# BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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| **In the Matter of Charges and Complaint Against:** | **Case No. 24-50922-1** |
| **MOHAMMED MERAJUL HOQUE, M.D.,** | FILED |
| **Respondent.** | MAY 13 2024 |
| | NEVADA STATE BOARD OF MEDICAL EXAMINERS |
| | By: |

## COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Mohammed Merajul Hoque, 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. 19019). Respondent was originally licensed by the Board on July 1, 2019.

2. Patient A[2] was a fifty-six (56) year-old female at the time of the events at issue.

3. Patient A had a CTA scan of her abdomen on September 16, 2020, which incidentally revealed a 2.8 cm right renal mass, suspicious for renal cell cancer.

4. Patient A was referred to a urologist who ordered ultrasound imaging that was performed on October 13, 2020, and confirmed a 3 cm right renal mass.

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[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 Victor M. Muro, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Ms. Pamela J. Beal.

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

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5. The urologist ordered a right-sided kidney biopsy for Patient A to either confirm or deny the diagnosis of malignant tissue on or around the right kidney.

6. On November 13, 2020, Patient A presented to Henderson Hospital for a right renal mass surgical biopsy, in which the order and ultrasound specified the location of the mass on the right kidney.

7. Just before the biopsy surgery on November 13, 2020, at 8:52 a.m., Respondent called a timeout to ensure that the surgical team was aware of the correct surgery, the correct location of the surgery on Patient A's body, and there appeared to be no issues noted in the time out.

8. Twenty-one (21) minutes later at 9:13 a.m. the order for the right renal biopsy was cancelled and at the exact same time (9:13 a.m.) an order for a left renal biopsy was created, presumably at the direction of Respondent.

9. Upon information and belief, Respondent changed or requested a change to the original order from Patient A's urologist of a right renal mass biopsy to a left renal biopsy because Respondent somehow mistakenly concluded that Patient A was there for a medical renal biopsy (for renal failure) and believed either kidney was suitable for the biopsy.

10. Respondent's surgical notes indicated that he had compared the ultrasound from October 13, 2020, as ordered by Patient A's urologist, and was using it as guidance in the biopsy procedure. However, the October 13, 2020, ultrasound clearly indicated that Patient A had a mass on her right kidney, not the left kidney which was biopsied on November 13, 2020.

11. In a follow-up visit with her urologist, he informed Patient A that Respondent biopsied her left kidney instead of the right kidney. Patient A opted out of having another biopsy and opted for surgery.

12. On December 17, 2020, Patient A underwent a right robotic radical nephrectomy.

## COUNT I

### NRS 630.301(4) - Malpractice

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

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

15. 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."

16. 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 he biopsied the otherwise healthy left kidney of Patient A when the ultrasound images and report clearly indicated that a right renal mass needed to be biopsied.

17. 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 Proper Medical Records**

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

19. 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.

20. Respondent failed to maintain accurate and complete medical records relating to the diagnosis, treatment and care of Patient A, by either presumably directing the alteration of the original order from Patient A's urologist for a right renal biopsy to a left renal biopsy and/or by failing to acknowledge and document that the biopsy was to be performed on the right kidney and justification of his medical decision to change the surgical procedure to the left kidney.

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

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## COUNT III

**NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation**

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

23. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

24. NAC 630.210 requires a physician to "seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."

25. Respondent failed to timely seek consultation with regard to Patient A's medical condition on November 13, 2020, and Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of Patient A's medical condition and such a timely consultation would have confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided to the patient. If Respondent was unsure or unaware of the underlying purpose for the order for the right vs. left kidney biopsy, he should have contacted Patient A's other providers, especially the ordering physician, who could have clarified that the biopsy was for a right renal mass before changing the order from right-sided surgery to left-sided surgery.

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

## COUNT IV

**NRS 630.306(1)(r) - Failure to Adequately Supervise a Medical Assistant**

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

28. NRS 630.306(1)(r) provides that a failure to adequately supervise a medical assistant pursuant to the regulations of the Board is an act that constitutes grounds for initiating disciplinary action.

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29. Mayra Flores is listed as the "Action Personnel" when the order for the right renal biopsy was cancelled and the order for the left renal biopsy was created. Both orders were created and cancelled by Ms. Flores at 9:13 a.m. on November 13, 2020, after the time out had taken place on the day of the incorrect biopsy. These actions were executed by Ms. Flores under the direct supervision of Respondent.

30. Upon information and belief, Mayra Flores is a medical assistant.[3]

31. By the conduct described herein, Respondent failed to adequately supervise, or supervise in any way, Mayra Flores, a medical assistant and/or another employee or contractor in their performance of medical clinical tasks.

32. 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

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[3] **NRS 630.0129 "Medical assistant" defined.**

1. "Medical assistant" means a person who:

(a) Performs clinical tasks under the supervision of a physician or physician assistant; and

(b) Does not hold a license, certificate or registration issued by a professional licensing or regulatory board in this State to perform such clinical tasks.

2. The term does not include a person who performs only administrative, clerical, executive or other nonclinical tasks.

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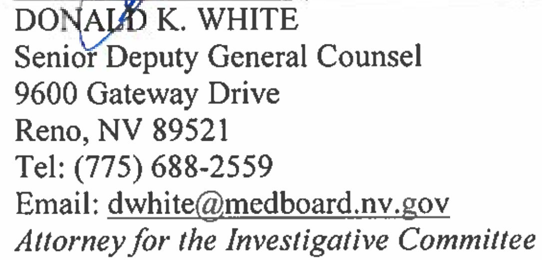
6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 10th day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

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## VERIFICATION

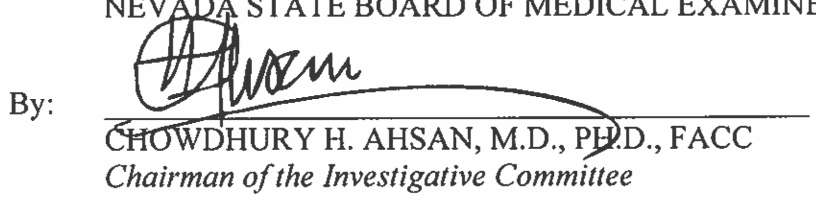
STATE OF NEVADA )
: ss.
COUNTY OF CLARK )

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 10th day of May, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



CHOWDHURY H. AHSAN, M.D., PH.D., FACC
*Chairman of the Investigative Committee*

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