IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
v.	)	**Case No. 10-04-3977**
FRANK ALLEN ZIMBA, M.D., LICENSE NO. 27269,	)	
Defendant.	)	

COMPLAINT

COMES NOW the Plaintiff, the State of Oklahoma ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Elizabeth A. Scott, Assistant Attorney General, and for its Complaint against the Defendant, Frank Allen Zimba, M.D., alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §480 *et seq.*

2. Defendant, Frank Allen Zimba, M.D., holds Oklahoma license no. 27269.

PATIENT AM-WRONG SITE SURGERY NEW YORK

3. On or about November 14, 2006, Patient AM authorized Defendant to perform a **Right** L2-3 Decompression and Discectomy. Instead, Defendant inappropriately performed a **Left** L2-3 Decompression and Discectomy.

4. The day after the surgery, Defendant realized that he had operated on the wrong side. He then notified the patient and the hospital administration. A review by the hospital revealed that the timeout was inadequate and that Defendant had not pre-marked the side on which he was to operate.

PATIENT BM-WRONG SITE SURGERY
NEW YORK

5. On or about March 19, 2007, Patient BM authorized Defendant to perform a **Left Side** L5-S1 Discectomy. Instead, Defendant inappropriately performed a **Right Side** L5-S1 Discectomy.

6. Immediately after the surgery, Defendant realized he had operated on the wrong side so he then correctly performed the Left Side L5-S1 Discectomy.

7. After completing the surgery on both the incorrect side and the correct side, Defendant reported his mistake to the hospital. However, **he did not report the wrong site surgery to the patient.**

PRIOR DISCIPLINARY ACTION

8. As a result of these two (2) wrong site surgeries, the New York State Board for Professional Medical Conduct initiated disciplinary action on Defendant's New York medical license. On or about August 2, 2008, Defendant executed a Consent Agreement and Order whereby he plead guilty to "Negligence on More Than One Occasion". As a result of Defendant's guilty plea, on or about September 4, 2008, he was Reprimanded, placed on Probation for one (1) year, and ordered to pay a $5,000.00 fine.

9. Based upon the disciplinary action in New York, on or about January 27, 2009, the Pennsylvania State Board of Medicine took disciplinary action on Defendant's Pennsylvania medical license. Defendant was Reprimanded, placed on Probation coterminous with his New York Probation, and was ordered to pay a $2,500.00 fine.

10. Based upon the disciplinary action in New York, on or about May 20, 2009, the Michigan State Board of Medicine took disciplinary action on Defendant's Michigan medical license. Defendant was ordered to pay a fine of $500.00.

CURRENT ALLEGATIONS OF UNPROFESSIONAL CONDUCT

PATIENT RSJ-WRONG SITE SURGERY
OKLAHOMA

11. On or about September 17, 2009, Defendant appeared before the Oklahoma State Board of Medical Licensure and Supervision in support of his application for an Oklahoma medical license. Defendant testified about his malpractice history, as well as his prior disciplinary action. After the full hearing, the Board granted Defendant's request for an Oklahoma medical license.

12. On or about February 12, 2010, Patient RSJ authorized Defendant to perform a **Single Level Right L5-S1** minimal transforaminal lumbar interbody fusion and pedicle screw fixation. Patient RSJ understood the plan and signed the Consent Form. Patient RSJ was in the United States Army and was referred to Defendant by Reynolds Army Community Hospital. The surgery was to be performed at Southwestern Medical Center in Lawton, Oklahoma.

13. Instead of performing the planned surgery on the **Right L5-S1 level**, Defendant mistakenly performed the procedure at the wrong level, the **Right L4-5 level.**

14. Before completing the surgery, Defendant recognized that he had mistakenly performed the procedure at the wrong level. He then proceeded to immediately perform the surgery at the correct level, the **Right L5-S1 level.**

15. After having performed the surgery at the correct level as well as the incorrect level, Defendant met with the patient's wife. Defendant did not tell the patient's wife about the fact that he had initially performed surgery at the incorrect level, but instead, lied to her and told her that he had to fuse an additional level because it was damaged. Defendant also met with the patient's mother. He did not tell the patient's mother about the fact that he had performed surgery at the incorrect level, but instead, lied to her and told her that he had trouble getting the screw in and that he had to do additional surgery because the screw would not go in.

16. The Operative Report prepared by Defendant does **not** reflect the fact that Defendant performed the surgery at the wrong level, but instead, just reports that a two (2) level surgery was performed.

17. Based upon the facts set forth in Defendant's Operative Report, the United States Army was billed for a two (2) level surgery.

18. On or about July 28, 2010, Board staff interviewed Defendant. At that time, Defendant admitted that he had performed surgery on Patient RSJ at the wrong level. Defendant additionally admitted that he had not been truthful with the patient or the patient's family about why he performed surgery at two (2) levels rather than one (1).

19. On or about August 2, 2010, Southwestern Medical Center learned through Board staff that it had billed the United States Army for Defendant's wrong site surgery. When hospital administrators learned this, they immediately notified the Army and corrected the bill and took off the charges for the wrong level surgery.

20. On or about August 9, 2010, Patient RSJ picked up his medical records from Defendant. He then telephoned Defendant and asked him what happened during this surgery. At this time, Defendant told the patient the truth for the first time, that he had operated at the wrong level and did not realize it until it was too late.

21. Defendant is guilty of unprofessional conduct in that he:

A. Engaged in conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. §509(8) and OAC 435:10-7-4(11).

B. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509(13) and OAC 435:10-7-4(39).

C. Obtained any fee by fraud, deceit, or misrepresentation, including fees from Medicare, Medicaid, or insurance in violation of OAC 435:10-7-4(28).

D. Engaged in gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4(15).

E. Abused the physician's position of trust by fraudulent representation in the doctor-patient relationship surgery in violation of OAC 435:10-7-4(44).

F. Used a false, fraudulent, or deceptive statement in any document connected with the practice of medicine and surgery in violation of OAC 435:10-7-4(19).

G. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment and medical necessity of treatment in violation of 59 O.S. §509(18) and of OAC 435:10-7-4(41).

Conclusion

WHEREFORE, the Plaintiff respectfully requests that the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by

law, up to and including suspension or revocation and any other appropriate action with respect to Defendant's medical license, and an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

Elizabeth A. Scott (OBA #12470)
Assistant Attorney General
State of Oklahoma
5104 N. Francis, Suite C
Oklahoma City, OK 73118
Attorney for the Plaintiff