COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2024-011

In the Matter of

YOUNG HO OH, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Young Ho Oh (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusion of law and impose the sanction set forth below in resolution of investigative Docket No. 19-309.

Findings of Fact

1. The Respondent graduated from New York University School of Medicine in 1995. He is certified by the American Board of Medical Specialties in Orthopedic Surgery and Orthopedic Sports Medicine. He has been licensed to practice medicine in Massachusetts under certificate number 205013 since February 2001. He is also licensed to practice medicine in California and New York. He has privileges at Harrington Memorial Hospital.

2. Patient A was an G.L. c. 4, § 7(26)(c) woman, active and living independently, when she went to the Respondent on G.L. c. 4, § 7(26)(c) 2013 for treatment G.L. c. 4, § 7(26)(c) pain.

3. On G.L. c. 4, § 7(26)(c) 2014, the Respondent performed a G.L. c. 4, § 7(26)(c) on Patient A at G.L. c. 4, § 7(26)(c) Hospital (G.L. c. 4, § 7(26)(c)).

4. During the procedure, the Respondent noted bleeding from Patient A's G.L. c. 4, § 7(26)(c) G.L. c. 4, § 7(26)(c)

5. Patient A lost 1000 cc of blood during the surgery, for which she received transfusions of two units of blood during the procedure.

6. At the conclusion of the procedure, the Respondent noted there was no significant bleeding and "the field appeared sufficiently dry." Patient A was transferred to the PACU at 7:57 p.m.

7. The PACU nurse assessed Patient A's right foot for pulses, finding them, and as a result of the finding, the Respondent did not perform his own vascular examination of Patient A while she was in the PACU.

8. Post-operative progress notes state Patient A experienced groin swelling and an increased output from the surgical drain.

9. Post-operatively, Patient A continued to experience bleeding.

10. Patient A was transferred to the ICU for closer observation.

11. Patient A received additional units of blood after her surgery.

12. At about 12:25 a.m. on April 9, 2014, the ICU nurse reported to the Respondent Patient A's right foot was pale and cold and did not have pulses. No imaging was ordered.

13. At 2:01 a.m. April 9, 2014, the Respondent noted that Patient A had no pulses in her right foot, no capillary refill, and no motor function. The Respondent called a vascular surgeon on call at UMass Medical Center (UMass) who recommended continued resuscitation

and close observation. At that time, the Respondent ordered a PVR (Pulse Volume Recording) test, but no imaging.

14. According to ICU notes, Patient A continued to experience lack of sensation, pulses, or capillary refill in her right leg, consistent with nerve injury.

15. The Respondent ordered a CT scan for Patient A, the results of which were available at 10:28 a.m. on April 9, 2014, stating there was evidence of a significant hematoma in Patient A's right hip and thigh.

16. The Respondent did not order a CT angiogram, as that test was not available at HMH.

17. The Respondent's final progress note at 5:46 p.m. on April 9, 2014, states "PT LOOKS GREAT," despite signs that the blood flow to Patient A right leg was significantly impaired.

18. The Respondent further noted Patient A was going to be transferred to a tertiary care center for vascular evaluation, but stated "STILL LESS THAN 24 HRS SINCE SURGERY – THEREFORE I FEEL HAS A GOOD PROGNOSIS RE: RLE PERFUSION."

19. At about 6:40 p.m. on April 9, 2014, Patient A was transferred to UMass's Vascular Surgery service.

20. By 9:48 p.m. on April 9, 2014, the UMass Vascular Surgery service had obtained a STAT CT-angiogram, which showed a complete blockage of the femoral artery and lack of blood flow in the leg consistent with clotting in the vessels. The vascular service noted Patient A's right leg had a lack of pulses, her foot was cool, pale, and severely mottled and Patient A had lack of sensation below her right knee.

21. At the time of the vascular surgeon's assessment, he deemed a portion of the limb was not salvageable due to lack of blood flow.

22. On April 11, 2014, the UMass Vascular Surgery service operated on Patient A, removing the blood clots from her femoral artery, repairing the artery, and performing an above the knee amputation of her right leg.

23. The Respondent's treatment of Patient A was negligent in the following respects:

a. He failed to recognize the lack of blood flow to Patient A's right leg in a timely manner;

b. He failed to recognize Patient A's bleeding during surgery, higher than normal blood loss, and difficulty obtaining hemostasis (stopping the loss of blood), were suggestive of vascular injury to her right leg;

c. He failed to personally perform a vascular or neurological examination of Patient A while she was in the recovery room.

24. The Respondent's treatment of Patient A resulted in Patient A requiring an above the knee amputation.

Conclusion of Law

The Respondent has violated 243 CMR 1.03(5)(a)17 by committing malpractice within the meaning of M.G.L. c. 112, § 61.

Sanction and Order

The Respondent's license is hereby REPRIMANDED. The Respondent is ORDERED to complete five additional continuing medical education (CME) credits focused on orthopedic surgical complications and five additional CME credits focused on appropriate documentation.

Documentation verifying the completion of the CMEs is due within 90 (ninety) days of ratification of this Consent Order.

Execution of this Consent Order

Complaint Counsel and the Respondent agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel, the Respondent, and the Respondent's counsel are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that he may have resulting from the Board's acceptance of this Consent Order.

The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement

Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated in the year following the date of imposition of this reprimand. The Respondent is further directed to certify to the Board within ten (10) days that the Respondent has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

Young Ho Oh, M.D.
Licensee

2/28/2024
Date

Jennifer A. Rymarski, Esq.
Attorney for the Licensee

02/28/2024
Date

Karen A. Robinson, Esq.
Complaint Counsel

2/28/2024
Date

So ORDERED by the Board of Registration in Medicine this 29th day of February, 2024.

Booker T. Bush, M.D.
Board Chair