OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against ROBERT BIEN, M.D., Respondent.	**Case No. 16-9727-1**

FILED
JUL 26 2016
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Robert Bien, 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. 5658), and has been so licensed by the Board since July 1, 1988. 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. All medical records of the patients (A & B) treated by Respondent were provided by Respondent pursuant to a Board Subpoena.

3. Previous to the preparation of this Complaint, the Board solicited the services of an independent medical expert (IME) to review the medical records of Patients A & B and render an opinion regarding whether Respondent, through his acts and omissions, violated the Medical Practice Act.

[1] The Investigative Committee of the Nevada State Board of Medical Examiners composed of Board members Beverly A Neyland, M.D., Rachakonda D. Prabhu, M.D., and Sandy Peltyn.

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Patient A

4. On or about September 1, 2011, Patient A presented to Respondent complaining of severe chronic pain secondary to multiple medical conditions, including seven (7) failed back surgeries. Patient A had an Intrathecal (IT) drug delivery system, originally placed in 2000, and this was replaced in March of 2011. This pump had originally provided Patient A with pain control, yet after the replacement, Patient A's pain become much more uncontrollable. Respondent investigated the Pump with a rotor and dye study and a break in the catheter was found. An IT pump revision was indicated given these findings

5. On or about September 2, 2011, Patient A complained of right leg and axial spine pain, but was able to ambulate with a walker to the procedure. The pump revision procedure was complicated by inadvertent placement of the catheter needle into the spinal cord. This procedure was aborted and Patient A was transferred to the hospital for evaluation. Patient A was found to have a new onset left leg numbness and weakness. MRI findings were consistent with a thoracic spinal cord injury. Patient A continued to have paraplegia and was eventually sent to a rehabilitation hospital, where she was unable to ambulate at all and was wheelchair-bound from that point on and she passed approximately one year later, around September 3, 2012.

6. On or about September 2, 2011, Respondent did not have any intraoperative images available for Patient A. Respondent, during all past and similar procedures, attached fluoroscopic images, except for Patient A's specific procedure. Patient A experienced a significant spinal cord injury from the catheter needle. This procedure is typically performed by advancing a catheter needle in the lumbar region to avoid spinal cord contact/injury. There is no documentation as to why Respondent placed the catheter in the thoracic region when it could have been placed easily in the lumbar region and no documentation indicating where exactly Respondent placed the catheter needle in Patient A's back.

7. On or about April 25, 2015, the Board's IME opined that Respondent performed sub-standard care by not clearly documenting the reasons for placing a thoracic intrathecal catheter and not saving any intraoperative imaging results for the medical record, and, thus committed malpractice.

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Patient B

8. On or about December 2011, Patient B presented to Respondent with a new vertebral compression fracture secondary to severe osteoporosis and was eager to have a vertebroplasty procedure repeated. Respondent had taken care of Patient B with significant comorbid medical conditions for years and had performed the verteboplasty procedure on the patient several times previously with positive outcomes.

9. On or about January 6, 2012, Patient B, who was ambulatory with a walker and had previously documented neurological examinations that did not show any focal lower extremity weakness, underwent a T5 vertebroplasty, which generally requires a neurological examination, and Respondent's procedure notes state that the aforementioned procedure was uncomplicated and that there was no evidence of bone cement extravasation and the plan was to follow-up with Patient B in two (2) weeks. No documentation was provided that Respondent saw Patient B prior to her discharge. Pursuant to the nursing records, Patient B arrived in post-anesthesia recovery with a non-functioning IV and in extreme pain, "crying & yelling," hypertensive (215/120), and was given two doses of Demerol and three dosages of Labetalol while in the recovery room. After three hours in the recovery room, Patient B was discharged by wheelchair, unable to ambulate with a walker, and the discharge instructions did not give advice regarding what to do if there was new neurological deficit.

10. On or about January 9, 2012, Patient B communicated with Respondent's office (POD #3) and was instructed to go to an emergency room for her complaints. On the CT examination, Patient B was found to have bone cement in the spinal canal, which caused new profound numbness and weakness in her lower extremity.

11. On or about January 11, 2012, Patient B underwent decompressive thoracic laminectomy surgery as she had suffered a serious spinal cord injury.

12. On or about January 2013, Patient B was deceased.

13. On or about April 25, 2015, the Board's IME opined that Patient B's hypertension and pain could have been the first signs of a spinal cord injury. In that situation, a neurological exam would be important to perform before allowing Patient B to leave the facility, and if an

exam had been performed by Respondent, then he may have noticed that his patient had a focal neurological deficit and investigated it further with imaging and neurosurgical consultation. It is possible that an early decompression may have avoided this injury, and, thus Respondent committed malpractice with regard to Patient B's care.

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

COUNT I

(NRS 630.3062(1): Failure to Maintain Proper Medical Records - Patient A)

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

16. NRS 630.3062(1) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is an act, among others, that constitutes grounds for initiating disciplinary action.

17. As demonstrated by, but not limited to, the above-outlined facts, Respondent violated NRS 630.3062(1) when he failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient A, who received thoracic intrathecal catheter treatment from the Respondent, who did not save any intraoperative imaging results for the medical record.

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

COUNT II

(NRS 630.301(4) Malpractice - Patient A)

19. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

20. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

21. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

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22. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he placed a thoracic intrathecal catheter in Patient A's spine.

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

COUNT III

(NRS 630.301(4) Malpractice - Patient B))

24. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

25. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

26. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

27. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he failed to performed any post-operative neurological examination of Patient B's spine.

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

WHEREFORE, the Investigative Committee prays:

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

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

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

4. That the Board make, issue and serve upon the Respondent, in writing, its findings of fact, conclusions of law and order, which shall include the sanctions imposed; and

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5. That the Board take such other and further action as may be just and proper in these premises.

DATED this 26 day of July, 2016.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Robert Kilroy, Esq.
General Counsel for the Board
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Beverly A. Neyland, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that she is the Chairwoman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against Respondent herein; that she has read the foregoing Complaint; and based upon information discovered during the course of the investigation into a complaint against Respondent, she believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

Dated this 26th day of July, 2016.

Beverly A. Neyland, M.D.

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 27th day of July 2016; I served a file stamp copy of the COMPLAINT & copy of the Patient Designation along with fingerprint information, by mailing via USPS e-certified return receipt mail to the following:

Robert Bien, M.D.
7050 Smoke Ranch Rd., Ste. 130
Las Vegas, NV 89128

Dated this 27th day of July, 2016.

Angelia L. Donohoe
Legal Assistant

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