

COPY

BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF NEVADA

\* \* \* \* \*

In the Matter of Charges and )

Complaint Against )

JOHN D. LEWIS, M.D., )

Respondent. )

Case No. 09-5834-1

FILED

JUL 10 2009

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners (Board), composed of Charles N. Held, M.D., Chairman, Jean Stoess, M.A., Member, and Benjamin J. Rodriguez, Member, at the time of the authorization of filing this formal complaint, by and through Edward O. Cousineau, counsel for the Investigative Committee, having a reasonable basis to believe that John D. Lewis, M.D., hereinafter referred to as "Respondent," has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent license to practice medicine is currently inactive, and at all times alleged herein, Respondent was licensed by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. In August of 2008, Respondent entered into a Consent Agreement with the Arizona Medical Board. An associated Findings of Fact, Conclusions of Law and Order imposed a letter of reprimand upon Respondent based upon a standard of care deviation and failure to maintain adequate and legible medical records regarding a patient treated by Respondent in January of 2007. (See Exhibit 1)

3. Section 630.301(3) of the Nevada Revised Statutes provides that any disciplinary action, including without limitation, the revocation, suspension, modification or limitation of the

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

1 license to practice any type of medicine by any other jurisdiction is grounds for disciplinary  
2 action.

3 4. The disciplinary action related to Respondent's license to practice medicine in the  
4 state of Arizona, constitute violations of the provisions of NRS 630.301(3).

5 5. Based upon the forgoing, Respondent has violated Nevada Revised Statutes  
6 630.301(3) and is subject to discipline by the Nevada State Board of Medical Examiners as  
7 provided in Nevada Revised Statute 630.352.

8 WHEREFORE, the Investigative Committee prays:

9 1. That the Board fix a time and place for a formal hearing;

10 2. That the Board give Respondent notice of the charges herein against him, the time  
11 and place set for the hearing, and the possible sanctions against him;

12 3. That the Board determine what sanctions it determines to impose for the violation or  
13 violations committed by Respondent; and

14 4. That the Board make, issue and serve on Respondent its findings of facts,  
15 conclusions of law and order, in writing, that includes the sanctions imposed.

16 DATED this 10<sup>th</sup> day of July, 2009.

17  
18 INVESTIGATIVE COMMITTEE OF THE  
19 NEVADA STATE BOARD OF MEDICAL EXAMINERS

20 By: \_\_\_\_\_



21 Edward O. Cousineau  
22 Attorney for the Investigative Committee of the  
23 Nevada State Board of Medical Examiners  
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VERIFICATION

STATE OF NEVADA        )  
                                  : ss.  
COUNTY OF DOUGLAS    )

Charles N. Held, 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 10<sup>th</sup> day of July, 2009.



Charles N. Held, M.D.

**CERTIFICATE OF MAILING**

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 10<sup>th</sup> day of July 2009, I served a file copy of the COMPLAINT, and a original copy of the SETTLEMENT, WAIVER AND CONSENT AGREEMENT along with fingerprinting information by mailing via USPS certified return receipt to the following:

John D. Lewis, M.D.  
901 W. La Lomas Rd.  
Tucson, AZ 85704-2709

Dated this 10<sup>th</sup> day of July 2009.



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Angelia Donohoe  
Legal Assistant

# **EXHIBIT**

**1**



1 express or implied, of the Board's statutory authority or jurisdiction regarding any other  
2 pending or future investigation, action or proceeding. The acceptance of this Consent  
3 Agreement does not preclude any other agency, subdivision or officer of this State from  
4 instituting other civil or criminal proceedings with respect to the conduct that is the subject  
5 of this Consent Agreement.

6 6. All admissions made by Respondent are solely for final disposition of this  
7 matter and any subsequent related administrative proceedings or civil litigation involving  
8 the Board and Respondent. Therefore, said admissions by Respondent are not intended  
9 or made for any other use, such as in the context of another state or federal government  
10 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
11 any other state or federal court.

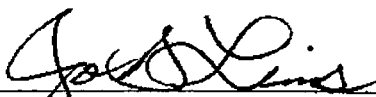
12 7. Upon signing this agreement, and returning this document (or a copy thereof) to  
13 the Board's Executive Director, Respondent may not revoke the acceptance of the  
14 Consent Agreement. Respondent may not make any modifications to the document. Any  
15 modifications to this original document are ineffective and void unless mutually approved  
16 by the parties.

17 8. If the Board does not adopt this Consent Agreement, Respondent will not  
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes  
19 bias, prejudice, prejudgment or other similar defense.

20 9. This Consent Agreement, once approved and signed, is a public record that will  
21 be publicly disseminated as a formal action of the Board and will be reported to the  
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

23 10. If any part of the Consent Agreement is later declared void or otherwise  
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force  
25 and effect.

1           11. Any violation of this Consent Agreement constitutes unprofessional conduct  
2 and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order,  
3 probation, consent agreement or stipulation issued or entered into by the board or its  
4 executive director under this chapter") and 32-1451.

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8 JOHN D. LEWIS, M.D.

DATED: 8/26/08

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1 **FINDINGS OF FACT**

2 1. The Board is the duly constituted authority for the regulation and control of  
3 the practice of allopathic medicine in the State of Arizona.

4 2. Respondent is the holder of license number 11783 for the practice of  
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-07-1024A after receiving a complaint  
7 regarding Respondent's care and treatment of a fifty-two year-old male patient ("GP").

8 4. On January 16, 2007 at 3:54 a.m., GP presented to the emergency  
9 department (ED) with flank pain and hypotension. GP had high blood pressure and took  
10 additional blood pressure medication the night before as he previously had without  
11 adverse effects. GP reported that he had been suffering from a cough and cold for two  
12 weeks. GP's blood pressure was 77/45 and he was afebrile. At 5:00 a.m. Respondent  
13 gave verbal orders to administer a 500 cc fluid bolus. However, when this did not correct  
14 GP's hypotension, Respondent ordered intravenous (IV) Dopamine (a pressor) at 6:17  
15 a.m. In response to the Board's investigation, Respondent stated he saw GP at 5:00 a.m.  
16 However, there was no documentation that Respondent presented to see GP until 7:25  
17 a.m.

18 5. At 7:00 a.m., the treating nurse noted that the Dopamine was at its maximal  
19 rate and contacted Respondent. At 7:25 a.m., Respondent presented to GP's room to  
20 evaluate him. Respondent performed a history and physical examination that included  
21 checking GP's blood pressure, respiratory rate and pulse. Respondent's assessment was  
22 septic shock and he ordered an additional IV pressor, one liter of fluid bolus and a dose of  
23 Timentin (an antibiotic). At 8:00 a.m., Respondent ordered a third liter of bolus fluid and  
24 consultations with a surgeon and critical care physician. At 8:27 a.m., the surgeon and  
25

1 critical care physician arrived for consultation. The critical care physician assumed care  
2 and treatment of GP.

3 6. GP's condition continued to deteriorate and he remained in the ED until 4:41  
4 p.m., when he was transferred to the intensive care unit. Subsequently, GP became  
5 unresponsive and was pronounced dead at 5:32 p.m. The cause of death was determined  
6 to be cardiopulmonary arrest and sepsis. GP's blood cultures were positive for gram  
7 positive cocci.

8 7. The standard of care in emergency medicine for a patient presenting with  
9 hypotension requires an emergency physician to conduct an immediate, appropriate  
10 history and physical examination.

11 8. Respondent deviated from the standard of care because he did not he did  
12 not present to evaluate GP until over three hours after he presented to the ED.

13 9. The standard of care for a patient presenting with hypotension requires an  
14 immediate consideration of, evaluation for and treatment of emergent, life threatening  
15 causes of hypotension.

16 10. Respondent deviated from the standard of care because he did not  
17 immediately consider, evaluate and treat the emergent, life threatening causes of GP's  
18 hypotension.

19 11. The standard of care in emergency medicine for a patient presenting with  
20 hypotension requires an emergency physician to immediately attempt to correct the  
21 hypotension.

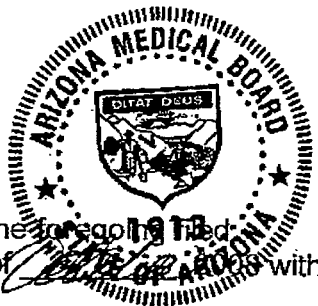
22 12. Respondent deviated from the standard of care because he did not  
23 immediately attempt to correct GP's hypotension.

24 13. The standard of care for septic shock requires immediate, empiric antibiotic  
25 therapy.



1 2. This Order is the final disposition of case number MD-07-1024A.  
2 DATED AND EFFECTIVE this 9th day of October, 2008.

3 (SEAL)



ARIZONA MEDICAL BOARD

4 By [Signature]  
5 Lisa S. Wynn  
6 Executive Director

7 ORIGINAL of the foregoing filed  
8 this 9th day of October, 2008 with:

9 Arizona Medical Board  
10 9545 E. Doubletree Ranch Road  
11 Scottsdale, AZ 85258

12 EXECUTED COPY of the foregoing mailed  
13 this 9th day of October, 2008 to:

14 John D. Lewis, M.D.  
15 Address of Record

16 [Signature]  
17 Investigational Review  
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