IN THE MATTER OF	*	**BEFORE THE**
PATRICK YAT-FU TONG, M.D.	*	**MARYLAND STATE**
Respondent	*	**BOARD OF PHYSICIANS**
License Number: D47821	*	**Case Number: 2220-0198A**
	*	

* *

ORDER FOR SUMMARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE

Disciplinary Panel A ("Panel A") of the Maryland State Board of Physicians (the "Board") hereby **SUMMARILY SUSPENDS** the license of **Patrick Yat-Fu Tong, M.D.** (the "Respondent"), **License Number D47821**, to practice medicine in the State of Maryland. Panel A takes such action pursuant to its authority under Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2019 Supp.), having concluded that the public health, safety, or welfare imperatively requires emergency action.

INVESTIGATIVE FINDINGS[1]

Panel A has reasonable cause to believe that the following facts are true:

I. BACKGROUND

1. At all relevant times, the Respondent was and is licensed to practice medicine in the State of Maryland. The Board initially issued the Respondent's Maryland medical license on August 7, 1995, under License Number D47821. His license is active through

[1] The statements about the Respondent's conduct set forth in this document are intended to provide the Respondent with reasonable notice of the basis for this suspension. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against the Respondent in connection with this action.

September 30, 2021. The Respondent holds inactive licenses to practice medicine in California and Missouri.

2. The Respondent is not currently board-certified in any medical specialty. He was board-certified in ophthalmology (general); however, the certification expired on December 31, 2015.

3. The Respondent maintains an office for the practice of ophthalmology in Columbia, Maryland. His letterhead states that his practice includes "Pediatric Ophthalmology, Adult Strabismus, and Hereditary Eye Diseases." He holds privileges at a hospital in Howard County, Maryland.

II. COMPLAINTS

COMPLAINT 1

4. On September 18, 2019, the Board received a written complaint from a parent ("Parent 1") of a former patient ("Patient 1") of the Respondent. The Respondent had treated Patient 1 for eight years, from the age of five to 13 years old.

5. Patient 1 initially presented to the Respondent in 2011, to be examined for possible color-blindness. The Respondent confirmed that Patient 1 was color-blind and also diagnosed Patient 1 with astigmatism.[2] For the latter condition, the Respondent prescribed glasses.

6. In or around 2012, the Respondent diagnosed Patient 1 with amblyopia.

[2] Astigmatism is the result of an irregularly shaped cornea or lens that prevents light from focusing properly on the retina. It causes distorted or blurred vision at any distance.

7. Amblyopia, commonly referred to as "lazy eye," is a disorder of sight in which the brain fails to process inputs from one eye and over time favors the other eye, resulting in decreased vision.

8. Parent 1 alleged that the Respondent advised that Patient 1's right eye was dominant and he would lose his sight in his left eye if the right eye was not patched (occlusion therapy) or treated with atropine drops (atropine penalization) to dilate the eye.

9. Atropine drops weaken the focusing mechanism of the stronger eye, reducing the near vision to such an extent that the child's brain "chooses" the image from the amblyopic eye rather than the blurred image from the stronger eye. The therapeutic goal of atropine penalization is to improve the visual acuity of the amblyopic eye.

10. Parent 1 further alleged that in 2017, the Respondent diagnosed Patient 1 with strabismus.

11. Strabismus, a condition commonly referred to as "cross-eyed," is a problem with eye alignment, in which both eyes do not look at the same place at the same time.

12. The Respondent advised that Patient 1's left eye was now dominant and needed to be corrected because his eyes were not lining up correctly.

13. The Respondent placed prisms in Patient 1's glasses to treat his diagnosis of strabismus.

14. The Respondent increased the prism strength at regular intervals from two prism diopters to 15 prism diopters.

15. Parent 1 alleged that the Respondent was planning to perform surgery on Patient 1's right eye to fix the muscle in place once the prisms corrected his right eye.

16. Parent 1 reported that as the Respondent increased the prism diopters for the last several times, Patient 1 complained of double vision, headaches, and being sick to his stomach. Patient 1 would often remove the prism glasses while doing schoolwork.

17. In or around August 2019, Parent 1 learned from a friend that the Respondent had recommended prisms for her daughter. The friend had sought a second opinion and was told that her daughter did not have the condition diagnosed by the Respondent and did not need prism glasses.

18. Thereafter, Parent 1 sought opinions from two pediatric ophthalmologists, both of whom advised her that Patient 1 should not be wearing prism glasses because the prisms could be damaging his eyes.

19. In her complaint, Parent 1 listed the names of several parents whose children were also treated with prism glasses by the Respondent.

COMPLAINTS 2 – 5

20. In January 2020, the Board received four anonymous complaints, all of which appeared to be filed by ophthalmologists, alleging that the Respondent prescribed medically unnecessary prism glasses to pediatric patients in the absence of clinical indication.

III. THE BOARD INVESTIGATION

21. The Board initiated an investigation of the Respondent's practice regarding pediatric patients. In furtherance of its investigation, the Board requested the Respondent to respond to Parent 1's complaint and conducted under-oath interviews of Parent 1 and two of the individuals mentioned in Parent 1's complaint ("Parent 2" and "Parent 3"). The

Board also subpoenaed from the Respondent the records of 10 pediatric patients ("Patients 1 – 10"), including Patient 1 and the patients named in the anonymous complaints.

22. The Board referred the patient records obtained from the Respondent and related materials to a peer review entity.

23. In addition to responding to the Complaint, the Respondent also provided written responses to the peer review reports.

Parents 2 and 3 Interviews

24. Parent 2 reported that the Respondent, within minutes after the appointment began, told her that her child's ("Child 1's") eyes were "uneven" and that Child 1 needed prism glasses after simply observing Child 1 sitting in a chair. The Respondent told Parent 2 that her child was attempting to correct the unevenness by tilting her head.

25. On the first visit, the Respondent inserted prisms in Child 1's glasses that he had cut from a sheet of plastic. The Respondent instructed Parent 2 that Child 1 was to wear the prism glasses 24 hours a day unless she was sleeping.

26. Parent 2 subsequently sought a second opinion from a pediatric ophthalmologist who advised that Child 1 did not need prism glasses.

27. Parent 3 reported that she did not observe any eye examination equipment in the Respondent's office when she took her child ("Child 2") to be examined. At the initial appointment, the Respondent observed that Child 2 tilted his head to the left. At the next visit, the Respondent applied prisms to Child 2's glasses and told Parent 3 that Child 2 should wear the glasses as much as possible.

28. Parent 3 subsequently sought a second opinion from a vision therapist who advised that Child 2's vision issues were attributable to the need to develop processing skills, not an eye misalignment.

IV. RELEVANT EYE DISORDERS

A. Amblyopia

29. The American Academy of Ophthalmology (the "AAO") describes amblyopia as "an important public health problem because of its prevalence among children and because visual impairment from amblyopia is lifelong and can be profound...With rare exception, amblyopia results in lifelong visual loss if it is untreated or inadequately treated in early childhood." AAO Preferred Practice Pattern ("PPP") Amblyopia, 2017.

30. The AAO PPP further states:

> Treatment of refractive error alone can improve the visual acuity in children who have untreated anisometropic and strabismic amblyopia. Visual acuity of children who have bilateral refractive amblyopia also can substantially improve with refractive correction alone. Additional treatment of patching and atropine drops would not be indicated until amblyopia did not resolve with the treatment of glasses alone.

31. Amblyopia, as determined by the AAO PPP, is a diagnosis based on best corrected vision with more than a two-line or greater difference of optotype between the eyes. In other words, if the difference between the vision in a child's eyes is less than two lines, the child does not have amblyopia.

B. Strabismus

32. If untreated or treated inadequately, strabismus may cause amblyopia.

33. The AAO has advised practitioners that, "Strabismus treatment in children involves glasses, patching or surgery." AAO Summary Benchmarks for PPP Strabismus, 2019.

34. Prism treatment is not standard of quality care in the AAO's recommendations for the treatment of either amblyopia or strabismus for children.

V. THE PEER REVIEW

35. Two peer reviewers ("Peer Reviewers 1 and 2"), who are board-certified in ophthalmology and specialize in pediatric ophthalmology, separately reviewed the ten patient records and submitted their individual reports to the Board.[3]

36. Both Peer Reviewers expressed their concern that the Respondent regularly used prism glasses to treat pediatric asymptomatic patients with minimal objective findings for visual acuity conditions that the Respondent had inappropriately diagnosed using non-standard techniques, in violation of the standard of quality care.

37. For example, and not in limitation, the Respondent diagnosed and treated patients for amblyopia based on his finding that there was a one-line difference between the eyes, not a two-line difference as set forth as the standard of care by the AAO. The Respondent also diagnosed strabismus, that he would then treat with prism glasses, based on his observation of a patient's head tilt. The Respondent perused patients' Facebook postings to confirm his finding of a patient's head tilt.[4]

38. In a letter to the Board, the Respondent elaborated on his belief that head posture, or head tilt, is associated with vertical eye misalignment and that an individual's

[3] Neither of the Peer Reviewers filed the aforementioned anonymous complaints.
[4] Both Peer Reviewers remarked that they found the Respondent's use of Facebook postings to confirm his diagnosis of a head tilt to be unusual and not standard practice.

efforts to fuse images causes somatic health issues such as gastrointestinal distress, moodiness, and stiff necks.

39. In his supplemental response to the Peer Reviewers' reports, the Respondent continued to defend his diagnostic and treatment methods, stating,

> I have uncovered new symptoms associated with any small eye misalignment, in situations where the eyes are not sufficiently misaligned to cause double vision, but sufficiently misaligned to cause symptoms. In a number of these patients, small amounts of prisms results *(sic)* in dramatic improvements.
> ...
> When the head is straight the misalignment is larger (that is precisely the reason why the individual tilts his head to decrease the magnitude of the misalignment). Therefore, if the head is straighter, allowing the angle of misalignment to become larger, the individual would accept or perhaps even welcome the prismatic compensation.

40. The Respondent consistently used a mathematical "equation" of his own creation to determine the power of the prism he gave to the child. The Respondent's equation is not based on clinical measurements. Instead, the equation uses a patient's functional eye height, fusional effort, head tilt, and prismatic compensation. The Respondent's equation consists of variables that cannot be measured; the equation has not been scientifically validated which calls into question its utility and appropriateness as a diagnostic tool.

41. The Respondent consistently failed to appropriately document strabismus using industry-accepted methods of measurements and failed to document adequately physical findings or complaints for which prism treatment would be appropriate.

42. Both Peer Reviewers expressed concern that the Respondent drove to a patient's home (Patient 3) and dropped off in the family's mailbox a pair of prism glasses

in which he had increased the power from 4 to 6 diopters. The mother had not returned to the Respondent's office to pick up the newly adjusted glasses and Patient 3 did not return after the Respondent dropped off the glasses. Both Peer Reviewers expressed concern not only that the Respondent prescribed prism glasses for an asymptomatic patient, but also that the Respondent's delivery of the glasses to the family's mailbox is not consistent with clinically appropriate behavior.

PATIENT-SPECIFIC FINDINGS

43. In addition to the above general findings, the peer reviewers concurred that the Respondent failed to meet the standard of quality care for nine of the ten patients for reasons including, but not limited to:

a. The Respondent diagnosed and treated pediatric patients with prism glasses, in the absence of symptoms or clinical indications of strabismus (Patients 1 -7, 9 – 10). Both Peer Reviewers expressed concern regarding the Respondent's frequent use of unnecessary prism glasses to treat pediatric patients based primarily on subclinical ("flick") findings. The Respondent often merely documented "head tilt" or left hypertropia with no numeric documentation of the degree of head tilt, or the amount of deviation in prism diopters (Patients 1 – 7, 9 – 10). Ophthalmologists do not diagnose or treat eye disorders based on head tilt alone;

b. The Respondent treated asymptomatic patients with prism glasses over a long period of time, often several years. The Respondent "urged" patients to wear the prism glasses full time and during frequent office visits regularly increased the

power of the prisms to unreasonable and often intolerable levels.[5] Patients complained of headaches, double vision or visual discomfort;

c. The Respondent diagnosed children with amblyopia who did not meet that diagnostic definition (Patients 1, 3, 7, and 10);

d. The Respondent's prescription of daily atropine drops to treat children whom he wrongly diagnosed with amblyopia is unnecessary and overly aggressive. In one instance (Patient 1), the treatment caused amblyopia in the aligned eye ("reverse amblyopia").

e. The Respondent advised parents, without medical substantiation, that using prism glasses will help ameliorate non-specific complaints including "moodiness," neck stiffness and gastrointestinal distress (Patients 2, 3, 6, and 10);

f. The Respondent proposed to perform eye surgery on two patients (Patients 1 and 2), both of whom were asymptomatic and did not require the prism glasses the Respondent had ordered them to wear, much less surgery for an eye problem that did not exist. Eye surgery for strabismus is based on prism measurements which the Respondent failed to perform.

BASIS FOR SUMMARY SUSPENSION

A child who wears prism glasses must force their eyes to overcome the double image the prism induces. The use of prism glasses on a pediatric patient who does not have strabismus has the potential of causing harm and long-term

[5] Adults would find it difficult to tolerate two prism diopters. The Respondent had prescribed prisms up to 15 prism diopters to his pediatric patients. Although a child's brain is developing, if forced to wear unnecessary prisms, the brain can adapt, but only to a point. Some of the patients wore prism glasses as ordered by the Respondent until they could not tolerate the magnitude of image displacement, ultimately refusing to wear the glasses.

damage, including intractable double vision, amblyopia, possible loss of fusion (depth perception), and possible development of strabismus that would require surgery to correct. In addition, forcing the eyes to pull the two images together constantly while wearing the prism glasses causes severe physical strain on the eyes, headaches, and general discomfort, as reported by many of the children whose care was reviewed.

CONCLUSION OF LAW

Based on the foregoing Investigative Findings, Panel A concludes that the public health, safety or welfare imperatively require emergency action in this case, pursuant to Md. Code Ann., State Gov't § 10-226(c)(2) (2014 Repl. Vol. & 2019 Supp.) and Md. Code Regs. 10.32.02.08B(7)(a).

ORDER

Based on the foregoing Investigative Findings and Conclusion of Law, it is, by a majority of a quorum of Panel A, hereby

ORDERED that, pursuant to the authority vested in the Board by Md. Code Ann., State Gov't § 10-226(c)(2) and Md. Code Regs. 10.32.02.08B(7)(a), the license of **PATRICK YAT-FU TONG, M.D.**, License Number D47821, to practice medicine in the State of Maryland is **SUMMARILY SUSPENDED**; and it is further

ORDERED that a post-deprivation summary suspension hearing in accordance with Md. Code Regs. 10.32.02.08E has been scheduled for **Wednesday, December 2, 2020, at 11:45 a.m.** before Disciplinary Panel A at the Maryland State Board of Physicians, 4201 Patterson Avenue, Baltimore, Maryland 21215; and it is further

ORDERED that at the conclusion of the post-deprivation summary suspension hearing held before Panel A, the Respondent, if dissatisfied with the result of the hearing, may request within ten (10) days an evidentiary hearing, such hearing to be held within thirty (30) days of the request before an Administrative Law Judge at the Office of Administrative Hearings, Administrative Law Building, 11101 Gilroy Road, Hunt Valley, Maryland 21031; and it is further

ORDERED that this Order for Summary Suspension is an Order of Panel A and, as such, is a **PUBLIC DOCUMENT**. *See* Health Occ. §§ 1-607, 14-411.1(b)(2) and Md. Code Ann., Gen. Prov. § 4-333(b)(6).

11/18/2020
Date

Signature on File

Christine A. Farrelly
Executive Director
Maryland State Board of Physicians