COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss.

Board of Registration in Medicine
Adjudicatory Case No. 2021-004

In the Matter of

RICHARD CHOI, M.D.

CONSENT ORDER

Pursuant to G.L. c. 30A, § 10, Richard Choi, M.D. (the "Respondent") and the Board of Registration in Medicine (the "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 conclusions of law and impose the sanction set forth below in resolution of investigative Docket No. 18-112.

FINDINGS OF FACT

Biographical Information

1. The Respondent was born on December 3, 1969. He graduated from the University of Medicine and Dentistry in Edison, New Jersey in 1995. He has been licensed to practice medicine in Massachusetts under certificate number 209648 since May 9, 2001. He is also licensed to practice medicine in New Hampshire.

The February 26, 2016 Incident

2. On or around the morning of February 26, 2016, the Respondent was performing a surgery in an operating room ("OR") in Lawrence General Hospital ("Lawrence General") with

other OR staff, including but not limited to a Certified Registered Nurse Anesthetist ("CRNA") Trainee from Northeastern University ("CRNA 1").

3. At some point during the surgery described in the preceding paragraph, CRNA 1, believing that a temperature adjustment was necessary to comply with pertinent protocol at Lawrence General, used the thermostat in the OR to raise the temperature in the room.

4. The Respondent grew angry with CRNA 1 because the latter adjusted the temperature in the OR as described in the preceding paragraph without first consulting him.

5. Following the surgery described in ¶¶ 2-3, above, the Respondent contacted another physician at Lawrence General who was familiar with CRNA 1 ("Physician A") and instructed the latter to remove CRNA 1 from the OR.

6. Based on the Respondent's instruction as described in the preceding paragraph, Physician A permitted CRNA 1 to leave Lawrence General for the remainder of February 26, 2016.

7. After Physician A permitted CRNA 1 to leave Lawrence General as described in the preceding paragraph and at or around 1:30 pm on that same day, the Respondent approached Physician A at a nurse's station in the Post-Anesthesia Care Unit (the "PACU") and yelled and cursed about CRNA 1's behavior in the OR that day, as described in ¶ 3, above.

8. The Respondent also threw a water bottle onto the ground during his interaction with Physician A as described in the preceding paragraph.

9. At least one (1) patient observed the Respondent's behavior at the nurse's station in the PACU on February 26, 2016 and Physician A felt very uncomfortable with the Respondent's conduct at that time.

The December 22, 2017 Incident

10. On December 22, 2017, members of the Lawrence General administration ("Lawrence General Administration") grew concerned over the Respondent's approach to addressing two (2) sets of parents of two (2) child-patients that the Respondent had operated on that day at Lawrence General and that required longer-than-normal stays in the PACU.

11. As a result of the concerns described in ¶ 10, above, Lawrence General Administration met with the Respondent in a dictation room behind the PACU after the Respondent addressed the first set of parents to discuss his approach to meeting the second set of parents.

12. The Respondent left the aforementioned meeting in the PACU dictation room abruptly, walking around a member of Lawrence General Administration that was then addressing him in order to do so.

13. Following the meeting in the PACU dictation room as described in ¶¶ 11-12, above, the Respondent went to speak with the second set of parents.

14. The Respondent addressed both sets of parents brusquely and unprofessionally when he spoke to them on December 22, 2017.

15. Later in the day on December 22, 2017, the Respondent mocked Physician A, who worked with him on both of the child-patient cases referenced in ¶ 10, above, to OR staff.

16. On January 5, 2018, as a result of his conduct on December 22, 2017 as described in ¶¶ 10-15, above, the Respondent's privileges at Lawrence General were involuntarily suspended for a period to last no longer than thirty (30) days.

17. On February 1, 2018, the Respondent's privileges at Lawrence General were reinstated after he met with Lawrence General Administration and agreed to certain terms for his return to work.

The May 11, 2018 Incident

18. At or around 7:15 am on May 11, 2018, the Respondent approached Physician B in the surgery department of Lawrence General to ask who was assigned to his OR that day.

19. Physician B, who was "running the board" for the surgery department in Lawrence General that day, informed the Respondent that Physician A and CRNA 1 were both assigned to the Respondent's OR.

20. As of May 11, 2018, CRNA 1 had not worked with the Respondent since the February 26, 2016 Incident, described above.

21. Upon learning that Physician A and CRNA 1 were both assigned to his OR, the Respondent became angry and asked Physician B, "Why are you doing this to me? Why are you trying to screw me over?"

22. The Respondent proceeded to loudly vocalize his grievances about that day's OR assignments to Physician B for approximately five (5) minutes, during which time he also stated to Physician B: "I hate this fucking place."

23. Multiple patients situated in cubicles in the general area of the Respondent and Patient B overheard some or all of their interaction as described in ¶¶ 18-22, above.

24. Later in the day on May 11, 2018, the Respondent requested and was granted a Leave of Absence from Lawrence General for a minimum of six (6) weeks in order to further address his behavior.

CONCLUSIONS OF LAW

A. The Respondent has engaged in conduct that undermines the public confidence in the integrity of the medical profession. *See Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982); and *Sugarman v. Board of Registration in Medicine*, 422 Mass. 338 (1996); and

B. The Respondent has violated a rule or regulation of the Board, to wit:

a. Board Policy 01-01 – Disruptive Physician Behavior (adopted June 13, 2001).

Sanction and Order

The Respondent's license is hereby reprimanded. This sanction is imposed for each violation of law listed in the Conclusion section and not a combination of any or all of them.

Execution of this Consent Order

Complaint Counsel, the Respondent, and the Respondent's counsel 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.

Richard Choi, M.D.
Licensee

10/26/20
Date

James Bello, Esq.

10/30/20
Date

Lawrence Perchick
Complaint Counsel

11/4/20
Date

So ORDERED by the Board of Registration in Medicine this 11th day of February, 2021.

George M. Abraham, M.D.
Board Chair