

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2022-046

In the Matter of
CAMY HUYNH, D.O.

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Camy Huynh, D.O. (Respondent) has practiced medicine in violation of law, regulation, or good and accepted medical practice, as set forth herein. The investigative docket number associated with this order to show cause is Docket Number 19-249.

Biographical Information

1. The Respondent graduated from the University of New England College of Osteopathic Medicine in 2003 and was issued a license to practice medicine in Massachusetts under certificate number 229165 on June 7, 2006. She specializes in internal medicine and worked as a hospitalist at Milford Regional Medical Center (MRMC) from approximately 2006 until May 21, 2019 when she was terminated.

Factual Allegations

Patient C:

2. In 2015, Patient C was a 90-year old male with a history of chronic obstructive pulmonary disease, deep vein thrombosis in 2014, heart block with a pacemaker, diabetes and hypertension.
3. The Respondent admitted Patient C to MRMC on February 6, 2015 at approximately 10:56 p.m. for shortness of breath and a productive cough with yellow sputum.
4. Patient C was on warfarin¹ but reportedly had missed two doses of his medication.
5. Patient C's last (INR)² was measured ten days earlier at 1.7.
6. The Respondent did not measure Patient C's INR on admission.
7. The Respondent did not document in the medical record the method she used (decision scoring or clinical gestalt) to determine Patient C's pretest probability of a pulmonary embolism.
8. In her written response to the Board the Respondent categorized Patient C's pretest probability of a pulmonary embolism as "high".
9. The Respondent ordered Patient C to have a CT Chest angiography and placed him on a therapeutic dose of lovenox, which is an anticoagulant that helps prevent blood clots.
10. Patient C's CT was completed February 7, 2015 at 6:32 a.m. and negative for a pulmonary embolism.
11. Patient C's INR was measured at approximately 8:00 a.m. on February 7, 2015 at 3.2, at which time the lovenox was discontinued.

¹ Warfarin is an anticoagulant used to prevent blood clots.

² An INR measures the time it takes for the liquid portion of a person's blood to clot. *See* my.clevelandclinic.org/health/diagnostics/17691-prothrombin-time-pt-test
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12. The Respondent's treatment of Patient C was negligent and failed to meet the standard of care in the following ways:

- a. The Respondent did not measure Patient C's INR level at admission;
- b. The Respondent incorrectly concluded Patient C's pre-test probability of a pulmonary embolism was "high" rather than "indeterminate" or "low"; and
- c. The Respondent did not appropriately document the method she used to determine Patient C's pretest probability of a pulmonary embolism.

Patient D:

13. Patient D was a 67-year old female who reported to the Emergency Department on April 29, 2015 after she tripped over her dog's leash and fell onto her face. Patient D received sutures for a laceration on her chin and was then sent home.

14. Patient D returned to MRMC on April 30, 2015 at approximately 1:13 a.m. with severe pain and bleeding in her mouth, at which time the Respondent admitted her.

15. Patient D suffered a complex mandibular fracture, a complex fracture of the base of the right maxillary antrum extending into the macula, and a nondisplaced fracture of the right orbital process.

16. The Emergency Department contacted the oral surgeon who recommended Patient D be admitted, given her severe pain, and planned to see her in the morning for a surgical consultation.

17. At the time of her admission Patient D was on warfarin and aspirin and her INR level measured 2.1.

18. The Respondent reported in her admission note on April 30, 2015 Patient D had blood visible in her mouth.

19. The Respondent wrote an order to start morphine IV for pain and IV fluids

because of acute renal failure from dehydration and inability to take oral hydration.

20. The Respondent also wrote an order to continue coumadin (an anticoagulant) with close monitoring and a plan to reverse the INR with vitamin K if bleeding worsens.

21. Notes from two cross-covering physicians at 8:03 a.m. on April 30, 2015 indicate nursing staff reported Patient D had a significant amount of bleeding from her mouth, was hypoxic and had difficulty speaking

22. Patient D was placed on a 100% non-rebreather and then transferred to the ICU.

23. The Respondent was negligent and failed to follow the standard of care in her treatment of Patient D in the following ways:

- a. The Respondent's admission note does not indicate why Patient D was taking warfarin or include a discussion of the risks and benefits of continuing both the aspirin and the warfarin given her ongoing bleeding and likely impending surgery;
- b. The Respondent wrote warfarin could be continued because Patient D's vital signs were stable. However, stable vital signs are not an appropriate consideration as a change in vital signs would occur *after* the patient experienced a significant loss of blood;
- c. The Respondent noted Patient D's fractures caused significant bleeding in her mouth but continued both the aspirin and the warfarin. Given the bleeding in Patient D's mouth, the warfarin should have been held, even if Patient D was at high risk of stroke from paroxysmal atrial fibrillation;
- d. Despite Patient D's limited range of motion due to her jaw fracture and bleeding mouth, the Respondent did not recognize her airway could have been compromised; and

- e. Given bleeding and the potential for surgery, the Respondent should have ordered a type and cross for blood products (FFP) in case Patient D's bleeding worsened.

Patient E:

24. On August 12, 2015 Patient E was a 56-year-old male with a history of sarcoidosis, dyslipidemia, and hypothyroidism who developed chest pain radiating to his upper shoulders and neck with some shortness of breath during a long car trip.

25. The Respondent read the admitting EKG on August 13, 2015 as showing no ST or T wave changes.

26. The Respondent admitted Patient E with a plan to follow up on his cardiac enzymes and an exercise stress test if the enzymes were negative.

27. An EKG at 4:17 a.m. on August 13, 2015 showed new ST elevations in leads I, II, and V4-V6 compared to the EKG on August 12, 2015 at 10:43 p.m.

28. An EKG at 4:37 a.m. on August 13, 2015 showed worsening ST elevations in leads I, II, aVF, and V3-V6 compared to the earlier EKGs.

29. The Respondent drafted a discharge summary at 6:52 a.m. on August 13, 2015 to transfer Patient E to a tertiary facility.

30. In her discharge summary, the Respondent reported the EKG on the floor when Patient E's pain worsened showed an ST segment elevation in lead 2 and possible aVF and a PR depression in lead 2.

31. The Respondent suggested Patient E's pain improved with Toradol and may have been due to pericarditis.

32. The Respondent further stated she spoke with the covering cardiologist who

recommended a transfer to rule out an acute myocardial infarction (MI).

33. The Respondent's care and treatment of Patient E was negligent and fell below the standard of care in the following ways:

- a. The Respondent failed to appreciate the ST elevations in leads I, aVF and V3-V6, which worsened between the EKGs performed at 4:17 a.m. and 4:37 a.m. By doing so, the Respondent failed to appreciate a possible ST elevation MI, which is below the standard of care; and
- b. The Respondent incorrectly focused on a PR depression in lead 2 as evidence of pericarditis rather than the acute MI.

Hospital Discipline & PLAS Assessment:

34. In 2019 the Respondent was ordered to complete a Post Licensure Assessment System (PLAS program) at the New York Comprehensive Clinical Competency Center (UNYCCCC) as a condition of her continued employment at MRMC.

35. The Respondent was terminated from MRMC on May 21, 2019 before the PLAS program was scheduled to begin.

36. The Respondent attended and completed the PLAS program in June 2019.

37. The evaluators at the PLAS program concluded there were significant gaps in the Respondent's clinical knowledge and her performance during the evaluation, which included four simulated patient encounters, did not meet an accepted standard of care.

Legal Basis for Proposed Relief

Pursuant to 243 C.M.R. 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician engaged in conduct which places into
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question the physician's competence to practice medicine, including negligence on repeated occasions.

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training, or other restrictions upon the Respondent's practice of medicine

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,



Julian N. Robinson, M.D.
Board Chair

Date: 11/17/2022