IN THE MATTER OF	*	**BEFORE THE MARYLAND**
VICTOR GONG, M.D.	*	**STATE BOARD**
RESPONDENT	*	**OF PHYSICIANS**
License No.: D32615	*	**CASE NO: 2006-0537**

* * * * * * * * * * * * *

CONSENT ORDER

The Maryland State Board of Physicians (the "Board"), on August 25, 2010, charged Victor Gong, M.D. (the "Respondent") (D.O.B. 3/21/56), license number D32615, with violating the Maryland Medical Practice Act (the "Act") codified at Md. Health Occ. Code Ann. ("Health Occ.") §§ 14-101 *et seq.* (2009 Repl. Vol.).

The pertinent provisions of the Act under which the Board voted charges are Health Occ. § 14-404:

> (a) *In general.* --Subject to the hearing provisions of § 14-405 of this subtitle, the Board, on the affirmative vote of a majority of the quorum, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
>
> (3) Is guilty of:
>
> .....
>
> (ii) Unprofessional conduct in the practice of medicine;
>
> (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State;[1]
>
> (27) Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes; and
>
> (40) Fails to keep adequate medical records as determined by appropriate peer review[;]

[1] Charges under this ground were dismissed.

In addition, Respondent is responsible for the acts of his Physician Assistant under Health Occ. §15-301:

(a) *Independent practice not authorized* – Nothing in this title may be construed to authorize a physician assistant to practice independent of a supervising physician.

(b) *Certificate Limitations* - A certificate issued to a physician assistant shall limit the physician assistant's scope of practice to medical acts:

(1) Delegated by the supervising physician.

(e) *Agency* - A physician assistant is the agent of the supervising physician in the performance of all practice-related activities, including the oral, written, or electronic ordering of diagnostic, therapeutic, and other medical services.

FINDINGS OF FACT

The Board makes the following findings of fact:

I. Background Findings

1. At all times relevant to the Charges, Respondent was and is licensed to practice medicine in Maryland. The Respondent was originally licensed to practice medicine in Maryland on July 29, 1985 under license number D32615.

2. On or about September 30, 2010, Respondent last renewed his license. Respondent's current license will expire on September 30, 2012.

3. Respondent also holds inactive licenses to practice medicine in Hawaii, New Jersey, and New York.

4. Respondent's self-designated specialty is family medicine and family medicine, geriatrics. Respondent is not Board certified.

5. At all times relevant to the Charges, Respondent maintained offices for the practice of medicine at 7408 Coastal Highway, Ocean City, Maryland, known as "75th Street Medical" and at 12601-D Coastal Highway, Ocean City, Maryland, known as

"126th Street Medical." Both of these offices operate as family practice and urgent care facilities.

6. On or about February 22, 2006, the Board received a complaint from a former co-worker of Respondent alleging concerns about Respondent's practice.

7. On March 2, 2006, the Board received a second complaint from several former co-workers and a patient alleging concerns about Respondent's practice.

8. On June 1, 2006, the Board opened case #2006-0537 for investigation.

9. On January 27, 2010, the Board voted to charge Respondent with unprofessional conduct in the practice of medicine, failing to meet standards of quality care in regard to treatment of patients as determined by peer review, prescribing drugs for illegal or illegitimate purposes, and inadequate documentation of medical records.

II. Findings of Unprofessional Conduct under § 14-404(a)(3)(ii) and Illegal Prescribing of Drugs under § 14-404(a)(27)

10. Included in the March 2, 2006 complaint were allegations that Respondent prescribed Lipitor, a drug used for lowering cholesterol, to a Physician's Assistant[2] who was employed by Respondent in the early 2000s. The complaint contains allegations that the prescription for Lipitor that was written for the Physician's Assistant was actually for Respondent's mother.

11. On September 7, 2006, the Board interviewed the Physician's Assistant. According to the Physician's Assistant, Respondent asked her about her health insurance coverage for prescriptions. The Physician's Assistant informed the Respondent that she was covered by her husband's insurance. The Respondent asked the Physician's Assistant whether she would mind if he wrote a prescription for Lipitor

[2] Respondent is aware of the identity of this Physician's Assistant.

for his mother, using the Physician's Assistant's name. The Physician's Assistant inquired if it was okay to do this and Respondent told her she would not get in trouble. The Physician's Assistant reported to Board staff that she did not have high cholesterol.

12. On November 3, 2009, the Board issued a Subpoena Duces Tecum to Craig's Drug Store, Cambridge, Maryland, requesting a "pharmacy run" for all prescriptions filled for the Physician's Assistant between January 1, 2003 and November 3, 2009.

13. On November 9, 2009, the Board received a computer printout from Craig's Drug Store regarding the Physician's Assistant, which indicates that there was a prescription written by Respondent, for the Physician's Assistant for Lipitor 20 mg, 68 tablets, taken twice a day, dated October 8, 2003.

14. Respondent did not evaluate the Physician's Assistant prior to writing a prescription in her name. Respondent did not maintain medical records regarding the Physician's Assistant. Respondent did not document that he wrote the prescription in the name of the Physician's Assistant.

III. Findings of Failure to Maintain Adequate Medical Documentation under §14-404(a)(40)

20. On April 29, 2009, the Board submitted twelve (12) patient records, which were obtained from Respondent by subpoena, to two board-certified physicians, one in family practice and the other in internal medicine, for peer review.

21. On July 28, 2009, the peer reviewers reported their findings to the Board. Out of twelve patient records, the experts agreed that PM, DB, TB, and EB) and that there was inadequate documentation on four patients (Patients PM, DB, TB, and EB).

Patient PM

22. On August 4, 2005, a Physician's Assistant[3] working under Respondent's supervision saw Patient PM (D.O.B. 1952), a summer visitor, for second degree sunburn to both lower extremities from the groin to just below her knees. The Physician's Assistant noted that Patient PM's extremities were bright red with blistering sores. The Physician's Assistant treated Patient PM with Vistaril[4] and an intramuscular (IM) injection of Medrol[5]. Additionally, Silvadene[6] cream was applied under gauze to the burn site. The Physician's Assistant instructed Patient PM to come back in 48 hours if not better or sooner if symptoms worsened. The Physician's Assistant prescribed Darvocet[7] for Patient PM without any description of the presence of pain or the degree of pain.

23. The peer reviewers stated that the documentation in the record was inadequate. The Physician's Assistant, who Respondent supervised, did not document discussion of potential side-effects from IM Medrol, such as delaying healing and increasing the likelihood of infection, did not document whether the patient had itching or was overly anxious as an indication for Vistaril, which has a potential for adverse side effects. Additionally, the Physician's Assistant did not document in the physical examination whether there was any evidence of infection. The Physician's Assistant did

---

[3] This Physician's Assistant is Mr. G, with whom Respondent had a Delegation Agreement in May 2005.

[4] Vistaril is an anti-histamine given to prevent itching.

[5] Medrol is a synthetic corticosteroid drug that acts as an anti-inflammatory.

[6] Silvadene is an anti-bacterial cream used primarily on burns.

[7] Darvocet, a Schedule IV Controlled Substance, is an analgesic in the opioid category. It is given to treat mild pain.

not document or elicit any information about the status of Patient PM's tetanus inoculations, which is important because burns are considered susceptible to tetanus, nor was there any documentation of a description of Patient PM's pain or the pain level. Respondent was responsible for the acts of the Physician's Assistant, whom he supervised.

Patient DB

24. On May 26, 2005, Patient DB (D.O.B. 1983), a summer visitor, presented with laceration of his right third finger caused by a glass bottle. Respondent examined Patient DB and noted that his neuromuscular reflexes were intact and there was good capillary refill. Respondent sutured the wound, applied a splint, and prescribed Keflex 1 gm[8]. Respondent noted on the Patient Discharge Sheet that Patient DB should follow up with his primary care physician in three days for a general check-up.

25. The medical documentation in this record was inadequate in that Respondent should have documented Patient DB's tetanus status.

Patient TB

26. On September 29, 2005, Patient TB (D.O.B. 1935), a local resident, who has a history of hypertension, diabetes, and hyperlipidemia presented to Respondent's office. On physical examination, Respondent noted the presence of a skin tag[9] on Patient TB's neck. Respondent documented a very brief history about the diabetes and hyperlipidemia. Under "impression," Respondent documented that Patient TB had a nevus and coded the visit as "448.1" (nevus.) Under "plan," Respondent documented

[8] Keflex is an antibiotic.

[9] A skin tag is small benign tumor usually located in areas where skin creases (e.g. neck, underarms).

"cryotherapy[10] to skin tag or nevus[11]" and "nevus (skin tag) on neck for twenty (20) years. It interferes when shaving." Additionally, Respondent ordered that Patient TB receive a flu shot. Patient TB was instructed to follow with an office appointment.

27. Respondent did not maintain adequate medical records in this case in that one is unable to determine why Patient TB presented to Respondent because Respondent failed to document the presenting problem. Respondent did not document a history of the skin lesion, other than its presence for twenty years. Respondent did not document a description of the skin lesion, whether there had been any changes in its appearance, whether it appeared benign or not, or any history of skin cancer.

28. Respondent did not document any history of prior treatment, and if Patient TB had received treatment at another office, Respondent failed to include important details of prior medical care. Respondent diagnosed hypertension but did not record a blood pressure.

Patient EB

29. On July 14, 2005, Patient EB (D.O.B. 4/3/35), a summer visitor, presented with diarrhea and dehydration. Respondent documented that Patient EB was dizzy, lightheaded, and weak, had abdominal cramping and felt nauseous. Respondent documented that Patient EB received an IV of normal saline that also contained 2 cc's (200 mL) of Tigan[12] and an additional IV of half-normal saline. Respondent prescribed

[10] Cryotherapy is the use of extreme cold in medical therapy. A common example of cryotherapy is cryosurgery (the application of extreme cold to destroy abnormal or diseased tissue).

[11] A nevus is a congenital pigmented segment of skin (e.g. birth mark, mole, etc.).

[12] Tigan is an anti-emetic used to prevent nausea and/or vomiting.

Lomotil[13] and Bactrim DS[14] for Patient EB and instructed him to follow-up with Respondent's office in one (1) day.

30. Respondent's medical documentation was inadequate in this case. Respondent failed to document a discussion of possible side effects of the medications given, especially Tigan. Respondent failed to document IV fluid rate of Tigan. (Respondent appropriately recorded all of Patient EB's vital signs and documented how long Patient EB was monitored before being discharged.)

Summary of Patients PM, DB, TB and EB in regard to documentation

31. Respondent failed to keep adequate medical documentation in violation of Health Occ. §14-404(a)(40) because:

a. Respondent's medical documentation is cursory, leaving out enough medical detail to be considered inadequate;

b. Respondent's documentation is very difficult to read with some areas that are illegible;

c. Respondent and Respondent's agent, the Physician's Assistant, failed to document the status of Patient PM and Patient DB's tetanus vaccinations, although required because these patients had wounds that warranted a check (sunburn and laceration that broke the skin);

d. Respondent's agent, the Physician's Assistant, failed to document discussion with Patient PM regarding medications used in the treatment and the possible side effects from such use;

e. Respondent failed to document side effects of Tigan given to Patient EB; and

b. Respondent failed to document IV fluid rate for Patient EB.

[13] Lomotil is an anti-diarrheal drug.

[14] Bactrim DS is an anti-biotic often prescribed for "Traveler's Diarrhea."

IV. Summary of Violations

32. Respondent's inappropriate prescribing of drugs for his mother in someone else's name for the purpose of obtaining insurance coverage is evidence of a violation of Health Occ. §14-404(a)(27) (Prescribes for illegal or illegitimate medical purposes).

33. Respondent's prescribing of drugs for illegal or illegitimate medical purposes (i.e. prescribing drugs for his mother in another person's name for the purpose of obtaining insurance coverage) constitutes unprofessional conduct in violation of Health Occ. §14-404(a)(3)(ii) (Is guilty of unprofessional conduct in the practice of medicine).

34. Respondent's inadequately completed medical records, including but not limited to those in paragraph 31 above, constitute a violation of Health Occ. §14-404(a)(40) (Fails to maintain adequate records).

35. Respondent, as supervisor, is responsible for the actions of his agent, the Physician's Assistant, in the treatment of Patient PM, as stated in Health Occ. §15-301(e) (A physician assistant is the agent of the supervising physician in the performance of all practice-related activities, including the oral, written, or electronic ordering of diagnostic, therapeutic, and other medical services).

CONCLUSION OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that Respondent is guilty of unprofessional conduct in the practice of medicine, in violation of H.O. § 14-404(a)(3)(ii); prescribed drugs for illegal or illegitimate medical

purposes in violation of H.O. § 14-404(a)(27); and failed to meet keep adequate medical records in violation of H.O. § 14-404(a)(40).

The Board dismisses the charge of failure to meet standards of quality medical care under H. O. § 14-404(a) (22) and dismisses the language "...sells...gives away, or administers..." in regard to its conclusion that Respondent violated H.O. § 14-404(a) (27).

ORDER

Based on the foregoing Findings of Fact and Conclusion of Law, it is this 2nd day of May, 2011, by a majority of the quorum of the Board considering this case hereby:

ORDERED that Respondent is **REPRIMANDED**, and it is further

ORDERED that Respondent is placed on Probation for a minimum of two (2) years, subject to the following conditions:

1. Within three (3) months of the date of this Order Respondent shall enroll in, and within nine (9) months of the date of this Order, Respondent shall successfully complete, a Board-approved course in medical record keeping;

2. Within five (5) months of the date of this Order, Respondent shall enroll in, and within twelve (12) months of the date of this Order, Respondent shall successfully complete, a Board-approved individual ethics tutorial that focuses on ethical prescribing and the violation such as occurred in this case;

    i. Respondent shall submit to the Board a written paper that has been approved by the ethics tutor, which addresses ethical prescribing and the violation such as occurred in this case;

    ii. Respondent shall authorize the ethics tutor to submit written verification to the Board of completion of the ethics tutorial, which shall include a description of Respondent's participation in the tutorial;

iii. Respondent shall sign a release, authorizing the ethics tutor to communicate with the Board;

3. The above courses shall be in addition to any continuing education requirements mandated for continuing licensure. The continuing education shall not count toward fulfilling continuing education requirements that Respondent must fulfill in order to renew his license to practice medicine;

4. Within one (1) year of the date of this Consent Order, Respondent's practice shall be subject to peer review by an appropriate peer review entity, or a chart review by a Board designee, which will focus on standards of quality care and documentation, to be determined at the discretion of the Board;

5. An unsatisfactory peer review by an appropriate peer review entity, shall be deemed a violation of probation;

6. Respondent shall be responsible for all costs associated with fulfilling the terms and conditions of this Consent Order; and be it further

ORDERED that any violation of the terms or conditions of this Consent Order shall be deemed a violation of this Consent Order; and be it further

ORDERED that if Respondent violates any of the terms and conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which the Board may have imposed in this case under §§ 14-404(a) and 14-405.1 of the Medical Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of probation being proved by a preponderance of the evidence; and be it further

ORDERED that after a minimum of two (2) years from the effective date of this Consent Order, and after the conclusion of a satisfactory peer review, Respondent may

submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated, through an order of the Board or designated Board committee. The Board, or designated Board committee, will grant the termination if Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and be it further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-611 *et seq.* (2009 Repl. Vol.)

5/2/11
Date

John Papavasiliou, Deputy Director
Maryland State Board of Physicians

CONSENT

I, Victor Gong, M.D., License No. D32615, by affixing my signature hereto, acknowledge that:

1. I have consulted with counsel, Richard Bloch, Esquire, and knowingly and voluntarily elected to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.
2. I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 14-405 (2009 Repl. Vol.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol.).

3. I acknowledge the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I am waiving those procedural and substantive protections.

4. I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Charges against me. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

5. I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

4/2/11
Date

Victor Gong, M.D.
Respondent

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Worcester, Maryland

I HEREBY CERTIFY that on this 2 day of April, 2011 before me, a Notary Public of the State and County aforesaid, personally appeared Victor

Gong, M.D, License number D32615, and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Ruby L Spear

Notary Public

My commission expires: 2/2012