STATE OF COLORADO **OFFICE OF ADMINISTRATIVE COURTS** 633 17TH Street, Suite 1300 Denver, Colorado 80202 **BEFORE THE COLORADO MEDICAL BOARD:** IN THE MATTER OF THE DISCIPLINARY PROCEEDING REGARDING THE LICENSE TO PRACTICE MEDICINE IN THE STATE OF COLORADO OF: **WARREN J. KORTZ, M.D.** **LICENSE NO. DR 26516,** Respondent.	▲**COURT USE ONLY**▲ **CASE NUMBER** ME 2013-
COMPLAINT, NOTICE OF DUTY TO ANSWER, NOTICE TO SET, NOTICE OF HEARING AND STATEMENT REGARDING OPTION TO ENGAGE IN ALTERNATIVE DISPUTE RESOLUTION	

To: WARREN J. KORTZ, M.D.

FORMAL COMPLAINT

Inquiry Panel B of the Colorado Medical Board (the "Board") makes this Formal Complaint against Warren Kortz, M.D. ("Respondent"), pursuant to section 12-36-118(5), C.R.S:

JURISDICTION AND THE PARTIES

1. Respondent is licensed to practice medicine in Colorado and holds License No. DR 26516.

2. The Board has jurisdiction over Respondent and the subject matter of these proceedings pursuant to Sections 12-36-101 *et seq.* and 24-4-101 *et seq.*, C.R.S.

FACTUAL BACKGROUND

3. On September 20, 2010, Porter Adventist Hospital (the "Hospital") reported to the Board that it placed Respondent under precautionary suspension of surgical procedures involving the Da Vinci robot (the "Robot") while Respondent obtained further training and proctoring. The suspension went into effect on or about July 27, 2010.

4. According to the Hospital, the suspension was initiated after Respondent had complications during 11 surgeries while using the Robot.

5. In the years 2008, 2009 and 2010, the standard of care for donor nephrectomy was for a surgeon to remove the kidney in either an open or laparoscopic procedure.

6. Donor nephrectomy using the Robot was not the standard of care in the years 2008, 2009 and 2010.

7. Respondent, however, told surgical Patients D.P., Patient E.W., Patient R.M., Patient C.C., Patient M.C., and Patient S.L. that the Robot was the "gold standard" for donor nephrectomy.

8. At all relevant times, Respondent told living donor patients that the safest, best operation for them is the Robot donor nephrectomy.

9. Respondent did not offer open procedures as a surgical option to Patients D.P., Patient E.W., Patient R.M., Patient C.C., Patient M.C., and Patient S.L.

10. Respondent did not discuss the alternatives, risks and benefits between open, laparoscopic, and the Robot surgical procedures with Patients D.P., Patient E.W.,

Patient R.M., Patient C.C., Patient M.C., and Patient S.L., other than to advise patients of the risk of conversion to an open surgical procedure.

Patient D.P.

11. Patient D. P. was a 48-year old male who consulted with Respondent about donating his left kidney.

12. Respondent told Patient D.P. that he would perform the donor nephrectomy using the Robot.

13. Respondent did not tell Patient D.P. that the Robot approach to donor nephrectomy was a newer approach than open or laparoscopic procedures.

14. Respondent did not tell Patient D.P. that the Robot approach does not have a long term track record.

15. Respondent did not tell Patient D.P. that an open surgery was a surgical option.

16. Respondent did not tell Patient D.P. that a laparoscopic surgery was a surgical option.

17. Respondent did not document discussing all three surgical options as a part of obtaining informed consent from Patient D.P. for the Robot surgery.

18. On August 22, 2008, Respondent attempted a left donor nephrectomy on Patient D.P. with the Robot.

19. During dissection, Respondent caused a hole to develop in Patient D.P.'s renal artery at the junction of his aorta.

20. Respondent converted D.P.'s Robot surgery to an open surgical procedure.

21. Renal artery and aortic injury are not expected complications in a donor nephrectomy.

22. Respondent controlled Patient D.P.'s bleeding and removed his left kidney.

23. Respondent was advised that the instrument count in the operating room was inaccurate.

24. Respondent closed Patient D.P.'s surgical incision and Patient D.P. was taken off the surgical table.

25. Radiological films were taken, showing a possible drain or sponge was retained inside Patient D.P.'s left renal fossa.

26. Patient D.P. was moved back to the surgical table, reopened and the drain or sponge was removed.

27. Respondent did not document that a surgical instrument was retained inside Patient D.P.

Patient E.W.

28. Patient E.W., a 26 year old female, consulted with Respondent about donating her left kidney.

29. A pre-operative CT of Patient E.W.'s abdomen and pelvis noted three punctate calcifications within the lower pole of Patient E.W.'s right kidney of about 1 mm and two punctate left calcifications.

30. Respondent did not document his discussions, if any, with Patient E.W. about the risks of future kidney stones with Patient E.W. or the risk of leaving her with a kidney with documented stones after a nephrectomy.

31. Respondent told Patient E.W. that he would perform the donor nephrectomy using the Robot.

32. Respondent did not tell Patient E.W. that the Robot approach to donor nephrectomy was a newer approach than open or laparoscopic procedures.

33. Respondent did not tell Patient E.W. that the Robot approach does not have a long term track record.

34. Respondent did not tell Patient E.W. that an open surgery was a surgical option.

35. Respondent did not tell Patient E.W. that a laparoscopic surgery was a surgical option.

36. Respondent did not document discussing all three surgical options as a part of obtaining informed consent from Patient E.W. for the Robot surgery.

37. On the Consent to Remove Organ for Transplant from a Living Donor form, Respondent wrote that there was a 5% chance that he might have to convert to an open procedure.

38. On September 26, 2008, Respondent attempted a left donor nephrectomy on Patient E.W. with the Robot.

39. During dissection of Patient E.W.'s left ovarian vein, a lumbar vein started bleeding.

40. While attempting to control Patient E.W.'s bleeding, Respondent injured Patient E.W.'s distal aorta with a harmonic scalpel held by the Robot.

41. Respondent made an 8 to10mm hole in Patient E.M.'s distal aorta on the left side with the harmonic scalpel.

42. Patient E.W. lost her blood pressure for several minutes and cardiopulmonary resuscitation was initiated.

43. Respondent converted Patient E.W.'s Robot nephrectomy to an open procedure to repair Patient E.W.'s aorta.

44. Respondent aborted Patient E.W.'s donor nephrectomy and did not harvest Patient E.W.'s kidney.

Patient R.M.

45. Patient R.M. is a 53 year old male who consulted with Respondent about donating his left kidney to his mother.

46. Respondent did not tell Patient R.M. that the Robot approach to donor nephrectomy was a newer approach than open or laparoscopic procedures.

47. Respondent did not tell Patient R.M. that the Robot approach does not have a long term track record.

48. Respondent did not tell Patient R.M. that an open surgery was a surgical option.

49. Respondent did not tell Patient R.M. that a laparoscopic surgery was a surgical option.

50. Respondent did not document discussing all three surgical options as a part of obtaining informed consent from Patient R.M. for the Robot surgery.

51. On the Consent to Remove Organ for Transplant from a Living Donor form, Respondent wrote that there was a 5% chance that he might have to convert to an open procedure.

52. On March 13, 2009, Respondent performed a left donor nephrectomy on Patient R.M. using the Robot.

53. During the surgery, Respondent used a weck hem-o-lok clip on Patient R.M.'s renal artery.

54. In the year 2006, the manufacturer of the weck hem-o-lok clip issued a warning that its clip is contraindicated during donor nephrectomy.

55. Respondent knew or should have known about the weck hem-o-lok clip contraindication.

56. Despite the manufacturer's warning, Respondent used the weck hem-o-lok clip on Patient R.M.'s renal artery.

Patient C.C.

57. Patient C.C. is a 42-year old female with a history of deep venous thrombosis and vesico-ureteral reflux as a child.

58. Patient C.C. consulted with Respondent about donating a kidney to her brother.

59. Respondent told Patient C.C. that he would perform the donor nephrectomy using the Robot.

60. Respondent did not tell Patient C.C. that the Robot approach to donor nephrectomy was a newer approach than open or laparoscopic procedures.

61. Respondent did not tell Patient C.C. that the Robot approach does not have a long term track record.

62. Respondent did not tell Patient C.C. that an open surgery was a surgical option.

63. Respondent did not tell Patient C.C. that a laparoscopic surgery was surgical option.

64. Respondent did not document discussing all three surgical options as a part of obtaining informed consent from Patient C.C. for the Robot surgery.

65. On the Consent to Remove Organ for Transplant from a Living Donor form, Respondent wrote that there was a 5% chance that he might have to convert to an open procedure.

66. Respondent performed a donor nephrectomy on Patient C.C. on March 18, 2009 using the Robot.

67. Despite a history of deep venous thrombosis, Respondent did not use any deep venous thrombosis prophylaxis, other than a serial compression device, on Patient C.C.

68. After Patient C.C.'s kidney was extracted, bleeding was noted from her aorta.

Patient J.S.

69. Patient J.S. was an 86-year old patient with metastatic cancer.

70. On December 2, 2009, Respondent performed a left adrenalectomy, distal pancreatectomy and splenectomy for metastatic transitional cell carcinoma to the left adrenal gland using the Robot.

71. This was a re-operative surgery because Patient J.S. had a previous left nephrectomy.

72. The standard of care for a re-operative adrenal cancer (or metastatic cancer), involving the splenic vein and pancreas is an open procedure.

73. During dissection with the Robot, Respondent noted bleeding from Patient J.S.'s aorta.

74. Respondent injured Patient J.S.'s aorta in dissection.

75. Respondent emergently converted the Robot surgery to an open surgery and, during the transition, the Robot's arm was inappropriately moved, causing a tear in Patient J.S.'s aorta.

76. Respondent repaired Patient J.S.'s aorta and post-operatively, renal failure ensued.

77. Patient J.S.'s family withdrew life support shortly after the surgery.

Patient M.C.

78. Patient M.C. was a 40-year old obese patient who consulted with Respondent about donating his left kidney.

79. Patient M.C. had a 30.7 body mass index.

80. Respondent told Patient M.C. that he would perform the donor nephrectomy using the Robot.

81. Respondent did not tell Patient M.C. that the Robot approach to donor nephrectomy was a newer approach than open or laparoscopic procedures.

82. Respondent did not tell Patient M.C. that the Robot approach does not have a long term track record.

83. Respondent did not tell Patient M.C. that an open surgery was a surgical option.

84. Respondent did not tell Patient M.C. that a laparoscopic surgery was a surgical option.

85. Respondent did not document discussing all three surgical options as a part of obtaining informed consent from Patient M.C. for the Robot surgery.

86. On the Consent to Remove Organ for Transplant from a Living Donor form, Respondent did not disclose the percent of chance that he may have to convert to an open procedure.

87. On January 27, 2010, Respondent attempted a left donor nephrectomy on Patient M.C. using the Robot.

88. Patient M.C. had a large amount of fat in his retroperitoneum.

89. During the surgery, Respondent used a weck hem-o-lok clip on Patient M.C., despite the manufacturer's contraindications for use.

90. Later in dissection, Respondent transected a renal artery branch to the lower pole of Patient M.C.'s kidney with the Robot's harmonic scalpel.

91. Because he transected a renal artery branch, Respondent disconnected the Robot and converted to an open surgical procedure to remove Patient M.C.'s kidney.

Patient S.L.

92. Patient S.L. was a 22-year old female who consulted with Respondent about donating a kidney to her brother.

93. Respondent told Patient S.L. that he would perform the donor nephrectomy using the Robot.

94. Respondent told Patient S.L. that the Robot was the "gold standard" for donor nephrectomy.

95. Respondent did not tell Patient S.L. that the Robot approach to donor nephrectomy was a newer approach than open or laparoscopic procedures.

96. Respondent did not tell Patient S.L. that the Robot approach does not have a long term track record.

97. Respondent did not tell Patient S.L. that an open surgery was a surgical option.

98. Respondent did not tell Patient S.L. that a laparoscopic surgery was a surgical option.

99. Respondent did not document discussing all three surgical options as a part of obtaining informed consent from Patient S.L. for the Robot surgery.

100. On the Consent to Remove Organ for Transplant from a Living Donor form, Respondent stated that there was a 1-2 percent chance that he may have to convert to an open procedure.

101. On May 21, 2010, Respondent attempted a left donor nephrectomy on Patient S.L. with the Robot.

102. Respondent made the decision as to how to position Patient S.L. for the surgery.

103. Respondent chose the padding for Patient S.L.

104. Respondent was comfortable with Patient S.L.'s positioning and padding prior to commencing the surgery.

105. The anesthesiologist documented that Respondent started Patient S.L.'s surgery at 10:07 a.m.

106. At 10:08 a.m., Respondent injured Patient S.L.'s aorta while inserting a trocar.

107. Patient S.L. had bleeding from her aorta.

108. Respondent converted the Robot procedure to an open procedure to repair Patient S.L.'s aorta injury.

109. Respondent aborted Patient S.L.'s donor nephrectomy and did not harvest her kidney.

110. Respondent was advised that there was an incorrect instrument count.

111. Respondent closed Patient S.L.'s surgical incision.

112. An x-ray technician entered the operating room to take x-rays of Patient S.L. to determine whether there was a retained instrument.

113. The x-ray technician told Respondent that a pole, under the table on which Patient S.L. was lying, might interfere with his ability to take proper x-rays of Patient S.L.

114. Respondent directed the x-ray technician to take the best x-ray that he could.

115. The x-rays were limited because of the pole.

116. Respondent read the x-ray, but did not see the retained foreign object in Patient S.L.

117. Patient S.L. was taken from the operating room and while recovering, began experiencing respiratory distress.

118. A second set of x-rays was taken which revealed a retained sponge in Patient S.L.

119. Respondent conducted a second operation on Patient S.L. to remove the sponge.

120. The second surgical procedure was open because Respondent needed a wide trocar to remove the sponge.

121. Patient S.L. sustained a peroneal nerve injury as a result of surgical padding pressure on her peroneal nerve during surgery.

122. Retained sponges are considered a "never event" by Medicare.

123. After the surgery, Porter Adventist Hospital reported Patient S.L.'s retained sponge incident to the Colorado Department of Public Health and Environment.

124. Patient S.L. was not the first patient of Respondent's to suffer a nerve injury due to improper surgical padding.

Patient R.S.

125. On July 8, 2009, Respondent performed an 8 hour repair of parastomal hernia and extensive lysis of adhesions surgery on 79-year old Patient R.S. with the Robot.

126. Patient R.S. sustained a brachial plexus injury due to surgical padding.

Patient S.A.L.

127. On August 14, 2009, Respondent performed a 10 hour sigmoid colectomy and repair of colovaginal fistula on 70-year old Patient S.A.L. with the Robot.

128. Patient S.A.L. sustained a brachial plexus injury due to surgical padding.

Patient R.D.

129. On February 9, 2009, Respondent performed a 7 hour completion AP resection of the colon as an open procedure on 61-year old Patient R.D.

130. Patient R.D. sustained a brachial plexus injury due to surgical padding.

Patient D.B.

131. Patient D.B. consulted with Respondent regarding a nissen fundoplication procedure.

132. In the year 2011, robotic nissen fundoplication was not the standard of care.

133. Respondent told Patient D.B. that he performs nissen fundoplication procedures using the Robot.

134. Respondent did not tell Patient D.B. that the Robot was a new approach to nissen fundoplications.

135. Respondent did not tell Patient D.P. that the Robot approach does not have a long term track record.

136. Respondent did not inform Patient D.B. that she had the option to have a laparoscopic procedure.

137. Respondent did not tell Patient D.B. that there was a risk her vagus nerve could be injured in the surgery or that she could develop gastroparesis as a result of a vagus nerve injury during the nissen fundoplication.

138. On March 21, 2011, Respondent performed a nissen fundoplication on Patient D.B. using the Robot.

139. Shortly after the surgery, Patient D.B. developed gastroparesis.

140. Patient D.B. consulted with a gastroenterologist who opined that Patient D.B.'s gastroparesis developed because her vagus nerve was damaged.

COUNT I
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

141. The Board incorporates by reference the allegations contained in Paragraphs 1-140 as if fully set forth herein.

142. Respondent failed to meet the generally accepted standard of medical practice by demonstrating a pattern or practice of failing to obtain proper informed consent for surgeries in which he used the Robot, including but not limited to the surgeries performed on Patient D.P., Patient E.W., Patient R.M., Patient C.C, Patient M.C., Patient S.L. and Patient D.B. It is unreasonable to attempt the robotic approach when the patient is not aware of the risks, benefits and alternatives to the Robot. Respondent committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Failing to inform patient's that using the Robot was not the standard of care at the time of surgery;
b. Failing to advise patients of all surgical options;
c. Failing to discuss the risks and benefits of all surgical options;
d. Failing to document discussing all surgical options as part of informed consent;
e. Failing to advise patients that the Robot was newer surgical technology; and
f. Failing to inform patients of his accurate conversion rate to open procedures.

COUNT II
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

143. The Board incorporates by reference the allegations contained in Paragraphs 1-142 as if fully set forth herein.

144. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient D.P. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. making a hole in Patient D.P.'s aorta and renal artery during dissection;
b. utilizing improper technique during dissection;
c. failing to visually recognize that he was dissecting too close to Patient D.P.'s structures;
d. failing to recognize the force he was using during dissection and, thus injuring Patient D.P.'s structures;
e. failing to recognize the traction placed on the renal artery, which may have caused the aorta to tear;
f. poking a hole in Patient D.P.'s artery with a sharp surgical instrument; and
g. closing Patient D.P.'s surgical incisions before obtaining a radiologist report regarding the retained sponge/instrument.

COUNT III
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

145. The Board incorporates by reference the allegations contained in Paragraphs 1-144 as if fully set forth herein.

146. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient E.W. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Failing to inform Patient E.W. of the risks of future stones or risks of leaving her with one kidney with documented stones;
b. Failing to use proper technique during dissection of Patient E.W.;
c. Injuring Patient E.W. with the harmonic scalpel during dissection;
d. Making an 8-10 mm hole in Patient E.W.'s distal aorta with the harmonic scalpel;
e. Failing to recognize the harmonic scalpel was near Patient E.W.'s aorta; and

f. Failing to harvest Patient E.W.'s kidney.

COUNT IV
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

147. The Board incorporates by reference the allegations contained in Paragraphs 1-146 as if fully set forth herein.

148. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient R.M. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Using a weck hem-o-lok clip on Patient R.M.'s renal artery

COUNT V
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

149. The Board incorporates by reference the allegations contained in Paragraphs 1-148 as if fully set forth herein.

150. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient C.C. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Failing to evaluate Patient C.C. for a hypercoaguable state; and
b. Failing to use DVT prophylaxis, other than a serial compression device, during Patient C.C.'s surgery.

COUNT VI
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

151. The Board incorporates by reference the allegations contained in Paragraphs 1-150 as if fully set forth herein.

152. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient J.S. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Using the Robot to perform surgery on a patient with recurrent, transitional cancer that is metastatic;
b. Injuring Patient J.S.'s aorta during surgery with the Robot;
c. Allowing the Robot to hold sutures when the Robot was undocked; and
d. Failing to effectively communicate with operating room personnel regarding the Robot.

COUNT VII
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

153. The Board incorporates by reference the allegations contained in Paragraphs 1-152 as if fully set forth herein.

154. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient M.C. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Using the Robot to perform a nephrectomy on a patient whose body mass index was too high;
b. Using a weck hem-o-lok clip on Patient M.C.'s renal artery; and
c. Injuring Patient M.C.'s artery with the harmonic scalpel held by the Robot.

COUNT VIII
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

155. The Board incorporates by reference the allegations contained in Paragraphs 1-154 as if fully set forth herein.

156. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient S.L. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Injuring Patient S.L.'s aorta with a trocar;
b. Improperly padding Patient S.L. for her surgical procedure;
c. Closing Patient S.L. before ensuring all surgical instruments were removed;
d. Mis-reading the x-ray which revealed a retained sponge;
e. Failing to order a second x-ray when he knew or should have known the first x-ray was not sufficient;
f. Requiring Patient S.L. to undergo a second surgery to remove the retained sponge; and
g. Causing Patient S.L. to sustain a nerve injury.

COUNT IX
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

157. The Board incorporates by reference the allegations contained in Paragraphs 1-156 as if fully set forth herein.

158. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient R.S. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Performing an excessively long surgery on Patient R.S.;
b. Failing to ensure that Patient R.S. was properly padded for surgery; and
c. Causing Patient R.S. to sustain a brachial plexus injury.

COUNT X
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

159. The Board incorporates by reference the allegations contained in Paragraphs 1-158 as if fully set forth herein.

160. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient S.A.L. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Performing an excessively long surgery on Patient S.A.L.;
b. Failing to ensure that Patient S.A.L. was properly padded for surgery; and
c. Causing Patient S.A.L. to sustain a brachial plexus injury.

COUNT XI
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(p) - substandard care)

161. The Board incorporates by reference the allegations contained in Paragraphs 1-160 as if fully set forth herein.

162. Respondent failed to meet the generally accepted standard of medical practice in his care and treatment of Patient R.D. and, therefore committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Performing an excessively long surgery on Patient R.D.;
b. Failing to ensure that Patient R.D. was properly padded for surgery; and
c. Causing Patient R.D. to sustain a brachial plexus injury.

COUNT XII
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1)(cc) failure to make essential entries in medical records)

163. The Board incorporates by reference the allegations contained in Paragraphs 1-162 as if fully set forth herein.

164. Documenting informed consent, inaccurate instrument counts, retained sponges, deep venous thrombosis work ups, and the prophylaxis used in surgery are essential entries for a patient's medical record.

165. Accurately documenting the conversation rate to open procedures is also an essential entry for a patient's medical record.

166. Respondent did not make all essential entries in the medical records of the patients identified above.

167. Respondent repeatedly failed to document the informed consent provided to the patients, incorrect instrument counts and retained sponges incidents.

168. Respondent repeatedly failed to make essential entries in the medical records of the patients identified above, in violation of Colo. Rev. Stat. § 12-36-117(1)(cc), by one or more of the following:

a. Failing to document that patients were told the Robot was a new approach to the surgery scheduled;
b. Failing to tell patients that they had the option for either an open or laparoscopic procedure in addition to the Robot;
c. Failing to document that the risks and benefits of open; laparoscopic and robotic procedures were discussed with patients;
d. Failing to document that the instrument count was inaccurate;
e. Failing to document retained sponges/instruments;

f. Failing to document the discussion, if any, with Patient E.W. of the risks of future stones;
g. Failing to document his discussion, if any, with Patient E.W. about the risk of leaving her with a kidney with documented stones;
h. Failing to document an accurate conversion rate to open procedures; and
i. Failing to document the deep venous thrombosis prophylaxis, if any, used during the surgery of Patient C.C.

COUNT XIII
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1) 117(1)(p) - substandard care)

169. The Board incorporates by reference the allegations contained in Paragraphs 1-168 as if fully set forth herein.

170. Respondent failed to meet the generally accepted standard of medical practice by demonstrating a pattern or practice of providing improper padding for surgical patients, leading to nerve injures. Respondent committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. Failing to ensure Patient S.L. was properly padded for surgery to avoid causing a peroneal nerve injury;
b. Failing to Patient R.S. was properly padded for surgery to avoid causing a brachial plexius injury;
c. Failing to ensure Patient S.A.L. was properly padded for surgery to avoid causing a brachial plexius injury; and
d. Failing to ensure Patient R.D. was properly padded for surgery to avoid causing a brachial plexius injury.

COUNT XIV
UNPROFESSIONAL CONDUCT
(Violation of Colo. Rev. Stat. §12-36-117(1) 117(1)(p) - substandard care)

171. The Board incorporates by reference the allegations contained in Paragraphs 1-170 as if fully set forth herein.

172. Respondent failed to meet the generally accepted standard of medical practice by demonstrating a pattern or practice of injuring patients during

dissection as demonstrated in his care and treatment of Patient D.P., Patient E.W., Patient J.S., Patient M.C. and Patient S.L. Respondent committed unprofessional conduct pursuant to Colo. Rev. Stat. § 12-36-117(1)(p), by one or more of the following:

a. injuring Patient D.P.'s renal artery during dissection;
b. injuring Patient E.W.'s distal aorta during dissection;
c. injuring Patient J.S.'s aorta during dissection;
d. injuring the renal artery to the lower pole of Patient M.C.'s kidney during dissection; and
e. injuring Patient S.L.'s aorta during dissection.

173. Renal and aortic artery injuries during donor nephrectomy are rare among competent, experienced surgeons.

WHEREFORE, the Board respectfully requests that an administrative law judge discipline Respondent's license to practice medicine in the State of Colorado, as provided by law.

Respectfully submitted this 2nd day of April, 2013

JOHN W. SUTHERS
Attorney General

JACK M. WESOKY 6001*
ALLISON R. AILER, 33008.*
Assistant Attorney General
Medical Board Unit
Business & Licensing Section
Attorneys for Panel B

1300 Broadway, 8th Floor
Denver, Colorado 80203
Telephone: 720-508-6392

*Counsel of Record