

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

**IN RE: FANG S. HORNG, M.D.
 License No.: 0101-023919**

ORDER

In accordance with the provisions of Sections 54.1-105, 54.1-110, 2.2-4020 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), a formal administrative hearing was convened before the Virginia Board of Medicine ("Board"), on October 30, 2009, in Richmond, Virginia, to receive and act upon evidence that Fang S. Horng, M.D., may have violated certain laws governing the practice of medicine and surgery in the Commonwealth of Virginia. These matters are set forth in the Board's Notice of Hearing and Statement of Particulars dated September 25, 2009.

Pursuant to Sections 2.2-4024.F and 54.1-2400(11) of the Code, the hearing was held before a panel of the Board with a member of the Board presiding. Amy Marschean, Senior Assistant Attorney General, was present as legal counsel for the Board. The proceedings were recorded by a certified court reporter. The case was prosecuted by Wayne Halbleib, Assistant Attorney General, assisted by Julia K. Bennett, Adjudication Specialist. Dr. Horng appeared at the formal administrative hearing and was represented by Chester Banks, Esq.

FINDINGS OF FACT

Now, having properly considered the evidence and testimony presented, the Board makes the following findings of fact by clear and convincing evidence:

1. Fang S. Horng, M.D., was issued license number 0101-023919 by the Board to practice medicine and surgery in the Commonwealth of Virginia on December 3, 1973. Said license is currently active and will expire on December 31, 2010, unless renewed or otherwise acted upon.

2. Dr. Horng has a long history of disciplinary action taken against his license by this Board. Specifically, Dr. Horng's Board history includes:

- a. Placement of his license on indefinite probation due to standard of care violations (Consent Order entered November 12, 1993);
- b. A reprimand and imposition of a fine due to boundary violations with a patient (Board Order entered February 16, 2000);
- c. Another reprimand and imposition of terms and conditions on his license due to standard of care violations (Board Order entered December 24, 2003);
- d. The indefinite suspension of his license, with said suspension stayed upon satisfaction of certain terms and conditions, due to standard of care violations (Board Order entered October 31, 2006); and
- e. A prohibition on performing in his office any and all medical or surgical procedures which require the use of conscious or moderate sedation, deep sedation, general anesthesia, and anxiolysis or inhalation agents (Board Order entered November 19, 2008, *nunc pro tunc* September 25, 2008).

In addition, Dr. Horng's medical license in other states has been revoked, suspended or surrendered based on the foregoing Virginia actions.

3. Dr. Horng practiced outside the scope of his medical license and engaged in the unlicensed practice of dentistry when, by his own admission:

a. On or about January 18, 2008, subsequent to having performed an incision and drainage on a left gum abscess in the area of Patient A's molar and premolar teeth on January 11, 2008, Dr. Horng extracted Patient A's left molar and premolar teeth based on his diagnosis of dental caries, cavity, and decay in both teeth.

b. On several occasions, Dr. Horng extracted Patient B's teeth and performed other dental procedures, as set forth below:

i. On or about September 28, 2007, Dr. Horng diagnosed Patient B's left upper canine and premolar teeth with cavities and/or tooth abscess and extracted both teeth.

ii. On or about January 25, 2008, Dr. Horng extracted additional teeth that he determined to be decayed. However, Dr. Horng failed to specify or document the precise teeth that were extracted.

iii. On or about February 4, 2008, Dr. Horng performed a local nerve block to treat Patient B's right lower canine tooth, which had broken off.

iv. From approximately September 2007 to September 2008, Dr. Horng frequently prescribed antibiotics and narcotics to Patient B for treatment of tooth abscesses, dental caries and decay, and broken teeth, without referring her to a dentist for evaluation and treatment.

4. On June 17, 2008, Dr. Horng administered Ceftriaxone (Schedule VI) intravenously to Patient I, and on July 26, 2008, he prescribed Amoxicillin (Schedule VI) to Patient I, notwithstanding the fact that these medications were contraindicated based on Patient I's reported symptoms and documented medication allergies. Further, when Patient I presented to Dr. Horng's office on August 4, 2008, complaining of, among other things, shortness of breath, sweating, and purple lips, he again provided inappropriate treatment to Patient I when he responded by intravenously administering Ceftriaxone to Patient I in his office. During administration of that medication by Dr. Horng, Patient I arrested and subsequently expired.

a. John M. Witherspoon, M.D., M.P.H., Professor of Medicine, Medical College of Virginia, Virginia Commonwealth University, Richmond, board certified in internal medicine, testified as an expert witness on behalf of the Commonwealth. Dr. Witherspoon testified that his review of all of Patient I's records contained in the Commonwealth's record revealed fundamental problems with Dr. Horng's medical care that began from the first visit on March 24, 2008. Given the acuity of the situation, Dr. Horng should have transferred Patient I to the hospital on August 4, 2008. Dr. Witherspoon testified that he believed the probable cause of Patient I's death was anaphylaxis from a medically unnecessary antibiotic administered intravenously in Dr. Horng's office.

b. James T. Rittelmeyer, M.D., Dr. Horng's expert, testified that in his opinion it was inappropriate for Dr. Horng to treat Patient I in his office on August 4, 2008, and that "in retrospect, she should have been [sent to] the emergency room." Even though Dr. Rittelmeyer testified that he did not review all of Patient I's medical records contained in the Commonwealth's records, he stated that in his opinion, Patient I died of aortic stenosis and congestive heart failure.

c. A second expert for Dr. Horng, James Dale, D.O., who had previously treated Patient I, also testified by telephone that Patient I should have been treated in the emergency room on August 4, 2008. He stated his belief that Patient I was misdiagnosed and died from a cardiopulmonary condition. He opined that Dr. Horng's practice poses a threat to his patients. Dr. Dale testified, "His [Dr. Horng's] past experience with corrective action has been very poor. " Dr. Dale testified, "In 2009, Dr. Horng does not provide a vital service to the [Luray] community."

5. On multiple occasions, Dr. Horng prescribed Methadone (Schedule II) to Patients C (from approximately November 2006 to October 2008), D and E (from approximately January to October 2008), F (from approximately January to September 2008), and J (from approximately September to October 2008) for detoxification or "weaning" from opioid addiction, although he is not qualified or registered to dispense narcotic drugs for opioid treatment as required under federal law (Controlled Substances Act of 1970, 21 U.S.C. 801, *et. seq.*) and regulation (21

C.F.R. 1306.04 and 1306.07), which specify that individuals may only receive Methadone as treatment for addiction at a registered narcotic treatment program.

6. Dr. Horng engaged in negligent, dangerous, or harmful conduct in his care and treatment of Patients A-K from approximately 2006 to 2008, including the prescribing of amphetamines, narcotics, and benzodiazepines, as set forth below:

a. Dr. Horng prescribed Adderall to Patients A and D without any diagnosis of a medical condition warranting such medication or based on a diagnosis of ADD or ADHD that was determined without performing an adequate assessment or evaluation and without obtaining an appropriate patient history of symptoms or prior treatment for said condition(s). Dr. Horng testified that he prescribed the Adderall to both patients based on their oral statements that they suffered from ADD or ADHD, but he failed to document symptoms or clinical history justifying these diagnoses.

b. On multiple occasions, Dr. Horng prescribed narcotics and other medications to patients, e.g., Patient B, without performing an adequate physical examination or assessment, including dates when the patient did not present for an office visit.

c. Dr. Horng inadequately documented his rationale for selecting or changing the types or doses of medications prescribed. For example, Dr. Horng noted no reason for adding Methadone to Patient B's narcotic regimen on or about September 28, 2007, nor did he document an explanation for simultaneously prescribing multiple narcotics to Patient B throughout the

treatment period. Further, Dr. Horng did not explain or document a discussion regarding the benefits and risks of such medications with patients.

d. Although Dr. Horng initially prescribed Methadone to Patients C, D, and F for the purpose of narcotic detoxification or weaning, he failed to taper the dosage of Methadone prescribed, and instead actually increased the dosage of Methadone prescribed to these patients over their respective treatment periods. Further, after prescribing Methadone to Patients C, D, E, and F over the course of several months (years in the case of Patient C) for the purpose of narcotic detoxification or weaning, Dr. Horng subsequently changed his rationale for prescribing Methadone to treatment of various chronic pain conditions, notwithstanding the lack of diagnostic testing, appropriate physical examinations or assessments, or other objective information verifying the existence of such chronic pain conditions or a determination of the etiology of such pain.

e. Dr. Horng regularly prescribed narcotics and benzodiazepines to patients without having an adequate medical rationale therefor or diagnosing a medical condition warranting such prescriptions. Further, Dr. Horng did not order or perform adequate diagnostic testing or studies to determine the etiology of patients' reported pain. For example, in the case of Patients B and H:

i. From approximately September 2007 to October 2008, Dr. Horng continuously prescribed narcotics to Patient B based on

diagnoses of chronic pain in the back, hip, knee, legs, and shoulders; osteoarthritis secondary to being overweight; neuralgia; chronic tooth abscesses and decayed teeth; fibromyalgia; ulcer; spondylitis; renal colic; ingrown toenail; and kidney stones. However, Dr. Horng never performed any diagnostic tests or studies or obtained any other objective evidence to verify Patient B's reported pain conditions or to determine the cause of her pain.

ii. On Patient H's first visit on January 23, 2008, Dr. Horng prescribed Percocet (Schedule II) after diagnosing her with h. pylori infection, and subsequently he continuously prescribed narcotics for such varied and non-chronic conditions as headache; dental toothache, gingivitis, caries, and abscess; urinary tract infection; gastritis; carbon monoxide poisoning; and arthritis "all over", conditions for which narcotics were not indicated.

f. Although Dr. Horng regularly prescribed narcotics, he failed to periodically review and monitor the efficacy of treatment, including determining the effect of prescribed medications on patients' activities of daily living.

g. Dr. Horng failed to appropriately monitor and manage Patients A, B, and K's usage of narcotic medications in that he did not perform any urine/serum drug screens to monitor their compliance with his medication regimen during the treatment period. Further, Dr. Horng failed to effectively

monitor Patient C-F's medication usage for compliance with his drug regimen in that urine drug screens he ordered did not screen specifically for the drugs he was prescribing.

h. Dr. Horng prescribed controlled substances to patients whom he was aware had a history of medication noncompliance or substance abuse, including use of illegal drugs, or exhibited drug-seeking behavior or other signs of medication addiction or dependence. For example, in the case of Patients B, G, and K:

i. Dr. Horng failed to note or appropriately respond to signs of Patient B's possible abuse or misuse of prescribed medications, as evidenced by her multiple requests for early refills beginning in approximately October 2007 and continuing to October 2008. Instead, Dr. Horng continued to prescribe narcotic and benzodiazepine medications to Patient B throughout the treatment period.

ii. On or about August 31, 2007, Dr. Horng noted in Patient G's record that no more narcotics would be provided for this patient, but then prescribed her Methadone for reported pain on two occasions on January 4, 2008 and February 19, 2008.

iii. Dr. Horng continued to regularly prescribe narcotics to Patient K after receiving the following information:

A. Records from an ob/gyn clinic visit on June 27, 2008 stating concerns that Patient K exhibited narcotics-seeking

behavior.

B. Records from an ob/gyn clinic visit on July 3, 2008 indicating that Patient K had a history of substance abuse and had previously undergone detox at another local hospital.

C. Records from an ob/gyn clinic visit on August 29, 2008 indicating that the treating physician refused to prescribe any narcotics and stated the patient should not be having postoperative pain severe enough to require pain medications at this point in time.

7. Dr. Horng engaged in negligent, dangerous, or harmful conduct in his care and treatment of Patients E and I with respect to his prescribing of weight loss medications, in that:

a. From approximately July 19, 2008 to October 11, 2008, Dr. Horng prescribed phentermine, a Schedule IV weight loss medication, to Patient E without documenting any medical diagnosis or condition justifying such prescription or otherwise explaining his rationale for prescribing that medication. Further, Dr. Horng did not satisfy the regulatory requirements for prescribing such medication, to include performing necessary laboratory work, e.g., a thyroid function test, prior to initiating treatment; obtaining an interpreted EKG within 90 days of the initial prescribing; and recording and prescribing a diet and exercise program.

b. From approximately March 24, 2008 to July 26, 2008, Dr. Horng prescribed phentermine to Patient I but failed to obtain an EKG performed and interpreted within 90 days of initially prescribing such medication, nor did he prescribe and record a diet and exercise program for weight loss.

8. Dr. Horng failed to properly manage and maintain timely, accurate, legible, and complete records for Patients A-K. For example, he did not document in Patient F's record that he dismissed her from his practice sometime after September 5, 2008, due to her failure to maintain a responsible party to monitor her Methadone consumption nor did he document a physical exam for Patient I on the date of her death, August 4, 2008.

9. Although Dr. Horng informed a Department of Health Professions' Inspector on October 14, 2008 that he had dismissed Patient F from his practice, he failed to provide written notice of such dismissal to the patient allowing her a reasonable time in which to obtain the services of another practitioner. Further, on or about March 7, 2008, Dr. Horng's nurse informed Patient H's husband by telephone that Patient H was dismissed from his practice, but Dr. Horng failed to provide any written notice of such dismissal to the patient.

10. Dr. Horng's Schedule II-V controlled substance records are not complete and accurate in that he failed to indicate whether the biennial inventory dated January 28, 2007 was taken at the open or close of business and failed to note correct quantities of drugs on the inventory. Further, records were not maintained or made available to a Department of Health Professions' Inspector showing the

date of drug receipt, the name and address of the person from whom drugs were received, and the kind and quantity of drugs received for the previous two years.

11. Contrary to the provisions of an Order of the Board entered October 31, 2006 and an Order of the Board entered November 19, 2008, *nunc pro tunc* September 25, 2008, Dr. Horng failed to maintain a course of conduct in his practice commensurate with the requirements of Title 54.1, Chapter 29 of the Code, and all laws of the Commonwealth, as evidenced by the multiple findings set forth above.

12. Dr. Horng stipulated to the facts in paragraphs 3 and 5 above.

13. The Board considered Dr. Horng's long disciplinary history with the Board and notes his demonstrated inability to respond to the Board's prior remedial and educational initiatives. For example, the Board's Order dated October 31, 2006, indicates at Findings of Fact 9 and 10 that Dr. Horng failed to appropriately treat pain management patients or to document patient treatment because of lack of time due to his heavy patient load, yet he persists in inappropriately treating pain management patients and not keeping complete and accurate patient records.

14. The Board heard testimony and reviewed letters that portray Dr. Horng as a caring and compassionate physician and an asset to his community.

CONCLUSIONS OF LAW

1. Finding of Fact No. 3 constitutes a violation of Sections 54.1-111.A (1) and (4) and 54.1-2915.A (3), (13), (16), and (18) of the Code.

2. Finding of Fact No. 4 constitutes a violation of Section 54.1-2915.A (3) and (13) of the Code.

3. Finding of Fact No. 5 constitutes a violation of Section 54.1-2915.A (17) of the Code.

4. Finding of Fact No. 6 constitutes a violation of Sections 54.1-2915.A (3), (13), and (16).

5. Finding of Fact No. 7 constitutes a violation of Section 54.1-2915.A (3), (12), (13), (16), and (18) of the Code, and 18 VAC 85-20-90(B) of the Board of Medicine's General Regulations.

6. Finding of Fact No. 8 constitutes a violation of Section 54.1-2915.A (3), (12), (13), (16), and (18) of the Code, and 18 VAC 85-20-26(C) of the Board of Medicine's General Regulations.

7. Finding of Fact No. 9 constitutes a violation of Section 54.1-2915.A (3), (12), (13), and (18) of the Code, and 18 VAC 85-20-28(B)(2) of the Board of Medicine General Regulations.

8. Finding of Fact No. 10 constitutes a violation of Sections 54.1-2915.A (17) and 54.1-3404 of the Code.

9. Finding of Fact No. 11 constitutes a violation of the Order of the Board entered October 31, 2006 and the Order of the Board entered November 19, 2008, *nunc pro tunc* September 25, 2008.

ORDER

WHEREFORE, based on the Findings of Fact and Conclusions of Law, it is hereby ORDERED that the license of Fang S. Horng, M.D., to practice medicine and surgery in the Commonwealth of Virginia, be, and hereby is, REVOKED.

Should Dr. Horng seek reinstatement of his license, he shall be noticed to appear before the Board, in accordance with the Administrative Process Act. As petitioner, Dr. Horng has the burden of proving his competency and fitness to practice medicine and surgery in the Commonwealth of Virginia in a safe and competent manner.

Pursuant to Section 54.1-2920 of the Code, upon entry of this Order, Dr. Horng shall forthwith give notice, by certified mail, of the suspension of his license to practice medicine and surgery to all patients to whom he is currently providing services. A copy of this notice shall be provided to the Board when sent to patients. Dr. Horng shall cooperate with other practitioners to ensure continuation of treatment in conformity with the wishes of the patient. Dr. Horng shall also notify any hospitals or other facilities where he is currently granted privileges, and any health insurance companies, health insurance administrators or health maintenance organization currently reimbursing him for his services as a physician.

Further, upon entry of this Order, Dr. Horng shall:

1. Return his current license to the Board office;
2. Surrender his Drug Enforcement Administration ("DEA") certificate and DEA 222 Schedule II order forms to the DEA and provide a copy of this surrender notification to the Board;
3. Submit written notification to any and all drug wholesalers or pharmacies that he has ordered from, or had an account with for the past five (5)

years, that he has surrendered his DEA license and request that the account be closed, a copy of which shall be provided to the Board; and

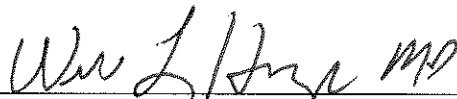
4. Properly dispose of all Schedule II-VI controlled substances, including physician's samples, remaining in his practice.

Upon entry of this Order, the license of Fang S. Horng, M.D., will be recorded as REVOKED and no longer current.

As provided by Rule 2A:2 of the Supreme Court of Virginia, Dr. Horng has thirty (30) days from the date of service (the date he actually received this decision or the date it was mailed to him, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with William L. Harp, M.D., Executive Director, Board of Medicine, at 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233. In the event that this decision is served by mail, three (3) days are added to that period.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD



William L. Harp, M.D.

Executive Director
Virginia Board of Medicine

ENTERED: 11/13/09