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BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF NEVADA

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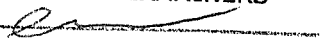
In the Matter of Charges and )  
Complaint Against )  
MARK HOEPFNER, M.D., )  
Respondent. )

Case No. 16-8164-1

FILED

JAN 27 2016

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

By: 

COMPLAINT

The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Mark Hoepfner, M.D. (Respondent), a licensed physician in Nevada. After investigating this matter, the IC has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act).

The IC alleges the following facts:

1. Respondent is currently licensed in active status (License No. 5680), and has been so licensed by the Board since July 1, 1988, and, at all times alleged herein, Respondent was licensed in an active status by the Board pursuant to the provisions of the Medical Practice Act.

2. Previous to the preparation of this Complaint, the Board solicited the services of an independent medical expert (IME) to review the medical records of Patient A and render an opinion regarding whether Respondent failed to perform to the standard of care and treatment, which could constitute malpractice under the Medical Practice Act.

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<sup>1</sup> The Investigative Committee of the Nevada State Board of Medical Examiners was composed of Board members Beverly A. Neyland, M.D., Bashir Chowdhry, M.D., and Ms. Sandy Peltyn.

1           3.       Patient A, a female, at the time of the events at issue, and, her true identity is not  
2 disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon  
3 Respondent along with a copy of this Complaint.

4           4.       On or about December 31, 2011, Patient A, a resident of Michigan, while visiting  
5 Las Vegas, Nevada and intending to stay until March 2012, was admitted into the emergency  
6 department (ED) with severe abdominal pain on her right side. A CT scan revealed an appendix  
7 of 12mm diameter and suggested appendicitis. Respondent noted that Patient A had abdominal  
8 pain, on-going diabetes and morbid obesity. Additionally, Respondent concluded that Patient A  
9 had probable mild, early acute appendicitis. Patient did not recall whether her appendix had been  
10 previously removed.

11           5.       On or about January 1, 2012, Respondent proceeded with an emergency  
12 laparoscopic appendectomy, and removed what he believed to be Patient A's remaining appendix,  
13 which Respondent measured at 5.2 x 1.3 x 0.3 cm.

14           6.       On or about January 2, 2012, Patient A was discharged in an improved and  
15 essentially pain-free condition. Respondent did not prescribe any antibiotics.

16           7.       On or about January 3, 2012, lab results returned indicating that "[t]here was no  
17 gross evidence of an appendix" in the specimen.

18           8.       On or about January 4, 2012, Respondent learned of the pathology findings.

19           9.       On or about January 5, 2012, after receiving the written pathology report,  
20 Respondent contacted and explained the pathology results to Patient A as what may have been  
21 evidence of stump appendicitis from a prior appendectomy or a disintegrated appendix at the time of  
22 surgery. Patient A reported to Respondent that she felt well, was eating fine and had no infection.  
23 Respondent directed Patient A to follow up with her primary care physician when she returned to  
24 Michigan.

25           10.      On or about March 28, 2012, Patient A underwent an appendectomy in Michigan  
26 after the hospital learned from the pathology report that Patient A's appendix was not removed.  
27 The structure obtained measured 7.5 x 1.0 x 0.9 cm.

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1           11.     In response to the Board’s inquiry, Respondent indicated that, at the time he operated,  
2 Patient A’s anatomy was relatively indiscernible and compromised due to Patient A’s past operations.  
3 Respondent removed what was discerned to be the appendix based on context, knowledge of past  
4 known and unknown abdominal procedures and diagnostic tests of this CT and ultrasound.

5           12.     The IME concluded that Respondent missed Patient A’s appendix during the  
6 appendectomy, and failed to properly notify Patient A about the significance of the pathology  
7 report. Accordingly, by taking Patient A to the operating room, Respondent had an obligation to  
8 take Patient A’s appendix out.

9           13.     The IME believes what Respondent found during the surgery was inconsistent with  
10 what the radiologist described in the CT scan (a 12 mm diameter appendix). If Respondent could  
11 not identify the appendix laparoscopically—which happened—then Respondent had an obligation  
12 to use the open technique to find the appendix. Importantly, Respondent was notified after the  
13 surgery that the specimen he collected from the surgery was not the appendix. However,  
14 Respondent did not conduct a follow-up physical examination of the patient, a repeat CT scan, or  
15 offer Patient A, a repeat surgery.

16           14.     The IME concluded that Respondent committed malpractice “for failing to treat  
17 this patient using [the] responsible care, skill, and knowledge that would be used under similar  
18 circumstances” because the evidence clearly shows that Respondent: i) failed to remove Patient  
19 A’s appendix; ii) did not perform a post operative visit; and iii) when Respondent was notified by  
20 the pathology report that the specimen he collected was not the appendix, Respondent should have  
21 taken immediate steps to notify Patient A, have another CT scan, or even conduct another surgery.

22           15.     The IME believed that this case represented a case of radiological, surgical and  
23 pathological discordance, because the Respondent was responsible for treating Patient A’s  
24 medical issue. By not treating Patient A with the reasonable care, skill, or and knowledge that  
25 would ordinarily be used under similar circumstances for appendicitis, Respondent committed  
26 medical malpractice.

27           16.     The IME believed that Respondent, knowing that Patient A was returning to  
28 Michigan, should have attempted to communicate with Patient A’s care provider, including

1 providing a letter explaining the events that occurred under Respondent's care and that the  
2 appendix was not removed.

3 17. Based upon the foregoing, the IC charges Respondent with the following violations  
4 of the Medical Practice Act.

5 **COUNT I**

6 **(Malpractice - NRS 630.301(4))**

7 18. All of the allegations in the above paragraphs are hereby incorporated as if fully set  
8 forth herein.

9 19. NRS 630.301(4) provides that malpractice, as defined in NAC 630.040, means the  
10 failure of a physician, in treating a patient, to use the reasonable care, skill or knowledge  
11 ordinarily used under similar circumstances, is grounds for discipline.

12 20. As demonstrated by, but not limited to, the above-outlined facts, Respondent  
13 committed malpractice in the course of providing care and treatment to Patient A when he: i)  
14 failed to remove Patient A's appendix; ii) did not perform a post operative visit; and iii) when  
15 Respondent was notified by the pathology report that the specimen he collected was not the  
16 appendix, Respondent failed to take immediate steps to notify Patient A, to have another CT scan,  
17 or even conduct another surgery.

18 21. By reason of the foregoing, Respondent is subject to discipline by the Board as  
19 provided in NRS 630.352.

20 **WHEREFORE**, the Investigative Committee prays:

21 1. That the Board give Respondent notice of the charges herein against him and give  
22 him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2)  
23 within twenty (20) days of service of the Complaint;

24 2. That the Board set a time and place for a formal hearing after holding an  
25 Early Case Conference pursuant to NRS 630.339(3);

26 3. That the Board determine the sanctions it will impose if it finds Respondent  
27 violated the Medical Practice Act;

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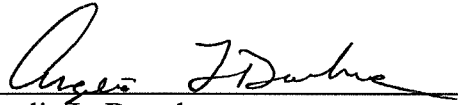


**CERTIFICATE OF MAILING**

1  
2 I hereby certify that I am employed by Nevada State Board of Medical Examiners and that  
3 on 27<sup>th</sup> day of January 2016; I served a file stamp copy of the COMPLAINT, PATIENT  
4 DESIGNATION & Fingerprint information, via USPS e-certified return receipt mail to the  
5 following:

6 Mark Hoepfner, M.D.  
7 c/o Robert C. McBride, Esq.  
8 Carroll, Kelly, Trotter, Franzen, McKenna & Peabody  
9 8329 W. Sunset Rd., Ste. 260  
Las Vegas, NV 89113

10 Dated this 27<sup>th</sup> day of January, 2016.

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13 Angelia L. Donohoe  
14 Legal Assistant  
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