. The Review Board **overturns** the Hearing Committee's penalty limiting the Respondent's license to practice medicine and ordering that the Respondent undergo retraining.

3. The Review Board votes unanimously to **revoke** the Respondent's license to practice medicine in New York State.

ROBERT M. BRIBER

MARYCLAIRE B. SHERWIN

WINSTON S. PRICE, M.D.

EDWARD SINNOTT, M.D.

WILLIAM A. STEWART, M.D.

IN THE MATTER OF MAXIMO CHUA, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chua

DATED: Albany, New York

7/27, **1994**

ROBERT M. BRIBER

IN THE MATTER OF MAXIMO CHUA, M.D.

MARYCLAIRE B. SHERWIN, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chua.

DATED: Malone, New York
July 13, 1994

Marycelaire B. Sherwin
MARYCLAIRE B. SHERWIN

IN THE MATTER OF MAXIMO CHUA, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chua.

DATED: Brooklyn, New York

_____, 1994

WINSTON S. PRICE, M.D.

IN THE MATTER OF MAXIMO CHUA, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chua.

DATED: Albany, New York
July 12, 1994

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF MAXIMO CHUA, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Chua.

DATED: Syracuse, New York

11 July , **1994**

William A. Stewart

WILLIAM A. STEWART, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

January 20, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ann Hroncich, Esq.
Associate Counsel
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5 Penn Plaza
New York, New York 10001

Robert Gottlieb, Esq.
353 Veterans Memorial Highway
Commack, New York 11725

Ronald R. Sussman, Esq.
470 Park Avenue South
New York, New York 10016

Maximo C. Chua
373 Route 111
Smithtown, New York 11787

James F. Farrel, Jr., Esq.
888 Veterans Memorial Highway
Hauppauge, New York 11788-2919

RE: In the Matter of Maximo C. Chua, M.D.

Dear Parties:

Enclosed please find the Interim Order signed by the Commissioner in the above referenced matter. Copies of this Interim Order have been sent to all other parties in this matter.

Very truly yours,

Tyrone T. Butler/lr

Tyrone T. Butler, Director
Bureau of Adjudication

TTB/lar
Enclosure

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

IN THE MATTER OF MAXIMO C. CHUA, M.D.	INTERIM ORDER

I have reviewed the Interim Report of the Hearing Committee on the issue of Imminent Danger in this matter, the Committee's finding that Maximo C. Chua, M.D., Respondent, does present an imminent danger to the health of the people of the State of New York, and the Hearing Committee's recommended action that the Summary Order be modified and remain in effect as detailed in the attached interim report.

Now, upon reading and filing the transcript of the hearing, the exhibits, and other evidence introduced at the hearing, the conclusions and recommendations of the Hearing Committee as set forth in the hearing committee's interim report dated: January 14, 1994,

I HEREBY ORDER THAT:

The Summary Order, dated November 16, 1993, imposed upon Respondent, Maximo C. Chua, M.D., shall be modified as set forth in the hearing committee's recommendation issued in the Interim Report dated: January 14, 1994, and attached hereto.

DATED: Albany, New York
January 19, 1994

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

TO: Ann Hroncich, Esq.
Associate Counsel
New York State Department of Health
Bureau of Professional Medical Conduct
Division of Legal Affairs
5 Penn Plaza
New York, New York 10001

Maximo C. Chua
373 Route 111
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Hauppauge, New York 11788-2919

Robert C. Gottlieb, Esq.
353 Veterans Memorial Highway
Commack, New York 11725

Ronald R. Sussman, Esq.
470 Park Avenue South
New York, New York 10016

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

IN THE MATTER

OF

MAXIMO C. CHUA, M.D.

INTERIM REPORT

Pursuant to Section 230(12) of the Public Health Law, following the completion of the parties' cases as to the question whether Respondent's continued practice of medicine in the state of New York constitutes an imminent danger to the public, the Hearing Committee has been asked to consider whether to retain, vacate, or modify the Order of the Commissioner of Health summarily suspending Respondent's license to practice medicine. More particularly, the Hearing Committee has been asked to consider whether Respondent may, pending the Committee's final determination of all issues in this matter, continue his practice of acupuncture.

As there have been no charges concerning Respondent's practice of acupuncture, no evidence has been presented as to imminent danger with respect to that practice. Accordingly, the Hearing Committee finds that Respondent's continued practice of acupuncture presents no imminent danger to the public. The Hearing Committee recognizes, however, that Respondent is not licensed to practice acupuncture in the state of New York except as an incident of his medical licensure. The

Committee also recognizes that it has no authority to grant Respondent a separate license for the practice of acupuncture within the state.

However, in order to permit Respondent to resume his practice of acupuncture, the Hearing Committee recommends, by vote of 3 to 0, to the Commissoner that his Order suspending Respondent's license to practice medicine be modified pending the Hearing Committee's final determination in this matter to the extent that Respondent be permitted to practice acupuncture as defined by New York Education Law, section 8211, with the following provisions:

1. The Hearing Committee recommends that, pursuant to Education Law section 8211 (b), Respondent do the following:

a) Advise each acupunture patient as to the importance of consulting a licensed physician as to the patient's condition;

b) keep on file with the patient's records the following form attesting to the patient's notice of such advise, in duplicate, with one copy to be retained by the patient, signed and datad by both Respondent and the patient:

WE, THE UNDERSIGNED, DO AFFIRM THAT (THE PATIENT) HAS BEEN ADVISED BY (RESPONDENT) TO CONSULT A LICENSED PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

_____ _____

(Signature) (Date)

_____ _____

(Signature) (Date)

2. The Hearing Committee further recommends that there be clear notice to the public for the limitations imposed upon Respondent's medical practice. To that end, the Hearing Committee recommends that there be prominently displayed in Respondent's office a notice that his practice is limited to acupuncture.

3. Finally, in order to ensure compliance with the terms of this modification, the Hearing Committee recommends that Respondent's practice and records be subject to unannounced inspection by a representative of the New York State Department of Health.

DATED: New York, New York

January 14, 1994

Thea Graves Pellman

Chairperson

Robert S. Bernstein, M.D.

Hilda Ratner, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Paula Wilson
Executive Deputy Commissioner

March 28, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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Robert C. Gottlieb, Esq.
353 Veterans Memorial Hwy.
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James F. Farrell, Jr., Esq.
888 Veterans Memorial Hwy.
Hauppauge, New York 11788-2919

Ronald R. Sussman, Esq.
470 Park Avenue South
New York, New York 10016

RE: In the Matter of Maximo Chua, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 94-46) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law, §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the administrative review board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

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 of the Hearing Committee's Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to the New York State Department of Health, Bureau of Adjudication, Corning Tower - Room 2503, Empire State Plaza, Albany, New York 12237-0030, **Attention: James F. Horan, Esq., Administrative Law Judge.** The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

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

Very truly yours,

Tyrone T. Butler

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:lar
Enclosure

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

IN THE MATTER :
OF :
MAXIMO C. CHUA, M.D. :

DETERMINATION
AND
ORDER
No. BPMC 94-46

THEA GRAVES PELLMAN, Chairperson, ROBERT S. BERNSTEIN, M.D., and HILDA RATNER, M.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) and 230(12) of the Public Health Law. ELLEN B. SIMON, ESQ., served as Administrative Officer for the Hearing Committee.

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

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct by reason of having practiced the profession of medicine with negligence and incompetence, each on more than one occasion, and with gross negligence and gross incompetence.

The charges are more specifically set forth in the

Statement of Charges, a copy of which is attached hereto and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Commissioner's Order and Notice of Hearing Dated:	November 16, 1993
Amendment to Statement of Charges date:	November 27, 1993
Prehearing Conference:	November 29, 1993
Hearing Dates:	December 9, 1993
	December 10, 1994
	December 17, 1993
	January 14, 1994
	January 28, 1994
Interim Report date:	January 14, 1994
Commissioner's Interim Report dated:	January 19, 1994
Deliberation date:	February 16, 1994
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Petitioner Appeared By:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: Ann Hroncich, Esq. Associate Counsel Roy Nemerson, Esq. Deputy Counsel, Of Counsel

Respondent Appeared By:

Wortman, Fumuso, Kelly,
Deverna & Snyder

888 Veterans Mem. Hgwy.
Hauppauge, New York
By: James F.
Farrell, Jr., Esq.

Siegel, Sommers & Schwartz
470 Park Avenue South
New York, New York
By: Ronald R. Sussman, Esq.,
Of Counsel

Robert C. Gottlieb, Esq.,
Of Counsel
353 Veterans Mem. Hgwy.
Commack, New York

Motion:

November 29, 1993: Pre-hearing motion by Petitioner to amend the Statement of Charges to include an additional factual allegation to the existing charges of practicing with negligence and incompetence - GRANTED.

WITNESSES

For the Petitioner: Pairojn Umpuntang
David Tricamo
Howard Chester, M.D.

For the Respondent: Richard S. Blum, M.D.

FINDINGS OF FACT

Numbers in parentheses 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

1. Maximo C. Chua, M.D. the Respondent, was authorized to practice medicine in New York state on September 16, 1974, by the issuance of license number 121419 by the New York State Education Department (Dept.'s Ex. 2).

2. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 to December 31, 1994, at 373 Route 111, Smithtown, New York 11787-4759 (Dept.'s Ex. 2).

3. According to Respondent's curriculum vitae (Dept.'s Ex. 10), between 1963 and 1983, Respondent practiced as an anesthesiologist and, in 1975, became a Fellow of the American College of Anesthesiology.

FINDINGS OF FACT AS TO PATIENT A

4. From approximately April 1993 to approximately July 1993, Respondent treated Patient A, who at the time was 14 years old, at his office, located at 373 Route 111, Smithtown, New York (Dept.'s Ex. 3).

5. On or about July 29, 1993, Respondent inappropriately administered to Patient A an intravenous mixture of vitamins (thiamine (B-1), pyridoxine (B-6), cyancobalamin (B-12), B complex, and liver-iron) and magnesium sulfate (Dept.'s Ex. 3, p. 1; Dept.'s Ex. 7, pp. 1-2; Transcript pp. (hereinafter T.) 47-49, 115-116, 145-146,316-328, 338-358].

6. The magnesium sulfate and the thiamine that Respondent administered to Patient A on or about July 29, 1993, had expired (Dept.'s Ex.6, p. 7).

7. The liver-iron vitamin that Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "for intramuscular use only" (Dept.'s Ex. 6, p. 7).

8. The cyancobalamin that Respondent intravenously administered to Patient A on or about July 29, 1993 was labelled "intramuscular or deep subcutaneous--not for intravenous use" (Dept.'s Ex. 6, p. 7).

9. The magnesium sulfate that Respondent administered to Patient A on or about July 29, 1993, was labelled "intravenous if diluted" (Dept.'s Ex. 6, p. 7).

10. The vitamin B complex that Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "anaphylactogenesis to parenteral thiamine has been reported" (Dept.'s Ex. 6, p. 7).

11. Upon receiving the above-described intravenous regimen, Patient A developed a severe acute allergic reaction and suffered respiratory arrest. Respondent did not take appropriate action in response to this event as follows (Dept.'s Ex. 3, pp. 1-2; Dept.'s Ex. 7; T. 366-371, 373-376, 445-447):

a. He failed to administer epinephrine;

b. he failed to establish a proper airway before administering oxygen or mouth-to-mouth resuscitation;

c. he failed to use an Ambu bag; and

d. he administered oxygen by an inappropriate means, e.g., through an oxygen tube in the mouth.

12. Patient A subsequently expired (Dept.'s Ex. 6).

13. Parenteral administration of vitamins, particularly intravenously, was clearly an inappropriate mode of administration, unjustifiably increasing the risk of an allergic reaction or anaphylaxis (T. 339-340, 345-346, 348-358, 501, 506-508, 521-523).

14. Particularly in light of this patient's allergies and asthma, the unacceptable risks of administering treatment in an unjustifiably risky manner were even greater (Dept.'s Ex. 3; T. 316-328, 338-358).

FINDINGS OF FACT AS TO PATIENT B

15. From approximately September 1992 to approximately August 1993, Respondent treated Patient B, who at the time was 65 years old, at his office, located at 373 Route 111, Smithtown, New York (Dept.'s Ex. 4).

16. On or about October 22, 1992, Respondent inappropriately administered to Patient B an intravenous mixture of 10 ml of B complex, liver iron, magnesium sulfate, potassium chloride, vitamin C, and pyroxidine (Dept.'s Ex. 4, p. 57; T. 344-345, 349, 352-353, 355, 525-535, 541-543).

17. On or about October 7, 1992, Respondent inappropriately administered a single isolated dose of 1 gm of streptomycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 67; T. 535-539, 543-545).

18. On or about December 1, 1992, Respondent inappropriately administered gentamycin intramuscularly to Patient B (Dept's. Ex. 4, p. 43; T. 539-541, 545-548).

19. On or about December 23, 1992, Respondent inappropriately administered both streptomycin and gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 35; T. 541, 550-551).

20. On or about December 1, 1992, Respondent inappropriately administered both streptomycin and gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 35; T. 541, 550-551).

21. On or about January 7, 1993, Respondent inappropriately administered gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 33; T. 539-541, 551-552).

22. On or about March 10, 1993, Respondent inappropriately administered both streptomycin and gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 21; T. 541, 552-553).

23. On or about March 12, 1993, Respondent inappropriately administered gentamycin intramuscularly to Patient B (Dept.'s Ex. 4, p. 19; T. 539-541, 553-557).

24. Respondent failed to perform or note adequate follow-up examinations relative to Patient B's condition and/or treatment in that, despite Respondent's use of multiple injections of intramuscular streptomycin and gentamycin on multiple occasions (T 535-557), Respondent failed to perform audiometry studies to ensure that no additional complications were being caused iatrogenically (Dept.'s Ex. 4; T. 538-541, 554-557).

25. Treatment with a single isolated dose of streptomycin was not indicated for Patient B's condition (Dept.'s Ex. 4; T. 535-539).

26. Treatment with gentamycin was not indicated for Patient B's condition (Dept.'s Ex. 4; T. 539-541).

27. Treatment with a combined dose of streptomycin and gentomycin was not indicated for Patient B's condition (Dept.'s Ex. 4; T. 541, 861-862).

28. Parenteral administration of vitamins, particularly intravenously, was clearly an inappropriate mode of administration, unjustifiably increasing the risk of an allergic reaction or anaphylaxis (T. 316-317, 319-325, 527-531, 532-535).

29. Particularly in light of this patient's asthma, the unacceptable risks of administering treatment in an unjustifiably risky manner were even greater (see Findings of Fact No's. 15 through 28 and the record citations therein).

FINDINGS OF FACT AS TO PATIENT C

30. From approximately September 1992 to approximately September 1993, Respondent treated Patient C, who at the time was 39 years old, at his office, located at 373 Route 111, Smithtown, New York (Dept.'s Ex. 5).

31. On or about February 9, 1993, Respondent inappropriately administered to Patient C an intravenous mixture of B vitamins, magnesium sulfate, and potassium chloride (Dept.'s Ex. 5, p. 70; T. 344, 355, 525, 527, 628-631).

32. On or about March 9, 1993, Respondent inappropriately administered a combined dose of streptomycin and gentamycin intramuscularly to Patient C (Dept.'s Ex. 5, p. 64; T. 631-633).

33. On or about March 23, 1993, Respondent inappropriately administered a single isolated dose of streptomycin intramuscularly to Patient C (Dept.'s Ex. 5, p. 62;

T. 633-634).

34. Parenteral administration of vitamins, particularly intravenously, was clearly an inappropriate mode of administration, unjustifiably increasing the risk of an allergic reaction or anaphylaxis (T. 321-323).

35. Treatment with a single isolated dose of streptomycin was not indicated for Patient C's condition (Dept.'s Ex. 5; T. 535-539).

36. Treatment with gentamycin was not indicated for Patient C's condition (Dept.'s Ex. 5; T. 539-541).

37. Treatment with a combined dose of streptomycin and gentamycin was not indicated for Patient C's condition (Dept.'s Ex. 5; T 541).

CONCLUSIONS

In reaching its findings, the Hearing Committee reasoned as follows:

As to charges A.2 and A.3, there is insufficient evidence to conclude that, on July 29, 1993, Respondent had available in his office appropriate emergency supplies and equipment in the event of respiratory arrest, considering his administration of intravenous therapy. If such supplies and equipment were not available, the Committee believes that they should have been; if they were available, the Committee believes that they should have been used, but they were not. In this

regard, the Committee placed great weight on the fact that Respondent was trained and experienced in anesthesiology and, therefore, should have been better prepared to respond to respiratory failure. Instead, he failed even to administer epinephrine.

As to charge A.3, it cannot be determined from the evidence that the injection itself caused Patient A's sever acute allergic reaction. Rather, it was one or more of the component ingredients in the injection that caused it, but it cannot be determined from the evidence which ingredient or ingredients it was.

As to charge B.3, the Hearing Committee could not sustain the charge that Respondent failed to perform any necessary laboratory studies to ensure that no additional complications were caused iatrogenically because the patient's record indicated that renal studies had been done (Dept.'s Ex. 4). However, as there is no indication in the record that any audiometric studies were done, the Committee sustained that part of the charge relating to such studies.

As to charge C.4, the evidence indicated that Respondent had advised Patient C to consult a hematologist and that the patient refused to do so (Resp.'s Ex. D, p. 2, paragraph 6). Accordingly, the Committee could not and did not sustain this charge.

In considering the charges of negligence and gross negligence, the Hearing Committee noted the testimony of Respondent's expert witness, Dr. Richard S. Blum, that Respondent's treatment of patients with vitamins and minerals was appropriate under the practice of homeopathic medicine (T. 750, 887, 888, et al). No evidence was presented that homeopathy is an accepted and recognized medical sub-specialty in New York state. Further, Dr. Blum himself admitted that he is not an expert on homeopathy, but, rather, that he had done "some independent review of various forms to get a feeling of the field of homeopathy" (T. 712). Moreover, there was no substantive evidence presented that Respondent is experienced in homeopathy medicine. His curriculum vitae (Dept.'s Ex. 10) does not reflect any specific training in its practice. It merely states Respondent's membership in 1989 in the Homeopathic Society of the State of New York (sic) and his 1990 Board certification in Naturopathic Medicine.

VOTE OF THE HEARING COMMITTEE

The Hearing Committee votes unanimously as follows:

FIRST SPECIFICATION:
(Negligence on more than one occasion)

SUSTAINED as to Paragraphs A, A.1 and A.3 (except that it cannot be determined from the evidence what particular ingredient or ingredients in the intravenous injection caused Patient A's severe acute allergic reaction); B, B.1, B.2, and B.3 (except as to necessary laboratory studies); C, C.1, C.2, and C.3.

NOT SUSTAINED as to Paragraphs A.2, B.3 (as to necessary laboratory studies), and C.4.

SECOND THROUGH FOURTH SPECIFICATIONS:
(Gross negligence)

SUSTAINED as to Paragraphs A, A.1. and A.3 (except as noted under the FIRST SPECIFICATION).

NOT SUSTAINED as to paragraphs A.2, B, B.1-B.3, C, C.1-C.4.

FIFTH SPECIFICATION:
(Incompetence on more than one occasion)

SUSTAINED as to paragraphs A, A.1, and A.3 (except as noted under the FIRST SPECIFICATION); B, B.1, B.2, and B.3 (except as to necessary laboratory studies).

NOT SUSTAINED as to Paragraphs A.2, B.3 (necessary laboratory studies); C, C.1-C.4.

SIXTH THROUGH EIGHTH SPECIFICATIONS:
(Gross incompetence)

SUSTAINED as to paragraphs A, A.1, and A.3 (except as noted under the FIRST SPECIFICATIONS).

NOT SUSTAINED as to paragraphs A.2, B, B.1-B.3, C, C.1-C.4.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee unanimously determines that the medical license of Respondent should be restricted to the practice of acupuncture in accordance with the terms and conditions of the Interim Order of the Commissioner of Health dated January 19, 1994, a copy of which is attached to and made a part of this Determination and Order.

The Hearing Committee further unanimously determines that Respondent should be required to comply with the following terms and conditions:

1. That Respondent apply for and participate in an evaluation of his knowledge and ability to practice medicine at the Physician Prescribed Educational Program (PPEP) at the Health Science Center, Syracuse, New York;

2. That if Respondent's evaluation by the PPEP indicates that he can be retrained, he be accepted into the PPEP;

3. That if Respondent is accepted for retraining at the PPEP, the restriction of his license to practice medicine be modified only to the extent necessary for the PPEP evaluation and retraining;

4. That Respondent successfully complete such PPEP course of study and present proof of such completion to the New York State Department of Health; and

5. That upon Respondent's successful completion of evaluation and retraining and his presentation of proof thereof, he be placed on probation for a period of two years.

ORDER

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

1. Respondent's license to practice medicine in the state of New York is restricted to the practice of acupuncture in accordance with the terms and conditions of the Interim Order of the Commissioner of Health dated January 19, 1994, a copy of which is attached to and made a part of this Determination and Order; and

IT IS FURTHER HEREBY ORDERED THAT:

2. Respondent comply with the following terms and conditions:

a. That Respondent apply for and participate in an evaluation of his knowledge and ability to practice medicine at the Physician Prescribed Educational Program (PPEP) at the Health Science Center, Syracuse, New York;

b. That if Respondent's evaluation by the PPEP indicates that he can be retrained, he be accepted into the PPEP;

c. That if Respondent is accepted for retraining at the PPEP, the restriction of his license to practice medicine be modified only to the extent necessary for the PPEP evaluation and retraining;

d. That Respondent successfully complete such PPEP course of study and present proof of such completion to the New York State Department of Health; and

e. That upon Respondent's successful completion of his evaluation and retraining and his presentation of proof thereof, he be placed on probation for a period of two years.

Dated: West Hempstead, New York
March 23, 1994

THEA GRAVES PELLMAN (Chairperson)

Robert S. Bernstein, M.D.
Hilda Ratner, M.D.

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

IN THE MATTER

OF

MAXIMO C. CHUA, M.D.

: COMMISSIONER'S
: ORDER AND
: NOTICE OF HEARING

TO: MAXIMO C. CHUA, M.D.
373 Route 111
Smithtown, New York 11787

The undersigned, Mark R. Chassin, M.D., Commissioner of Health of the State of New York, after an investigation, upon the recommendation of a committee on professional medical conduct of the State Board for Professional Medical Conduct, and upon the Statement of Charges attached hereto and made a part hereof, has determined that the continued practice of medicine in the State of New York by MAXIMO C. CHUA, M.D., the Respondent, constitutes an imminent danger to the health of the people of this state.

It is therefore:

ORDERED, pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993), that effective immediately MAXIMO C. CHUA, M.D., Respondent, shall not practice medicine in the State of New York. This Order shall remain in effect unless modified

or vacated by the Commissioner of Health pursuant to N.Y. Pub. Health Law Section 230(12) (McKinney Supp. 1993).

PLEASE TAKE NOTICE that a hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1993), and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1993). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 30th day of November, 1993 at 10:00 a.m. at 5 Penn Plaza, 6th Floor, New York, New York 10001 and at such other adjourned dates, times and places as the committee may direct. The Respondent may file an answer to the Statement of Charges with the below-named attorney for the Department of Health.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. The Respondent shall appear in person at the hearing and may be represented by counsel. The Respondent has the right to produce witnesses and evidence on his behalf, to issue or have subpoenas issued on his behalf for the production of witnesses and documents and to cross-examine witnesses and examine evidence produced against him. A summary of the Department of Health Hearing Rules is enclosed. Pursuant to Section 301(5) of the

State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The hearing will proceed whether or not the Respondent appears at the hearing. Scheduled hearing dates are considered dates certain and, therefore, adjournment requests are not routinely granted. Requests for adjournments must be made in writing to the Administrative Law Judge's Office, Empire State Plaza, Corning Tower Building, 25th Floor, Albany, New York 12237-0026 and by telephone (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty or sanction to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET FORTH IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1993). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
November 16, 1993

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

Inquiries should be directed to:

Ann Hroncich
Associate Counsel
N.Y.S. Department of Health
5 Penn Plaza, 6th Floor
New York, New York 10001
Tel. No.: 212-613-2615

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
MAXIMO C. CHUA, M.D.	:	CHARGES

----------X

MAXIMO C. CHUA, M.D., the Respondent, was authorized to practice medicine in New York State on September 16, 1974, by the issuance of license number 121419, by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 to December 31, 1994.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A, who at the time was 14 years old, at his office, which is located at 373 Route 111, Smithtown, New York, from approximately April 1993 to approximately July 1993. (The identities of Patient A and the other patients are disclosed in the attached Appendix.) Patient A had a personal and family history of severe asthma, and a personal history of allergies to a variety of substances as well as multiple endocrinological problems.

1. On or about July 29, 1993, Respondent inappropriately administered an intravenous mixture of vitamins (thiamine (B-1), pyridoxine (B-6), cyancobalamin (B-12), B complex, and liver-iron), and magnesium sulfate.

   a. The magnesium sulfate and the two containers/bottles of thiamine which Respondent administered to Patient A on or about July 29, 1993, had expired.

   b. The liver-iron vitamin which Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "for intramuscular use only".

   c. The cyancobalamin which Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "intramuscular or deep subcutaneous - not for intravenous use".

   d. The magnesium sulfate which Respondent administered to Patient A on or about

July 29, 1993, was labelled "intravenous if diluted".

e. The vitamin B complex which Respondent intravenously administered to Patient A on or about July 29, 1993, was labelled "anaphylactogenesis to parenteral thiamine has been reported".

2. On or about July 29, 1993, Respondent failed to have available appropriate emergency care supplies and equipment in light of the fact that he was administering intravenous therapy.

3. Upon receiving the above-described intravenous regimen, Patient A developed a severe acute allergic reaction to the intravenous injection and suffered a respiratory arrest. Respondent failed to take appropriate action in response to this event, and Patient A subsequently expired.

B. Respondent treated Patient B, who at the time was 65 years old, at his office, which is located at 373 Route 111, Smithtown, New York, from approximately September 1992 to

approximately August 1993. Respondent was treating Patient B for asthma and other conditions.

1. On or about October 22, 1992, Respondent inappropriately administered an intravenous mixture of 10 ml of B complex, liver, iron, magnesium sulfate, potassium chloride, vitamin C, and pyridoxine to Patient B.

2. On several occasions from approximately October 1992 to March 1993, Respondent inappropriately administered streptomycin and/or garamycin/gentamycin as follows:

   a. On or about October 7, 1992, Respondent inappropriately administered streptomycin intramuscularly to Patient B.

   b. On or about December 1, 1992, January 7, 1993, and March 12, 1993, Respondent inappropriately administered garamycin/gentamycin intramuscularly to Patient B.

c. On or about December 23, 1992, December 31, 1992, and March 10, 1993, Respondent inappropriately administered both streptomycin and gentamycin intramuscularly to Patient B.

3. Respondent failed to perform or note adequate follow-up examinations relative to Patient B's condition and/or treatment, including but not limited to the following:

a. Despite Respondent's use of multiple injections of intramuscular streptomycin and gentamycin on multiple occasions, Respondent failed to perform any laboratory or audiometry studies to ensure that no additional complications were being caused on an iatrogenic basis.

C. Respondent treated Patient C, who at the time was 39 years old, at his office, which is located at 373 Route 111, Smithtown, New York, from approximately September 1992 to approximately September 1993. Respondent was treating Patient C for his history of Chronic Fatigue Syndrome.

1. On or about February 9, 1993, Respondent inappropriately administered an intravenous mixture of B vitamins, magnesium sulfate, and potassium chloride to Patient C.

2. On or about March 23, 1993, Respondent inappropriately administered streptomycin intramuscularly to Patient C.

3. On or about March 9, 1993, Respondent inappropriately administered streptomycin and gentamycin intramuscularly to Patient C.

4. Despite the fact that Respondent knew that Patient C was leukopenic and thrombocytopenic, Respondent conducted some evaluations but upon obtaining the results of those evaluations, he failed to appropriately follow up upon such conditions.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH NEGLIGENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion under N.Y. Educ. Law Section 6530(3) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed at least two of the following:

1. The facts contained in paragraphs A., A.1., A.1.a-e, and/or A.2 and/or 3, and/or B., B.1. and/or B.2. and/or B.2.a-c, and/or B.3. and/or B.3.a. and/or C., C.1., C.2., C.3, and/or C.4.

SECOND THROUGH FOURTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession with gross negligence under N.Y. Educ. Law Section 6530(4) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed the following:

2. The facts contained in paragraphs A., A.1., A.1.a-e, and/or A.2 and/or 3.

3. The facts contained in paragraphs B., B.1. and/or B.2. and/or B.2.a-c, and/or B.3. and/or B.3.a.

4. The facts contained in paragraphs C., C.1., C.2., C.3., and/or C.4.

FIFTH SPECIFICATION

PRACTICING WITH INCOMPETENCE

ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with incompetence on more than one occasion under N.Y. Educ. Law Section 6530(5) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed at least two of the following:

5. The facts contained in paragraphs A., A.1., A.1.a-e, and/or A.2 and/or 3, and/or B., B.1. and/or B.2. and/or B.2.a-c, and/or B.3. and/or B.3.a. and/or C., C.1., C.2., C.3., and/or C.4.

SIXTH THROUGH EIGHTH SPECIFICATIONS

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession with gross incompetence under N.Y. Educ. Law Section 6530(6) (McKinney Supp. 1993), in that Petitioner charges Respondent with having committed the following:

6. The facts contained in paragraphs A., A.1., A.1.a-e, and/or A.2 and/or 3.

7. The facts contained in paragraphs and/or B., B.1. and/or B.2. and/or B.2.a-c, B.3. and/or B.3.a.

8. The facts contained in paragraphs C., C.1., C.2., C.3, and/or C.4.

DATED: New York, New York
November 16, 1993

CHRIS STERN HYMAN
Counsel
Bureau of Professional Medical
Conduct