

PUBLIC PUBLIC

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

In the Matter of

Victor Ho, M.D. (Respondent)

Administrative Review Board (ARB)

Determination and Order No. 04-146

**A proceeding to review a Determination by a
Committee (Committee) from the Board for
Professional Medical Conduct (BPMC)**

COPY

**Before ARB Members Grossman, Lynch, Pellman, Wagle and Briber
Administrative Law Judge James F. Horan drafted the Determination**

For the Department of Health (Petitioner):

Dianne Abeloff, Esq.

For the Respondent:

Robert Asher, Esq.

After a hearing below, a BPMC Committee found that the Respondent practiced medicine with negligence on more than one occasion in treating two patients. The Committee voted to suspend the Respondent's License to practice in New York State (License), to stay the suspension and to place the Respondent on probation under terms that appear at Appendix II to the Committee's Determination. In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney 2004), both parties ask the ARB to modify that Determination. After reviewing the hearing record and the parties' review submissions, the ARB votes 4-1 to affirm the Committee's Determination that the Respondent committed misconduct and to sustain the penalty the Committee imposed.

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(2-5) & 6530(32) (McKinney Supp. 2004) by committing professional misconduct under the following specifications:

- practicing medicine fraudulently,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion, and,
- failing to maintain accurate records.

The charges involved the medical treatment that the Respondent provided to

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Patient A . The record referred to the Patients by initials to protect patient privacy. A BPMC Committee conducted a hearing into the charges and rendered the Determination now on review.

The Committee dismissed all charges relating to and dismissed the charges that the Respondent practiced fraudulently, practiced with gross negligence or practiced with incompetence on more than one occasion.

The Committee found that the Respondent practiced with negligence on more than one occasion in treating Patient A . The Committee sustained the Factual Allegations charging that the Respondent:

- operated on Patient A to determine the origin of a brain lesion;
- failed to offer Patient A additional alternatives for obtaining the diagnosis of the lesion which, given the Patient's medical history, had a likelihood of being a brain tumor;
- failed to offer Patient A the option of further surgery until the Patient had deteriorated neurologically;

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The Committee found that, after a biopsy failed to provide diagnostic material to determine the origin of a lesion in Patient A's brain, the Respondent bore the responsibility to inform the Patient about other procedures that could determine the lesion's origin. The Committee found the Respondent committed a separate negligent act by allowing the Patient's condition to deteriorate.

The Committee found that by the end of December 2000, the growing lesion and brain swelling made clear that the cause was likely a malignant tumor rather than a simple hemorrhage. As to Patient B, the Committee found the Respondent negligent for damaging the carotid artery during surgery. The Respondent indicated following the surgery that the complication arose due to arteries lying in an anomalous position. The Committee found no abnormal location for the artery and the Committee faulted the Respondent for also trying to shift blame for the complication to another physician.

The Committee voted to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation for two years, under the terms that appear as Appendix II to the Committee's Determination. The Committee found the Respondent unable to admit his mistakes. The Committee determined that the Respondent followed Patient A too conservatively, while the Patient deteriorated before the Respondent's eyes,

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The Committee concluded that the stayed suspension and probation would deter the Respondent from sidestepping total responsibility for his patients and promote requisite accountability.

Review History and Issues

The Committee rendered their Determination on June 29, 2004. This proceeding commenced on July 14 & 15, 2004, when the ARB received the Review Notices from both the Petitioner and Respondent. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and response brief and the Respondent's brief and response brief. The record closed when the ARB received the Petitioner's response brief on September 2, 2004.

The Respondent argues that no factual basis exists in the record for the Committee's findings concerning Patient A and asks that the ARB dismiss the case.

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The Petitioner asks that the ARB modify the Committee's Determination, by changing the penalty from stayed suspension/probation to revocation. The Respondent notes that the Committee found the Respondent unable to admit mistakes. The Respondent argues that the probation cannot teach the Respondent character and responsibility and that only revocation will protect the public.

Determination

The ARB has considered the record and the parties' briefs. We vote 4-1 to affirm the Committee's Determination that the Respondent practiced with negligence on more than one occasion, but we modify the grounds on which the Committee found negligence. We vote 4-1 to affirm the Committee's Determination to suspend the Respondent's License for two years, to stay the suspension and to place the Respondent on probation, under the terms that appear at Appendix II to the Committee's Determination.

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We vote 4-1 to affirm the Committee's Determination that the Respondent practiced with negligence on more than one occasion in treating Patient A. The majority agrees with the Committee that the Respondent committed separate negligent acts by failing to offer the Patient options about further diagnostic steps and in ignoring the Patient's deterioration. The dissenting

member considers the Respondent's conduct a single negligent act and would dismiss the negligence on more than one occasion charge.

The four-member majority rejects the Petitioner's request that we revoke the Respondent's License.

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The majority concludes that the stayed suspension and two years probation constitutes the appropriate penalty for the Respondent's misconduct.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER**:

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB affirms the Committee's Determination to suspend the Respondent's License, to stay the suspension and to place the Respondent on probation under the terms at Appendix II to the Committee's Determination.
3. The ARB modifies the Committee's Determination by dismissing the findings that the Respondent **TEXT REDACTED**.

Robert M. Briber
Thea Graves Pellman
Datta G. Wagle, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

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

**IN THE MATTER
OF
VICTOR HO, M.D.**

DETERMINATION

AND

ORDER

BPMC #04-146

COPY

LINDA D. LEWIS, M.D., Chairperson, **ZORAIDA NAVARRO, M.D.** and **LOIS A. JORDAN**, 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 Section 230(10)(e) of the Public Health Law. **CHRISTINE C. TRASKOS, ESQ.**, served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **DONALD P. BERENS, Jr.**, General Counsel, **DIANNE ABELOFF, ESQ.**, Associate Counsel, of Counsel. The Respondent appeared by **ROBERT S. ASHER, ESQ.**, of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

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

STATEMENT OF CHARGES

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The accompanying Statement of Charges alleged specifications of professional misconduct, including allegations of negligence, gross negligence, incompetence, fraudulent practice and failure to maintain accurate medical records. The charges are more specifically set forth in the Statement of Charges dated October 10, 2003, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	October 10, 2003
Pre-Hearing Conference	November 5, 2003
Hearing Dates:	November 24, 2003
	January 10, 2004
	January 15, 2004
	January 29, 2004
	February 9, 2004
	April 1, 2004
	April 7, 2004
	April 19, 2004

WITNESSES

For the Petitioner:

George W. Tyson, M.D.
Patricia Roche, D.O.

For the Respondent:

Victor Ho, M.D.
Donald Stephenson, RPA
Richard Pinto, M.D.
Suying Song, M.D.
Harold Fodstad, M.D.
Kenneth Wooh, M.D.

Wise Young, Ph.D., M.D.
Richard Fraser, M.D.

FINDINGS OF FACT

1. Respondent was licensed to practice medicine in New York State on or about July 24, 1979 by issuance of license number 139169 by the New York State Education Department. (Pet. Exh. 2)

PATIENT A

2. On or about December 6, 1999, Patient A went to Staten Island University Hospital (SIUH) with complaints of blurred vision, perioral numbness, tingling and speech dysarthria. Patient A had a history of breast cancer 10 years prior and a spot was found on her lung on x-ray on December 6, 1999. The chest x-ray raised the issue of a tumor. Respondent examined Patient A on December 7th. A CT scan without contrast had already been performed on December 6th. A CT scan was performed with and without contrast on December 7th which showed a hyperdense right parietal lobe mass, compatible with hemorrhage. Hemorrhage into an underlying mass or less likely vascular lesion could not be excluded on the basis of this examination. (Pet. Exh 5, 6(A)(F), Resp. Exh C, Ho 696)
3. The CT scans of December 6th and 7th represent either a metastatic lesion with a hemorrhage or a spontaneous hemorrhage. A spontaneous hemorrhage results from problems with blood vessels not a tumor. (Tyson 55, 56, Roche 260, Pinto 1175, 1196, 1200, Fraser 1415, 1417)

4. Respondent made a differential diagnosis of metastatic tumor or primary hemorrhage, but he favored the diagnosis of metastatic tumor. (Pet. Exh.3, 5, Resp. Exh. C; Ho 697-698)

5. Respondent after reviewing the CT scans of December 6th and 7th decided to perform a craniotomy for a diagnosis.(Ho 698) At the time of the surgery on December 8th, Respondent found a lesion, that consisted mainly of blood. (Ho 701). A portion of solid brain was biopsied. (Ho 704)

6. During the December 8th biopsy, Respondent sent tissue down to pathology for a frozen section. (Ho 704) The pathologist informed Respondent that there was no overt tumor. (Ho 709) Respondent removed more tissue and sent it to pathology. (Pet. Exh. 5, Tyson 60, Ho 705, 709-710)

7. Respondent ordered a post-operative CT scan on December 9th (Exh. 5, p.62) The CT scan showed that the lesion was still present and in the same location. The tissue he removed consisted of reactive glial cells. (Tyson 67,69, Exh 5, pp.75-76)

8. On December 10th, Respondent learned that the material removed was not diagnostic. The pathology of the lesion was unknown. The pathologist at SIUH sent the material out to another institution for further evaluation. (Pet. Exh. 5)

9. On or about December 17th, Respondent learned that the pathologist from Memorial Sloan Kettering could not reach a diagnosis either. The pathologist found that the tissue submitted was "non-diagnostic material. As you point out, there is satellitosis with some atypical glial nuclei represented. These raise the issue of an underlying glioma that has not been optimally sampled, but again, your negative p53 and MIB-1 lend no support to this. Consideration must be given to resampling." (Ho 729; Pet. Exh.5 page 35)
10. Respondent had various options and responsibilities upon learning that he had not obtained any diagnostic material; not all of them ideal. First, he had to inform the patient and her other physicians that the biopsy did not produce any diagnostic material, that at the present time, he did not know the origin of the lesion. The patient could undergo other procedures such as stereotatic biopsy. It was the patient's decision whether she wanted to undergo the second procedure in an attempt to discover the origin of the lesion and then devise an appropriate treatment plan. Respondent's actions deprived the patient of this opportunity. (Tyson 69-72, 74,83-84, 89)
11. Respondent did not perform any further diagnostic tests because he had already performed the biopsy and had at that time looked all around and did not see any tumor cells other than the ones he removed. Two pathologists told Respondent that the tissue submitted was not diagnostic. The patient should have been offered a second diagnostic procedure. (Ho 729, 736, Fraser 1461, 1482)

2. Respondent's treatment plan was just to monitor the patient with periodic imaging studies. The next study was performed approximately 3 weeks after the non-definitive biopsy. The December 30th CT scan shows the lesion in exactly the same location as it was on the December 6, 7, and 9th CT scans, except now the lesion has grown and is surrounded by swelling of the brain. The fact that the lesion has grown (doubled in size) and swelling which is new, further increased the suspicion of an underlying malignant tumor and not a recurring hemorrhage. Most hematomas resolve themselves and would not enlarge in size. (Pet. Exh. 6C(i); Tyson 77,78, 166, Roche 267, 268, 271, Fraser 1427-1428)
3. Respondent failed to act upon this new information. He again just observed the patient despite the clear indication that the tumor was growing, the patient's clinical condition was declining, and he still had no explanation for the lesion's existence. The patient was dysarthriac, had seizures, and she had trouble moving her left hand. (Exh."O", pp. 17-18, 1/3/00 note; Tyson 79, 89, 170, Ho 740, 742)
4. Patient A returned to Respondent's office on January 3, 2000, approximately one month post biopsy. On that date, the neurologist, in Respondent's office, Benjamin Kong, examined her and found that she was unable to ambulate or stand on her own. (Exh. 3, p. 7) Dr. Quo recommended admission to an in patient rehabilitation program for speech therapy and gait training.(Exh."O", p. 16) Respondent also examined her, but no neurological examination was documented. He found only significant speech dysarthria. (Exh. 3, p.6) Respondent testified that Patient A was clinically stable. This finding

was neither consistent with the examination by the neurologist in Respondent's office, nor the family's evaluation of the patient. She was admitted to SIUH that afternoon for monitoring of her seizures, speech and gait therapy . (Pet. Exh.3,5; Resp.'s "O"; Ho 749, 852)

15. An MRI was performed on January 3rd, which showed that the lesion was in exactly the same place as on December 6th, when originally viewed, except now the lesion had grown and the brain was significantly displaced by the mass and the swelling around it, with a shift. (Fraser 1432) The lesion grew from 1.5x1.5cm on December 6th to 4x3.5cm on December 30th. This amount of swelling and edema indicated that the lesion was increasing in size. (Pet. Exh. 6D(i); Tyson 81-83, Roche 269, 270, 31, Fraser 1432)
16. By January 13th, the patient lost consciousness and was intubated. (Ex. "O", p. 19) A CT scan with and without contrast was performed. These scans show that the lesion was in the same location as on December 6th and had grown to over an inch in diameter taking up 15-20% of the brain on the right side. The displacement of the ventricles was even more severe than on the January 3rd scan indicating that the brain was more compressed and displacement had increased. Respondent finally realized it was time to operate, which he did. This time he actually sampled the

tumor and obtained diagnostic material. Patient A had metastatic lung cancer. (Pet. Exh.5, 6E; Tyson 86-88, 168, Roche 271, 273, Pinto 1194, Fraser 1445)

17. The lesion was a tumor not a resolving hematoma, as Respondent testified to at the SBPMC hearing and wrote in his summary on this patient. (Resp. Exh C; Pet. Exh 5) Respondent further testified “ Retrospectively, it’s easy. She had a tumor there. I should have known it all along.” (Ho 829,832)

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CONCLUSIONS OF LAW

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

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of the specifications of professional misconduct should be sustained. The rationale for the Committee's conclusions regarding each specification of misconduct is set forth below.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties. George W. Tyson, M.D., testified for the Department. At present Dr. Tyson is a board certified in neurosurgery and is an Associate Dean at the University at Stony Brook. He also continues as a Professor of Neurosurgery there after serving as Chair of the Department for Neurosurgery for 11 years. The Hearing Committee found Dr. Tyson to be a credible witness. They believe that he is very knowledgeable despite not having done active surgery in the past 5 years. The Hearing Committee believes that the standards of medical practice have remained the same. (Exh. 14; Tyson 19-21) Patricia Roche, D. O., also testified for the Department. Dr. Roche is board certified in general radiology and neuroradiology and is presently an Assistant Professor at Stony Brook University. (Roche 256-257; Exh. 15) The Hearing Committee found her testimony to be very credible.

The Respondent called Richard Fraser, M.D. as his expert witness. Dr. Fraser was Chief of Neurosurgery and program director of what is now the Weil Medical College of Cornell University. He has since retired but remains there as a Professor of Neurosurgery. (Fraser 1408-1409) The Hearing Committee found Dr. Fraser to be a well trained and honest witness. Respondent also called Wise Young, Ph.D, M.D. who is presently a Professor and Chair of the Department of Cell Biology and Neuroscience at Rutgers University. Dr. Young also did extensive research on the treatment of spinal cord injury at

NYU. Although the Hearing Committee found Dr. Young to be very knowledgeable, they found that his testimony served more as a character witness who had worked with Respondent in the past. (Young 1369-1371; Exh. 'L').

Likewise, the Committee found the testimony of both Richard Pinto, M.D. and Harold Fodstad, M.D., Ph.D to be credible but not particularly helpful regarding the alleged charges. The Committee further found Donald Stephenson, RPA to be very knowledgeable, straight forward and honest. They also found Dr. Wooh to be credible and note that Dr. Song was very meticulous in her approach to patients.

Respondent also took the stand on his own behalf. The Hearing Committee found Respondent to be very arrogant, condescending and unwilling to own up to his mistakes.

PATIENT A

Factual Allegations A, A.3 and A.4: SUSTAINED

Factual Allegations A. 1 and A.2: NOT SUSTAINED

Charge A.1, alleges that on or about December 8 1999, Respondent failed to recognize that he had failed to locate and biopsy the brain lesion that he intended to biopsy. The Hearing Committee finds that Respondent did not know on December 8th that he had not gotten tissue until the final pathology report was issued a few days later, thus this Charge is not sustained by the evidence in the record. (Pet. Exh. 5)

Charge A.2 alleges that Respondent inaccurately and inappropriately informed Patient A's other treating physicians that he had actually removed Patient A's brain lesion,

even though he did not. It is also alleged that Respondent knew that these communications were false and he made them with the intent to mislead. The Hearing Committee finds that the December 10, 1999 report to Dr. Dimaso, Patient A's primary care physician, indicates that Respondent believed that he had taken out all of the abnormal tissue that existed at the time. The Hearing Committee finds that there was no intent to mislead other physicians. (Exh. 3, p. 16; Ho 728-729) The Hearing Committee further notes that the language used in the report is commonly accepted medical terminology. (Fraser 1423-125) As a result, the Hearing Committee does not sustain Charge A.2.

Charge A.3 alleges that Respondent failed to offer Patient A additional alternatives for obtaining the diagnosis of the lesion which, given the patient's history, had a likelihood of being a brain tumor. The Hearing Committee concurs with Dr. Tyson that after the initial biopsy was non-diagnostic, the standard of care required Respondent to give Patient A the option to undergo another procedure to try again to get a diagnostic sample of tissue. (Tyson 69) There are other procedures that exist that are more precise, such as a stereotactic biopsy. (Tyson 69-70) Dr. Tyson concluded that Respondent should have offered the patient a second operation with an explanation of known risks and that "there really isn't much hope for this patient" if she doesn't have additional surgery. (Tyson 83-84) The Hearing Committee finds that Respondent was negligent for failure to offer additional alternatives to Patient A.

Charge A. 4 alleges that Respondent failed to offer Patient A the option of further surgery until January 13, 2000, which was after the patient had deteriorated neurologically. Respondent testified that on 12/30/ 99 he believed that Patient A was "at least clinically

stable.” (Ho 750-751) Dr. Tyson notes that by the end of December, it became clear that the lesion was growing and causing brain swelling. It was not a simple hemorrhage and it became mandatory to inform Patient A that it was likely a malignant tumor. (Tyson 89) The Hearing Committee concurs and notes that the evidence indicates that Patient A was having seizures and had an MRI on 12/30/ 99 that showed that the tumor was bigger. They find that Respondent was negligent for ignoring the patient’s deterioration and that he had an ongoing responsibility for her care. While not incompetent or grossly negligent, the Hearing Committee concludes that Respondent acted with negligence on two occasions with respect to care of Patient A. As a result, the Fourth Specification is sustained.

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DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be suspended for a period of two (2) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent will be placed on standard probation. The complete terms of probation are attached to this Determination and Order as Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for a two year stayed suspension with standard probation. They find no incompetence or gross negligence by Respondent. The Hearing Committee however is troubled by Respondent's attitude that he cannot own up to his mistakes. The Hearing Committee believes that Respondent followed Patient A too conservatively, while she deteriorated in front of his eyes. They also find that when Respondent's judgment is questioned, he tends to blame others.

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In conclusion, the Hearing Committee believes that a two year stayed probation will deter Respondent from side-stepping total responsibility for patients under his care and promote requisite accountability. Under the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

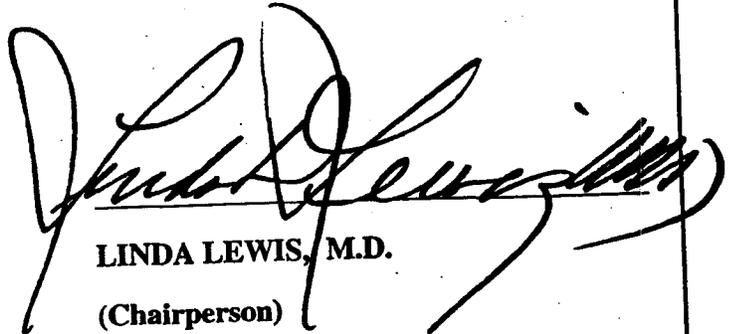
ORDER

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

1. The Fourth Specification of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) is **SUSTAINED**; and
2. The **TEXT REDACTED** Specifications of Professional Medical Misconduct against Respondent, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **NOT SUSTAINED**;
3. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **TWO (2) YEARS**, said suspension to be **STAYED**; and
4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and
5. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: New York, New York

June 24, 2004



LINDA LEWIS, M.D.

(Chairperson)

ZORAIDA NAVARRO, M.D.

LOIS JORDAN

TO: Dianne Abeloff Esq.
Associate Counsel
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Bureau of Professional Medical Conduct
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Victor Ho, M.D.
1460 Victory Blvd.
Staten Island, N.Y. 10301

APPENDIX I

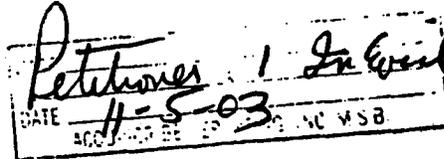
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NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
VICTOR HO, M.D.

NOTICE
OF
HEARING

TO: Victor Ho, M.D.
1460 Victory Blvd.
Staten Island, N.Y. 10301



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 24, 2003, at 10:00 a.m., at the Offices of the New York State Department of Health, 5 Penn Plaza, 6th floor, NY, NY, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the 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. SEAN O'BRIEN, 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 York, New York
October 10, 2003



Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Dianne Abeloff
Associate Counsel
Bureau of Professional Medical Conduct
212-268-6806

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

IN THE MATTER
OF
VICTOR HO, M.D.

STATEMENT
OF
CHARGES

VICTOR HO, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 24, 1979, by the issuance of license number 139169 by the New York State Education Department.

FACTUAL ALLEGATIONS

- A. On or about December 6, 1999, January 13 and 19, 2000, Respondent operated on Patient A (the patients are identified in the attached Appendix) at Staten Island University Hospital (SIUH). Respondent's care deviated from accepted medical conduct, in that:
1. On or about December 8, 1999, Respondent failed to recognize that he had failed to locate and biopsy the brain lesion that he intended to biopsy.
 2. Respondent inaccurately and inappropriately informed Patient A's other treating physicians that he had actually removed Patient A's brain lesion even though he did not remove the lesion.

- a. Respondent knew that these communications were false and he made them with the intent to mislead.
3. After ^uthe non-diagnostic biopsy, Respondent failed to offer Patient A additional alternatives for obtaining the diagnosis of the lesion which, given the patient's history, had a likelihood of being a brain tumor.
4. Respondent failed to offer Patient A the option of further surgery until January 13, 2000, which was after the patient had deteriorated neurologically while still under Respondent's care; this was an inappropriate amount of time to wait before giving her the option of further surgery.

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SPECIFICATION OF CHARGES

FIRST THROUGH THIRD SPECIFICATIONS

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:

1. The facts in Paragraph A and its subparagraphs

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FOURTH SPECIFICATION

NEGLECT 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:

4. The facts in Paragraph A and its subparagraphs;

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FIFTH 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:

5. The facts in Paragraph A and its subparagraphs;

TEXT REDACTED

SIXTH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law §6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

6. The facts in Paragraph A, A2, and A2a.

SEVENTH 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:

7. The facts in Paragraph A and A2.

DATED: October 10, 2003
New York, New York



Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

Standard Terms of Probation

1. Respondent shall conduct himself/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession.
2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street Suite 303, Troy, New York 12180-2299; said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.
3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.
4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].
5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.
6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.
7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.