# WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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### STATE OF WISCONSIN BEFORE THE MEDICAL EXAMINING BOARD

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IN THE MATTER OF THE LICENSE OF

FINAL DECISION AND ORDER FOR REMEDIAL EDUCATION

DAVID D. KIM, M.D., RESPONDENT.

ORDER 0001495

Division of Enforcement Case #09 MED 122

The parties to this action for the purposes of Wis. Stat. § 227.53, are:

David D. Kim, MD 245 E. Falcon Hill Way Green Bay, WI 54302

Wisconsin Medical Examining Board P.O. Box 8935 Madison, WI 53708-8935

Department of Safety and Professional Services Division of Enforcement P.O. Box 8935 Madison, WI 53708-8935

#### PROCEDURAL HISTORY

An informal settlement conference was held in this matter on March 21, 2011. Pursuant to the recommendation of the committee, the parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

## **FINDINGS OF FACT**

- 1. Respondent David Dou-Ouk Kim (dob 9/10/1963) is and was at all times relevant to the facts set forth herein a physician and surgeon licensed in the State of Wisconsin pursuant to license # 32318, first granted on 7/1/1991. Respondent is an ophthalmologist, and is certified by the American Board of Ophthalmology.
- 2. On January 6, 2003, Respondent performed cataract extraction on the left eye of Patient B. Phacoemulsification was used to dissolve the nucleus. Instrumentation was then use to suction the cortical material out of the capsule. As the residual cortical material was being removed from the capsular bag, there was a surge in vacuum and the entire capsular bag was

caught up in the vacuum, resulting in a tear and in some hemorrhaging. This is a recognized complication in the procedure. As a result of the capsular bag being torn, Respondent placed the intraocular lens in the anterior chamber of the left eye; Respondent inadvertently inverted the lens during placement.

- 3. Notwithstanding the complication in the procedure described above, Respondent charted: "There was a surge in the vacuum and the entire capsular bag came with the surge. A limited anterior vitrectomy was done. Viscoelastic material was then added. A Alcon 16.5 was then placed in the anterior capsule. The residual viscoelastic material was then removed from the anterior chamber using the automated I/A. The wound was then checked for leakage and found to be water tight. 10.0 nylon patch and shield was applied. Overall, the patient tolerated the procedure well, and **the procedure went without complication**." [Emphasis supplied.]
- 4. Respondent did not chart any hemorrhaging in his operative note. Respondent's office note of January 7, 2003 states: "She also had unfortunately an incident where an AC IOL had to be placed secondary to hemorrhage. It looks fine at this point in time."
- 5. From January until May 2003, Respondent continued to follow the patient through the course of her recovery. The patient's vision improved, although the patient had complaints of distortion and visual acuity problems in the left eye which Respondent felt was consistent with typical postoperative inflammation from the surgery, particularly in light of the tear of the capsular bag. At no time did Respondent recognize that he had inverted the lens.
- 6. Respondent represented to the informal settlement conference committee that he has taken steps to prevent the inadvertent inversion of placement of an intraocular lens in the future, by adding a stop-and-check during every such procedure.

#### **CONCLUSION OF LAW**

The Wisconsin Medical Examining Board has jurisdiction to act in this matter pursuant to Wis. Stat. § 448.02(3), and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5). This order does not constitute a disciplinary action.

### **ORDER**

NOW, THEREFORE, IT IS HEREBY ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED, that David D. Kim, M.D., shall, no later than December 31, 2012, demonstrate satisfactory completion of one of the following, or a substantially equivalent course which has been preapproved by the Board or its designee:

"Intensive Course in Medical Record Keeping with Individual Preceptorships" offered by the Case Western University School of Medicine; or

"Medical Record Keeping Course" offered by the University of California at San Diego, School of Medicine, Physician Assessment and Clinical Education Program; or

"Patient Care Documentation Seminar" including the Personalized Implementation Program, offered by the Center for Personalized Education for Physicians, Denver, Colorado.

IT IS FURTHER ORDERED, that Respondent shall pay the COSTS of investigating and prosecuting this matter of \$2,250, within 90 days of this Order.

IT IS FURTHER ORDERED, that pursuant to Wis. Stats. §§ 227.51(3) and 448.02(4), violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may impose additional conditions and requirements for a violation of any of the terms of this Order after reasonable notice and an opportunity to be heard. In the event Respondent fails to timely submit payment of the costs or fails to comply with the ordered continuing education as set forth above, the Respondent's license may, in the discretion of the board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has paid the costs and completed the continuing education.

Dated this April 18, 2012.

WISCONSIN MEDICAL EXAMINING BOARD

by:

a member of the Board

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