IN THE MATTER OF

HEIN NGUYEN, M.D.

Respondent.

BEFORE THE

MARYLAND STATE

BOARD OF PHYSICIANS

License Number D57210

Case Number 2015-0632B

FINAL DECISION AND ORDER

INTRODUCTION

On January 20, 2016, Hein Nguyen, M.D., a general surgeon, was charged under the Maryland Medical Practice Act ("Act") with professional incompetence, failure to meet appropriate standards for the delivery of quality medical care, and failure to keep adequate medical records. See Md. Code Ann., Health Occ. ("Health Occ.") §§ 14-404(a)(4), (22), (40). The charges concerned two wrong site surgeries performed by Dr. Nguyen.

On May 17, 2016, the case was forwarded to the Office of Administrative Hearings ("OAH") for an evidentiary hearing and a proposed decision. A two-day hearing was held before an Administrative Law Judge ("ALJ") at OAH. At the hearing, the State presented testimony from Jason C. Roland, M.D., who was qualified as an expert in general and minimally invasive surgery. Dr. Nguyen testified on his own behalf and presented testimony from Paul P. Lin, M.D., FACS, who was qualified as an expert in general surgery, and two character witnesses.

On November 21, 2016, the ALJ issued a proposed decision concluding that Dr. Nguyen failed to meet appropriate standards for the delivery of quality medical care, in violation of Health Occ. § 14-404(a)(22) and failed to keep adequate medical records, in violation of Health Occ. § 14-404(a)(40). The ALJ did not find that Dr. Nguyen was professionally, physically, or mentally incompetent, in violation of Health Occ. § 14-404(a)(4). Accordingly, the ALJ

1 In this decision, standards for the delivery of quality medical care and standard of care are used interchangeably.
proposed that the charges for failure to meet appropriate standards for the delivery of quality medical care and failure to keep adequate medical records be upheld and recommended the charge for professional, physical, or mental incompetence be dismissed. The ALJ recommended that the Board reprimand Dr. Nguyen and require him to take a course in medical record keeping if the Board did not feel that the coursework he already completed was sufficient.

On December 13, 2016, the State filed exceptions to the ALJ’s proposed decision, and Dr. Nguyen filed a response to the State’s exceptions. On March 8, 2017, both parties appeared before Disciplinary Panel A (“Panel A”) of the Maryland State Board of Physicians (“Board”) for an oral exceptions hearing.

FINDINGS OF FACT

Panel A adopts the ALJ’s proposed findings of fact 1 - 95. See ALJ proposed decision, attached as Exhibit 1. These facts are incorporated by reference into the body of this document as if set forth in full. Neither party filed exceptions to any of the factual findings and the factual findings were proved by a preponderance of the evidence. The Panel also adopts the ALJ’s discussion set forth on pages 19-45.

This case concerns two surgeries performed by Dr. Nguyen at a Maryland Hospital. The first surgery was performed on January 9, 2015. On the day of the surgery, Dr. Nguyen met with Patient A, obtained informed consent from Patient A for a right inguinal hernia repair with mesh, and marked the patient’s right side with a pen to designate that she was scheduled for surgery on her right side. The patient was then brought into the operating room. Dr. Nguyen testified that he observed a bulge on the patient’s left side and prepped the left side of the patient for surgery. Before the surgery began, two time-outs were called and in each time-out the procedure was announced as a right-side inguinal hernia repair. Dr. Nguyen, however, completed the surgery
for the left inguinal hernia repair, instead of the right side, as scheduled. Dr. Nguyen did not
document a bulge on the left side or any other indication necessitating performing a hernia repair
on the left side.

Following the surgery, the patient was transferred to the recovery room and Dr. Nguyen
went to transcribe his operating note. At that time, Dr. Nguyen realized that he had performed
the surgery on the wrong side. Dr. Nguyen alerted the hospital staff, informed the patient’s
family, and told the patient what had happened when she awoke from the anesthesia. Thereafter,
the patient elected to have Dr. Nguyen proceed with the right inguinal hernia repair. Later the
same day, Dr. Nguyen performed the surgery on the right side and successfully repaired the
hernia.

The second patient, Patient B, was referred to Dr. Nguyen by a urologist for a right
adrenal mass and a thyroid nodule in the right lobe of the thyroid. Patient B was scheduled for
surgery on January 28, 2015. Dr. Nguyen met with the patient prior to the surgery and obtained
informed consent for the right thyroid lobectomy and adrenalectomy. He did not obtain informed
consent for the removal of Patient B’s kidney or any other organ. Dr. Nguyen first performed the
right thyroid lobectomy and took a frozen section for pathology analysis. The pathology report
came back negative for cancer, so Dr. Nguyen left the remainder of the thyroid gland intact and
proceeded to perform the adrenalectomy.

During the adrenalectomy, Dr. Nguyen encountered a six-inch abdominal wall of fat,
which contained the adrenal gland, adrenal mass, and the kidney. Dr. Nguyen attempted to
separate the kidney from the adrenal gland, but was unable to do so because the tissues were
stuck together. Dr. Nguyen then inserted a GelPort, which allowed him to put his hand into the
abdominal cavity, and, again, tried to separate the mass from the kidney. Dr. Nguyen felt what he
thought was the adrenal gland, but he was unable to dissect the mass from the kidney. Due to his concern that the mass might be cancerous, Dr. Nguyen ultimately decided to remove what he suspected was the adrenal mass and the kidney. Dr. Nguyen did not obtain informed consent from the patient or the patient’s family before removing the kidney. The pathology report conducted following the surgery revealed that Dr. Nguyen removed a benign kidney and abundant fat, which contained a segment of the ureter, but that he did not remove the adrenal mass, as intended.

Dr. Nguyen saw Patient B for a two-week follow up visit at which time he recommended a second surgery to remove the adrenal gland. Dr. Nguyen gave the patient the option to have another surgeon perform the procedure, but the patient elected for Dr. Nguyen to perform the surgery. On April 22, 2015, Patient B returned to Dr. Nguyen for a second surgery where Dr. Nguyen planned to perform an open right adrenalectomy and removal of the gallbladder. For the second surgery, Dr. Nguyen asked another general surgeon to assist in the procedure. Dr. Nguyen removed the gallbladder without incident and removed a mass, which both surgeons thought was the adrenal mass. Dr. Nguyen then sent the mass to pathology for analysis to confirm that the mass removed was in fact the adrenal mass.

The pathologist reported a distinctly lobulated lesion measuring 6.5 x 4.5 centimeters, which appeared to be different from the surrounding tissue. The pathology report, however conclusively determined that there was no evidence of any adrenal tissue in the mass that was submitted for analysis. At the conclusion of both surgeries, the right adrenal gland had not been removed.

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2 The patient also had symptoms of gallstones, which were confirmed by an ultrasound. (T. 346.) The patient elected to have his gallbladder removed during the second surgery. (T. 346.)
On March 17, 2015, the Board received a mandated 10-Day Report from the hospital notifying the Board that Dr. Nguyen agreed to a voluntary suspension while a formal investigation was completed by the Medical Executive Committee. The Board initiated an investigation, and, as a result of the Board’s investigation, charges were issued. The proceedings in this case stemmed from the Board’s charges which were issued on January 20, 2016.

**UNDISPUTED ISSUES**

Before addressing the exceptions filed by the State, the Panel notes that neither party filed exceptions pertaining to the findings of the ALJ with respect to the surgery performed on Patient A. The ALJ found that the facts were undisputed and Dr. Nguyen admitted that he performed surgery on the wrong side and that his record-keeping was deficient. The Panel adopts the ALJ’s undisputed findings of facts, conclusions of law, and discussion related to the wrong-side surgery that Dr. Nguyen performed on Patient A.

There were also no exceptions filed with respect to the ALJ’s findings that Dr. Nguyen failed to meet the standard of care when he did not obtain informed consent for the removal of Patient B’s kidney prior to the January 28, 2015 surgery and did not keep adequate medical records with respect to the pre-operative assessment of Patient B prior to the January 28, 2015 surgery. The Panel adopts the ALJ’s undisputed findings of facts, conclusions of law, and discussion related to the standard of care and record keeping violations that the ALJ found for Patient B.

**EXCEPTIONS**

In its exceptions, the State requests that the Panel reject the ALJ’s findings that Dr. Nguyen’s failure to remove Patient B’s right adrenal gland and the removal of Patient B’s healthy right kidney did not constitute professional incompetence or a failure to meet appropriate
standards for the delivery of quality medical and surgical care. It is undisputed that the goal of Patient B’s surgery was to remove a 5.5 centimeter mass attached to the adrenal gland. Dr. Roland, the State’s expert, testified that Dr. Nguyen failed to meet the standard of care because he intended to remove the adrenal gland and failed to do so. Dr. Roland also opined that Dr. Nguyen was professionally incompetent because he did not demonstrate that he could effectively remove an adrenal gland. Dr. Lin testified on behalf of Dr. Nguyen and explained that while the removal of the adrenal gland was the intended procedure, it was only the working premise and that the actual goal of the surgery was to remove the mass that was identified on the preoperative studies. Accordingly, Dr. Lin opined that Dr. Nguyen did not violate the standard of care by failing to remove the adrenal gland mass. The ALJ agreed with Dr. Lin that the failure to remove the adrenal gland mass was not a violation of the standard of care nor indicative of professional incompetence. The Panel agrees.

The State also argues that Dr. Nguyen was professionally incompetent and violated the standard of care when he removed Patient B’s healthy right kidney without a justifiable basis to do so. The State argues that Dr. Nguyen could have, but did not take frozen sections of the mass to confirm his suspicions of cancer, consulted with another surgeon, or stopped the surgery to refer the procedure to another surgeon in lieu of removing the patient’s healthy kidney. Dr. Nguyen testified that he removed the kidney because he suspected that the mass could be cancerous and he was unable to dissect the kidney from the mass. In Dr. Roland’s opinion, there was insufficient indication of cancer to justify the removal of the kidney. The ALJ found that the removal of the kidney under these circumstances was reasonable because it was necessary to remove the mass and the kidney was adherent to the mass. The ALJ concluded that even though there was no malignancy or adrenal tissue removed, it was still reasonable for Dr. Nguyen to
remove the kidney based on the information available to him at the time of the procedure. The Panel agrees with the ALJ that the removal of Patient B’s kidney under the circumstances presented in this case did not violate the standard of care or rise to the level of professional incompetence.

Finally, the State argues that the ALJ should have found that Dr. Nguyen failed to keep adequate medical records when he erroneously represented in his operative note that he removed the adrenal gland when he did not. Dr. Nguyen admitted that his documentation for Patient B could have been better, and the medical record keeping violation with respect to the preoperative assessment is undisputed. While there were certainly deficiencies in Dr. Nguyen’s record keeping, the Panel does not find that the description of removing the adrenal gland constituted a failure to keep adequate medical records because this is the procedure that Dr. Nguyen thought he performed at the time of the surgery.

CONCLUSIONS OF LAW

The Panel concludes that Dr. Nguyen failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care for Patients A and B, in violation of Health Occ. § 14-404(a)(22), and failed to keep adequate medical records for Patients A and B, in violation of Health Occ. § 14-404(a)(40). The Panel does not find that Dr. Nguyen was professionally, physically, or mentally incompetent. Accordingly, the charge of professional, physical, or mental incompetence, Health Occ. § 14-404(a)(4), is dismissed.

SANCTION

The State takes exception to the ALJ’s proposed sanction of a reprimand and a course in medical record keeping and requests that the Panel impose a reprimand and probation for a minimum of two years with conditions to include a course in medical recordkeeping, a Panel-
approved supervisor, and a peer or chart review. The State’s recommended sanction, which included supervision, was based, in part, on the State’s contention that Dr. Nguyen was professionally incompetent to practice surgery. The Panel, however, dismissed that charge.

Dr. Nguyen requests that the Panel adopt the ALJ’s proposed sanction of a reprimand. The Panel agrees that a reprimand is appropriate in this case, but also believes that Dr. Nguyen would benefit from taking a Board-approved course in medical record keeping. Accordingly, the Panel will impose a period of probation for the length of time that it takes Dr. Nguyen to complete a Board-approved course in medical record keeping.

ORDER

It is, on the affirmative vote of a majority of the quorum of Board Disciplinary Panel A, hereby

ORDERED that Hien Nguyen, M.D. is REPRIMANDED; and it is further

ORDERED that Dr. Nguyen is placed on PROBATION\(^3\) until he has complied with the following terms and conditions:

1. Dr. Nguyen shall successfully complete a Board disciplinary panel-approved course in medical record keeping. The course may not be used to fulfill the continuing medical education credits required for license renewal;

2. Dr. Nguyen shall be responsible for submitting written documentation to the Board of his successful completion of the course; and

3. Dr. Nguyen shall comply with the Maryland Medical Practice Act, Md. Code Ann., Health Occ. §§ 14-101—14-702, and all laws and regulations governing the practice of medicine in Maryland; and it is further

\(^3\) If Dr. Nguyen’s license expires while he is on probation, the probationary period and any probationary conditions will be tolled.
ORDERED that, after Dr. Nguyen has successfully completed the Board-approved medical record keeping course, presented documentation to the Board, and if there are no pending complaints related to the charges, Panel A or the Board will administratively terminate the probation. The administrative termination of probation will be issued through an order of Panel A or the Board; and it is further

ORDERED that if Panel A or the Board determines, after notice and an opportunity for a hearing before an Administrative Law Judge of the Office of Administrative Hearings if there is a genuine dispute as to a material fact or a show cause hearing before Panel A or the Board if there is no genuine dispute as to a material fact, that Dr. Nguyen has failed to comply with any term or condition of probation or this Order, Panel A or the Board may reprimand Dr. Nguyen, place Dr. Nguyen on probation with appropriate terms and conditions, or suspend or revoke Dr. Nguyen’s license to practice medicine in Maryland. Panel A or the Board may, in addition to one or more of the sanctions set forth above, impose a civil monetary fine upon Dr. Nguyen; and it is further

ORDERED that Dr. Nguyen is responsible for all costs incurred in fulfilling the terms and conditions of this final order; and it is further

ORDERED that this final order is a PUBLIC DOCUMENT.