OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **CHARLES BRIAN KIM, M.D., Respondent.**	**Case No. 23-40843-1**

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Charles Brian Kim, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 14791). Respondent was originally licensed by the Board on May 15, 2013.

2. Patient A[2] was a seventy-one (71) year-old male at the time of the events at issue.

3. On March 26, 2019, Patient A presented to Respondent for an initial visit. Respondent noted that Patient A had a left inguinal hernia. Patient A agreed to have Respondent perform a robotically assisted left inguinal hernia repair (hereinafter referred to as "the surgery").

4. On May 20, 2019, Respondent performed the surgery on Patient A. At this time, Respondent was aware that Patient A was a Jehovah's Witness and that pursuant to his religious

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Carl N. Williams, Jr., M.D., and Col. Eric D. Wade, USAF (Ret.).

[2] Patient A's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

convictions, Patient A did not want to have a blood transfusion under any circumstances prior to starting the procedure.

5. During the surgery on May 20, 2019, while Respondent was operating the robotic device, Patient A suffered a through-and-through injury to his abdominal aorta. The punctures in Patient A's aorta caused substantial bleeding. Patient A's blood pressure dropped precipitously, indicating hypotension.

6. Respondent's operating notes do not indicate that Respondent noticed a major expanding hematoma in Patient A's abdomen area at this time. Respondent's operating notes also do not indicate any problems with the robotic entry into Patient A's abdomen.

7. After discovery of Patient A's hypotension, an accompanying anesthesiologist then inserted an arterial line and a central line into Patient A, gave fluids to Patient A, and performed a Transesophageal Echocardiogram (TEE) to evaluate Patient A's heart.

8. Respondent did not perform an immediate laparotomy and instead first performed a diagnostic laparoscopy. Respondent reintroduced a camera into Patient A's abdomen, but Respondent did not discern any reason for Patient A's hypotension.

9. Patient A continued to decompensate, leading Respondent to consider a vascular injury. Respondent left the operating room and discussed the situation with Patient A's wife. Patient A's wife refused to have blood products given to Patient A, due to Patient A's Jehovah's Witness affiliation.

10. Respondent and a vascular-trained colleague returned to the operating room. Respondent and his colleague performed an exploratory laparotomy, which revealed the two (2) punctures in Patient A's abdominal aorta. Respondent repaired the injury to Patient A's abdominal aorta. Patient A was then brought to the ICU. Due to the significant loss of blood, Patient A's condition deteriorated quickly after entering the ICU, and Patient A died on May 20, 2019.

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COUNT I

NRS 630.301(4) - Malpractice

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

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

13. 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."

14. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A on May 20, 2019, by not timely observing Patient A's major vascular injury and by not immediately converting the case to an open laparotomy.

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

COUNT II

NRS 630.3062(1)(a) - Failure to Maintain Appropriate Medical Records

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

17. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

18. Respondent failed to maintain complete and proper medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent's medical records were not accurate and complete by failing, on May 20, 2019, to note any issues with the robotic laparoscopic procedure, including entry into Patient A's abdomen.

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19. 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 what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 19th day of April, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

WILLIAM P. SHOGREN
Deputy General Counsel
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Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 19 day of April, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 19th day of April, 2023, I served a file-stamped copy of the foregoing **COMPLAINT** as well as file-stamped copy of the **PATIENT DESIGNATION** and required fingerprinting materials, via USPS Certified Mail, postage pre-paid, to the following parties:

CHARLES BRIAN KIM, M.D.
7955 W. Badura Ave., #337
Las Vegas, NV 89113

Tracking No.. 9171 9690 0935 0254 7677 25

DATED this 19th day of April, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners