STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 05-3156PL
WALTER INKYUN CHOUNG, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Notice was provided and on November 8, 2005, a formal hearing was held in this case. Authority for conducting the hearing is set forth in Sections 120.569 and 120.57(1), Florida Statutes (2005). The hearing location was the Marion County Government Complex, Room 105, 601 Southeast Twenty-fifth Avenue, Ocala, Florida. The hearing was conducted by Charles C. Adams, Administrative Law Judge.

APPEARANCES

For Petitioner: Ephraim D. Livingston
Assistant General Counsel
Department of Health
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For Respondent: Bruce D. Lamb, Esquire
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STATEMENT OF THE ISSUE

Should discipline be imposed against Respondent's medical license for alleged violations of Sections 456.072(1)(aa), and 458.331(1)(p), Florida Statutes (2003)?

PRELIMINARY STATEMENT

On January 31, 2005, by an Administrative Complaint in Department of Health, Petitioner v. Walter Inkyun Choung, M.D., Respondent, Department of Health (DOH) Case No. 2004-11965, Respondent was accused of violating the aforementioned statutes in relation to care provided Patient D.M. In particular the allegations are related to an incision made by Respondent on Patient D.M.'s left knee, when the patient had been scheduled for surgery on the right knee.

On August 31, 2005, Petitioner forwarded the case to Robert S. Cohen, Director of the Division of Administrative Hearings (DOAH), for conduct of a formal hearing pursuant to Respondent's Petition Requesting a Formal Hearing. The case was established as DOAH Case No. 05-3156PL and assigned to the present administrative law judge. A written notice of the hearing date was provided and the hearing proceeded as noticed.

Petitioner requested that official recognition be made of Sections 456.072(1)(aa) and 458.331(1)(p), Florida Statutes (2003), Section 456.073(5), Florida Statutes (2004), and Florida Administrative Code Rule 64B8-8.001. No objection was made to the motion. At the commencement of the hearing official recognition was given to those provisions.

Respondent filed a Motion to Deem Request for Admissions Admitted or, in the Alternative, to Compel Petitioner to Serve Better Responses to Request for Admissions, Motion to Compel Better Responses to Interrogatories, and Motion to Compel Better Responses to Request for Production. At the commencement of the

hearing oral argument was entertained concerning the motions. The motions were denied for reasons explained in the hearing transcript that is submitted with this Recommended Order. This denial was in recognition of opportunities available to the parties in presenting their respective cases without prejudice to their rights.

Consistent with a pre-hearing order the parties prepared a stipulation of facts. That fact stipulation has been incorporated as part of the findings of fact in the Recommended Order.

The parties essentially agree to the facts in this case. The hearing was conducted to allow refinement of those facts, if a party so desired, and to allow establishment of a record for mitigation and aggravation. § 120.569(1), Fla. Stat. (2005).

Petitioner did not call witnesses. Petitioner's Exhibits numbered one through three were admitted. Respondent testified in his own behalf. He called Dr. Alex Villacastin, Dr. R. E. Hari Iyer, and Joyce Brancato as his witnesses. Respondent's Exhibits numbered one through three were admitted.

On December 5, 2005, the hearing transcript was filed. On December 15, 2005, the parties filed proposed recommended orders which have been considered in preparing the Recommended Order.

FINDINGS OF FACT

Stipulated Facts

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this (Administrative) Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME66779.

3. Respondent's address of record is Nature Coast Orthopedics, P.O. Box 640580, Beverly Hills, Florida 34464-0580.

4. Respondent is board-certified in orthopedic surgery.

5. On or about February 25, 2004, Respondent scheduled or had Patient D.M. scheduled for an anterior cruciate ligament (repair of a tear in a ligament), repair of the right knee at Seven Rivers Regional Medical Center in Crystal River, Florida.

6. On or about February 25, 2004, Patient D.M. a 25-year-old male, was prepped for surgery and taken to the operating room.

7. On or about February 25, 2004, Respondent entered the operating room and initiated the surgery with an incision of Patient D.M.'s left knee.

8. On or about February 25, 2004, the intended and/or planned surgical site for Patient D.M., was his right knee.

9. Subsequent to performing the incision to Patient D.M.'s left knee, Respondent realized that he was performing surgery on Patient D.M.'s wrong knee.

10. Respondent applied a steri-strip to Patient D.M.'s left knee subsequent to making an incision on the left knee.

11. Respondent made a skin incision on Patient D.M.'s left knee.

Additional Facts

12. Respondent graduated from medical school in 1989. He was in residency for five years and has been in practice for about

11 years beyond that time. Other than his disciplinary history with the State of Florida, Board of Medicine (the Board of Medicine) he has no disciplinary past with other boards or jurisdictions.

13. Respondent is board-certified by the American Board of Orthopedic Surgery.

14. Respondent has active privileges at Seven Rivers Regional Medical Center (Seven Rivers Regional) and Health South Citrus Service Center, an outpatient facility. Those facilities are located in Crystal River, Florida, and Lancanto, Florida, respectively.

15. Respondent has an office practice that employs 12 staff. They include a receptionist, billing personnel, what is described as back-help, a Physician's Assistant (P.A.) and medical assistants. Respondent supervises the P.A., pursuant to registration with the State of Florida.

16. Respondent takes emergency calls at Seven Rivers Regional, to include pediatric orthopedic calls. Respondent also takes hand calls which are related to injuries in that portion of the anatomy below the shoulders.

17. After an 1998 incident involving a wrong-site surgery for which discipline was imposed by the Board of Medicine on Respondent, discussed in detail later in the facts, Respondent made some changes to his practice in dealing with the problem of wrong-site surgery. This involved the imposition of other checks and balances. One of the changes was referred to as a time-out, promoted by changes in hospital rules at what is now Seven Rivers

Regional and by Respondent's choice. In 1998 the hospital was known as Seven Rivers Hospital. Persons other than Respondent were engaged in the establishment of additional checks and balances to avoid wrong-site surgeries. The risk manager and director of nursing at Seven Rivers Regional were engaged in this process.

18. The time-out related to the cessation of other activities in treating the patient, to confirm the correct surgery site. Before commencing the surgical procedure the limb involved in the procedure would be marked by nursing staff. The nursing staff would then confirm the site, followed by the time-out period shortly after the preparation for surgery. Confirmation would verbally be made with different staff members, documentation was expected to be checked and any image studies checked to confirm the proper site.

19. Generally, following the 1998 incident involving wrong-site surgery by Respondent, Seven Rivers Hospital established rules addressing the problem of wrong-site surgeries. Greater emphasis was made to enforce those rules after the Respondent‘s second incident considered in this case.

20. In the present case it was intended that reconstruction be made of the anterior cruciate ligament of the right knee of Patient D.M., through arthroscopic reconstruction.

21. The patient in the present case was seen in Respondent's office prior to surgery. The expectation was that the office staff would confer with the staff at Seven Rivers Regional concerning the type of procedure to be performed, to be followed

later by orders from the Respondent that were faxed to the operating room staff at Seven Rivers Regional. Those orders would describe the limb involved in the surgery.

22. In the present case the circulating nurse, together with the surgical technician were involved with preparing the limb for surgery, applying antiseptic solution and draping the patient's limb. Those persons are hospital employees. Prior to surgery, the wrong limb was marked by the nursing staff and the draping took place in the operating room. Patient D.M. underwent general anesthesia prior to the surgery. Before the procedure commenced in the present case, Respondent asked the nurse in the operating room if the correct limb had been prepared and the response was in the affirmative. Respondent started the procedure. The only means of confirmation by Respondent at that point was by verbal communication between the circulating nurse and Respondent. Respondent realized that he was ultimately responsible to make certain that the surgery was performed at the correct site.

23. In the present case Respondent took an 11 blade and made a slight incision. He noticed that the video-screen which was normally placed on the opposite side of the intended limb to be examined, was on the same side as the limb that had been prepared for examination. As Respondent made the incision he was uncomfortable with that setting. He turned to the circulating nurse and asked if he could see the patient's chart. By review of the chart he discovered that he had made an incision on the wrong knee, that had been draped and prepared for examination. The incision was about a quarter-inch in size and the surgical knife

had been placed about a half-inch into the skin. In this case no second incision was made as would be normal for this type of surgery. Having discovered his error Respondent placed surgical tape across the incision he had made and the draping was broken down from the unintended site and a new draping placed on the intended site. After these changes surgery was performed on the proper knee.

24. Respondent did not consult with any family member before proceeding to perform surgery on the appropriate knee, having addressed the wrong knee in the beginning. The family was informed after the procedure was completed. The patient was informed of the mistake after awakening from anesthesia.

25. The Respondent made entries into the medical record concerning the incident in the present case.

26. After the surgery in the present case Respondent followed-up the patient at his office. No complications were experienced by the patient in either site, the wrong knee or the proper knee. The initial visit involving Patient D.M. took place on February 17, 2004, and the surgery was performed on February 25, 2004. The last scheduled appointment at Respondent's office was August 26, 2004, but Patient D.M. declined that appointment having returned to work, after expressing his view that to come to Respondent's office was an imposition.

27. Respondent made the risk manager and director of nursing aware of the error in the treatment of Patient D.M. The incident was reviewed by the hospital. No action was taken against

Respondent's privileges to practice at Seven Rivers Regional as a result of the incident.

28. Following the present incident Respondent has varied his approach. The changes are to involve more people in the time-out period than before the present incident. This includes the anesthesia staff, surgical technician, circulating nurse, and Respondent. Resort is now made to the surgical consent record and any imaging studies that were performed to confirm that the proper site is addressed in the surgery.

29. Prior to the present incident Respondent did not follow a practice of taking the patient's chart with him to the surgery. He depended on orders that had been sent by fax and hard copies following the transmittal of the initial fax to the hospital, to create the basis for surgical site identification by others.

30. In the present case the doctor's orders forwarded to Seven Rivers Regional made clear that the arthroscopy was to be performed on the right knee. The comment section to the pre-operative patient care flow sheet refers to the right knee as the limb to be addressed by the arthroscopy. Likewise the special consent to operation or other procedures refers to the right knee. The anesthesia questionnaire involved with Patient D.M. refers to the right knee, in relation to the procedure in the arthroscopy. All are appropriate references to the location of the site for surgery.

31. Joyce Brancato is the CEO of Seven Rivers Regional. She identified that there are four orthopedic surgeons who practice at the hospital. All four, including Respondent, attend adult cases.

Three including Respondent, treat hand calls, and a like number respond to pediatric cases, to include Respondent.

32. If Respondent were suspended it would mean that at certain times during the month patients would have to be diverted or transferred from Seven Rivers Regional to another hospital. There would be an influence on inpatient orthopedic care, in that Respondent provides 63 percent of inpatient surgical care at the facility. In particular, patients who present at the emergency room needing hip repair or fracture repair would be inconvenienced.

33. If Respondent were placed on probation, he would not be allowed to supervise his P.A., who in turn could not see patients that the P.A. follows. No other doctor is available in the practice to supervise the P.A.

34. If Respondent were suspended, services would not be provided through his clinic leaving the patients to seek care elsewhere.

35. Additionally, Respondent is the sole orthopedic physician, to his knowledge, who admits Medicare patients to Seven Rivers Regional.

36. As a result of the present incident Respondent received no pecuniary benefit or self-gain.

37. None of the allegations in the Administrative Complaint involve controlled substance violations.

Prior Discipline

38. In relation to a prior disciplinary case against Respondent, that incident took place at Seven Rivers Hospital, now

Seven Rivers Regional. The surgery in the prior case took place in 1998. It also involved a wrong-site surgery.

39. As Respondent explained at the November 8, 2005 hearing, the prior case involved a female patient scheduled for a knee arthroscopy. The surgical site identification protocol involved at the time was to have the nursing staff prepare the patient for the surgery. As a consequence, when the Respondent entered the operating room the unintended knee had been draped. Respondent confirmed the surgery site by conferring with a nurse in attendance and starting the procedure. Incisions were made to examine the knee, the wrong knee, the incisions were about a quarter of an inch in length, one for the camera to view the site and one for the surgical instruments used to address the underlying pathology. When the wrong knee was examined following the incisions, Respondent did not find the pathology that he expected given the patient's prior history and physical examination that had been conducted. Other than the incisions being made in the wrong knee, there were no other consequences in the way of impacts to the patient's health.

40. In the prior case in which the wrong knee had been prepped by staff, Respondent recognizes that he as the surgeon was responsible to ensure that surgery commenced on the correct knee.

41. In the prior case, after realizing that he had commenced surgery on the wrong knee, Respondent stopped the procedure, he went to the waiting area and spoke to the patient's husband and explained the circumstances and absent any objection indicated

that he intended to proceed with the case involving the correct knee.

42. Before the correct knee could be addressed, there was a delay associated with the breaking down the sterile field on the incorrect knee and starting the process anew to address the correct knee.

43. After conversing with the husband Respondent returned to the operating room and performed surgery on the correct knee.

44. During the pendency of these events the patient was anesthetized. When the patient recovered from the anesthesia Respondent explained what had occurred.

45. The expected pathology was discovered in the proper knee and addressed and the patient satisfactorily recovered from surgery without complications.

46. In the prior case, Respondent made a record indicating that he had initiated the surgery in the wrong site.

47. All requirements incumbent upon Respondent in view of the terms of the Consent Order entered in the prior case, DOH Case No. 98-16838 were met by Respondent.

CONCLUSIONS OF LAW

48. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding in accordance with Sections 120.569, 120.57(1), and 456.073, Florida Statutes (2005).

49. The parties by their agreement and stipulation of facts have removed disputes over issues of material fact. § 120.569(1), Fla. Stat. (2005).

50. Through this arrangement the hearing was designed to create a record that would form the basis for establishing appropriate punishment for Respondent consistent with Chapters 456 and 458, Florida Statutes (2003), and Florida Administrative Code Chapter 64B8, and under the guidance set forth in final orders by the Board of Medicine in cases similar to the present case. Nonetheless, clear and convincing evidence was presented to establish violations of Section 456.072(1)(aa), Florida Statutes (2003), which creates a ground for discipline under Count I for:

> Performing or attempting to perform health care service . . . a wrong-site procedure . . . that is medically unnecessary . . .

This was in relation to surgery for Patient D.M.

51. Additionally, clear and convincing evidence was established to show a violation, in Count II of Section 458.331(1)(p), Florida Statutes (2003), which subjects Respondent to discipline for:

> Performing professional services which have not been duly authorized by the patient . . .

Again this violation was in relation to surgery on the wrong knee of Patient D.M.

52. The record established clear and convincing evidence in accordance with the decisions in Department of Banking and Finance Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996) and Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987). The term clear and convincing evidence is explained in the case In re: Davey, 645 So. 2d 398 (Fla. 1994), quoting, with approval from Slomowitz v. Walker, 429 So. 2d 797 (Fla. 4th DCA 1983).

53. Respondent's argument in the conclusion of law to the proposed recommended order that Section 456.072(1)(aa), Florida Statutes (2003), is unconstitutional on its face is an argument not subject to consideration in this forum. See Department of Revenue v. Young American Builders, 330 So. 2d 864 (Fla. 1st DCA 1976) and Key Haven Associated Enterprises, Inc., v. Board of Trustees of Internal Improvement Trust Fund, et. al, 427 So. 2d 153 (Fla. 1982).

54. Respondent's argument in relation to Section 458.331(1)(p), Florida Statutes (2003), to the effect that Patient D.M. authorized knee surgery and Respondent acted accordingly, in that even though the surgery began on the wrong knee, that there was still necessary authorization, is not an appropriate reading of the disciplinary statute. Patient D.M. expected surgery to be performed on his right knee, not his left knee. Authority was provided for the right knee, not the left knee. When Respondent began surgery on the left knee, he acted without authority from Patient D.M.

55. In the proposed recommended order by Respondent, argument is offered about the alleged non-compliance by the Department of Health with the requirements in Section 120.53(1), Florida Statutes (2005), for maintaining a subject matter index of all its final orders. As explained in the hearing transcript in relation to motions filed before the final hearing, whatever the practical problems experienced by Respondent in obtaining access to final orders, ultimately Respondent did not suffer prejudice in preparing for the final hearing, having gained access to final

orders of the Board of Medicine concerning wrong patients, wrong-sites, wrong procedures, etc. Likewise Respondent has not shown prejudice in the preparation for and presentation at the final hearing by any failure by the Department of Health, through its web-site to maintain a summary of final orders it issued after July 1, 2001, as required by Section 456.081, Florida Statutes (2005), given Respondent's efforts and success at discovering Board of Medicine final orders dealing with similar subject matter to that in this case.

56. Section 456.079(2), Florida Statutes (2005), sets the requirement for disciplinary guidelines of the Board of Medicine in imposing punishment, where it states:

> The disciplinary guidelines shall specify a meaningful range of designated penalties based upon the severity and repetition of specific offenses . . . and that such penalties be consistently applied by the Board.

57. The Board of Medicine does have disciplinary guidelines set forth in Florida Administrative Code Chapter 64B8, and access to the final orders introduced at hearing allows a comparison of punishment in prior cases, under their facts, to the present record to establish appropriate punishment here.

58. The parties were encouraged to cite and discuss final orders by the Board of Medicine in their proposed recommended orders. Respondent took advantage of that opportunity. Petitioner did not.

59. Sections 456.072(2) and 458.331(2), Florida Statutes (2003), establish basic guidance for imposition of punishment. Florida Administrative Code Chapter 64B8 offers more specific

guidance in terms of the administration of punishment.

60. The range of suggested penalties under Florida Administrative Code Rule 64B8-8.001, pertaining to Section 456.072(1)(aa), Florida Statutes (2003), is from a $5,000.00 to $10,000.00 administrative fine, and suspension to revocation. That rule establishes a range of punishment in relation to Section 458.331(1)(p), Florida Statutes (2003), from probation to revocation and an administrative fine of $5,000.00-$10,000.00.

61. In considering the appropriate punishment, Florida Administrative Code Rule 64B8-8.001(3) establishes aggravating and mitigating circumstances. They are as follows:

> (a) Exposure of patient or public to injury or potential injury, physical or otherwise: none, slight, severe, or death;
>
> (b) Legal status at the time of the offense: no restraints, or legal constraints;
>
> (c) The number of counts or separate offenses established;
>
> (d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;
>
> (e) The disciplinary history of the applicant or licensee in any jurisdiction and the length of practice;
>
> (f) Pecuniary benefit or self-gain inuring to the applicant or licensee;
>
> (g) The involvement in any violation of Section 458.331, F.S., of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure.
>
> (h) Where a licensee has been charged with violating the standard of care pursuant to

Section 458.331(1)(t), F.S., but the licensee, who is also the records owner pursuant to Section 456.057(1), F.S., fails to keep and/or produce the medical records.

(i) Any other relevant mitigating factors.

62. Under Florida Administrative Code Rule 64B8-8.001(3), dealing with mitigation and aggravation, the nature of the injury to D.M. was slight; no restraints or constraints were in place against Respondent; there are two counts but one incident involving lack of authorization and conduct of a wrong-site surgery; this was a second offense of the same type; the first disciplinary event comparable in its terms led to a $5,000.00 administrative fine, attendance at five hours of Continuing Medical Education in risk management and a letter of concern from the Board of Medicine; Respondent on this occasion derived no pecuniary benefit or self gain; this case did not involve controlled substances; this was not a standard of care violation under Section 458.331(1)(t), Florida Statutes; and Respondent has acted cooperatively beginning with the discovery of his mistake and continuing through the final hearing itself. On the other hand, there was no meaningful improvement in Respondent's approach to patient identification at Seven Rivers Regional between 1998 and 2004. A pause, a time-out from undertaking surgical procedures to allow discussion among the physician and staff without resort by Respondent to documentation identifying the proper surgical site immediately prior to or in the surgical setting, leads to the conclusion that there was no meaningful difference between the circumstances in the first incident and the second incident when attempting to limit this form of error in

identifying the surgery site. It was only after the second incident that Respondent personally established a useful approach to identifying the surgical site.

63. Respondent also refers to Florida Administrative Code Rule 64B8-8.007, which describes the inability of a physician on probation to act in a supervisory capacity for a P.A. This would be a hardship for Respondent's P.A. should probation be imposed. But that reality is not the focus of this proceeding.

64. Section 456.072(4), Florida Statutes (2003) calls for the assessment of costs related to the investigation and prosecution of this case as part of the process.

65. Being mindful of the disciplinary parameters established by statute and the guidance provided by rule, as well as the final orders cited by Respondent in the proposed recommended order, and based upon the findings of fact and legal conclusion that Respondent has violated those provisions within Counts I and II to the Administrative Complaint, it is

RECOMMENDED:

That a final order be entered finding Respondent in violation of Sections 456.072(1)(aa) and 458.331(p), Florida Statutes (2003), and for these violations that Respondent be placed on a period of probation for one year with indirect supervision; perform 100 hours of community service to be completed during the probation; be required to undergo quality assurance consultation and review of practice methods by a qualified risk manager, to

establish necessary changes to avoid a third wrong-site surgery; make payment of an administrative fine in the amount of $10,000.00; provide payment of costs of the investigation and prosecution of this case and be required to present a one-hour lecture to peers at a facility where he practices on the perils of wrong-site surgery and how to avoid them.

DONE AND ENTERED this 20th day of January, 2006, in Tallahassee, Leon County, Florida.

CHARLES C. ADAMS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 20th day of January, 2006.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.