BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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

In the Matter of Charges and

Complaint Against

VICTOR R. BRUCE, M.D.,

Respondent.

Case No. 14-12252-1

FILED
FEB 13 2014

COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), composed at the time of filing of Beverly A. Neyland, M.D., Chairwoman, Sue Lowden, Member, and Bashir Chowdhry, M.D., Member, by and through Erin L. Albright, Esq., Board General Counsel and attorney for the IC, having a reasonable basis to believe that Victor R. Bruce, 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 formal Complaint, stating the IC's charges and allegations as follows:

FACTUAL BACKGROUND

A. Respondent's Nevada Medical License

1. Respondent is currently licensed in active status (License No. 8652), and has been so licensed by the Board since May 27, 1998, pursuant to the provisions of the Medical Practice Act. Respondent's specialty listed with the Board is internal medicine.

B. Respondent's Care and Treatment of Patient A

2. Patient A was a thirty-seven (37)-year-old female at the time the incidents in question commenced. Her true identity is not disclosed in this Complaint to protect her identity,

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but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

3. On or about September 10, 2008, Patient A established with Respondent as her pain management specialist. Patient A presented with a history of Adult Attention Deficit Disorder (AADD) and obesity. Respondent did not confirm Patient A's AADD diagnosis. Respondent did not check Patient A's prescription records on the Prescription Monitoring Program (PMP).

4. During this visit, Respondent did not record Patient A's height, vital signs, weight, social history, allergies, family history, prior drug or alcohol history or past medical history. Respondent prescribed Patient A Adderall to treat her AADD and Oxycodone/APAP 5/325 mg twice daily to treat neck pain. There is no documentation demonstrating that Respondent attempted to treat Patient A's neck pain with a non-narcotic substance prior to prescribing Oxycodone/APAP.

5. On or about April 23, 2009, Patient A presented to Respondent with complaints of pain stemming from a recent motor vehicle accident. Patient A's medical records lack any documentation evidencing Respondent performed a physical exam on Patient A. Patient A's medical records also lack any documentation demonstrating the location or character of Patient A's pain. Further, Respondent did not order testing or imaging to determine the etiology of Patient A's pain. Regardless, Respondent prescribed Patient A one hundred (100) 10/500 milligram (mg) tablets of Lortab with directions to take two tablets every 4 hours.

6. On or about May 22, 2009, Respondent increased Patient A's Oxycodone to fifteen (15) mg every four (4) hours. There is no documentation in Patient A's chart demonstrating the basis for this increase.

7. On or about December 8, 2009, Respondent changed Patient A's medication from Oxycodone to Opana ER 40mg/d daily, which is equal to eighty (80) mg of Oxycodone, with Endocet for breakthrough pain. There is no documentation in Patient A's chart demonstrating the basis for this increase.

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8. On or about June 16, 2010, Respondent changed Patient A's diagnosis from AADD to Chronic Fatigue Syndrome. There is no documentation in Patient A's chart demonstrating the basis for this change in diagnosis.

9. On or about October 10, 2011, Patient A underwent a computer tomography (CT) scan at Mountain View Hospital. The CT scan showed a four (4)-centimeter mass on Patient A's liver. The CT scan report recommended the mass be further evaluated by Patient A's primary care physician, which was noted by Respondent in Patient A's medical chart.

10. Patient A's medical records lack any documentation and/or evidence demonstrating that Respondent further evaluated the four (4)-centimeter mass on Patient A's liver.

11. Patient A's medical records lack any documentation and/or evidence demonstrating that Respondent ordered and/or performed diagnostic tests on the four (4)-centimeter mass on Patient A's liver.

12. Patient A's medical chart lacks documentation regarding the nature and intensity of the patient's pain, the effect of pain on the patient's ability to function and the presence of recognized medical indications for the use of controlled substances.

13. As part of his treatment of Patient A, Respondent required Patient A to submit to urine drug tests. Patient A tested positive for methamphetamine on the following dates: September 8, 2010, October 4, 2010, January 28, 2011 and June 15, 2011. Patient A tested positive for marijuana on the following dates: September 8, 2010, October 4, 2010, January 28, 2011, October 10, 2011 and January 3, 2012. Patient A's medical chart lacks documentation demonstrating that Respondent counseled Patient A regarding these positive test results. Further, Respondent failed to discharge Patient A from his practice after Patient A repeatedly tested positive for illicit drugs.

C. <u>Respondent's Care and Treatment of Patient B</u>

14. Patient B was a twenty-seven (27)-year-old male at the time the incidents in question commenced. His true identity is not disclosed in this Complaint to protect his identity, but his identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

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15. On or about September 2, 2009, Patient B established with Respondent as his pain management specialist. Patient B had a history of lumbar pain stemming from a motor vehicle accident in 1978.

16. Patient B's medical chart lacks documentation demonstrating that Respondent performed a family history, social history or past medical history on Patient B. Respondent failed to request Patient B's prior medical records. Respondent also failed to document Patient B's prior narcotic use through the PMP.

17. During this initial visit, Patient B reported to Respondent that he had "tried some of his friend's Roxicodone with good results." Despite this information, which should have alerted Respondent that Patient B had the potential for abuse or diversion, Respondent prescribed Patient B one hundred and twenty (120) tablets of fifteen (15) mg Roxicodone with instructions to take one (1) tablet four (4) times daily.

18. Respondent's office notes for Patient B from September 2, 2009 through March 23, 2010 lack vital signs and appear to be cloned, as the chief complaint and plan is exactly the same on each note.

19. On or about May 5, 2011, Patient B presented to Respondent. During this appointment, Patient B's blood pressure was 152/100; indicating Patient B was suffering from hypertension.

20. On or about June 3, 2011, Patient B presented to Respondent. During this appointment, Patient B's blood pressure was 149/101; indicating Patient B was suffering from hypertension.

21. Patient B's medical records lack any documentation and/or evidence demonstrating that Respondent informed Patient B of the markedly elevated blood pressure readings on either May 5, 2011 or June 3, 2011.

22. Patient B's medical records lack any documentation and/or evidence demonstrating that Respondent ordered diagnostic testing regarding the elevated blood pressure readings on either May 5, 2011 or June 3, 2011.

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23. Patient B's medical chart lacks any documentation and/or evidence demonstrating that Respondent diagnosed and/or treated Patient B's hypertension on either May 5, 2011 or June 3, 2011.

24. By January 13, 2012, Respondent increased Patient B's medication to three (3) tablets of Opana ER forty (40) mg in the morning, two (2) tablets of Opana ER forty (40) mg in the evening, coupled with thirty (30) mg of Roxicodone every five (5) to six (6) hours. Patient B's medical chart lacks documentation regarding the nature and intensity of the patient's pain, the effect of pain on the patient's ability to function and the presence of recognized medical indications for the use of controlled substances. There is no documentation in Patient B's medical chart supporting the continued increase and/or change in Patient B's prescription medication.

D. <u>Respondent's Care and Treatment of Patient C</u>

25. Patient C was a thirty-two (32)-year-old male at the time the incidents in question commenced. His true identity is not disclosed in this Complaint to protect his identity, but his identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

26. Patient C established with Respondent as his pain management specialist on or about October 6, 2010. Patient C had a history of left flank pain, seizures and anxiety. Patient C's medical chart lacks documentation demonstrating that Respondent performed a family history, social history or past medical history on Patient C. Respondent failed to request Patient C's prior medical records. Respondent also failed to document Patient C's prior narcotic use through the PMP.

27. Patient C was being treated by Respondent for seizures that resulted from a gunshot wound to the head. Respondent was treating Patient C with Keppra and Tegritol.

28. Patient C's medical records lack any documentation and/or evidence demonstrating that Respondent consulted with a neurologist regarding his care and treatment of Patient C's seizures.

29. Patient C's medical records lack any documentation and/or evidence demonstrating that Respondent was monitoring Patient C's Tegritol levels.

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30. Patient C's medical records lack any documentation and/or evidence demonstrating that Respondent was periodically testing Patient C's white blood counts to monitor possible toxicities from medication.

31. Patient C's medical records lack any documentation and/or evidence demonstrating that Respondent was periodically testing Patient C's renal functions to monitor for possible toxicities from medication.

32. Patient C had elevated blood pressure readings on the following dates: February 16, 2011, March 16, 2011, June 14, 2011, August 12, 2011, and November 7, 2011. Patient C's medical chart lacks any documentation and/or evidence demonstrating that Respondent diagnosed and/or treated Patient C's elevated blood pressure readings on said dates.

33. Patient C's medical chart lacks documentation regarding the nature and intensity of the patient's pain, the effect of pain on the patient's ability to function and the presence of recognized medical indications for the use of controlled substances.

E. Respondent's Care and Treatment of Patient D

34. Patient D was a forty-five (45)-year-old male at the time the incidents in question commenced. His true identity is not disclosed in this Complaint to protect his identity, but his identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

35. Patient D established with Respondent as his pain management specialist on or about April 10, 2010. Patient D had a history of lumbar back pain. Patient D's medical chart lacks documentation demonstrating that Respondent performed a family history, social history or past medical history on Patient D. Respondent failed to request Patient D's prior medical records. Respondent also failed to document Patient D's prior narcotic use through the PMP.

36. During this initial visit, Patient D reported to Respondent that he had tried "whatever pain meds he can get from friends." Despite this information, which should have alerted Respondent that Patient D had the potential for abuse or diversion, Respondent prescribed Patient D Oxycodone 10/325 mg every four (4) hours.

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37. On or about May 4, 2010, Respondent increased Patient D's Oxycodone prescription to thirty (30) mg every four (4) hours despite the fact that the patient did not complain of back pain, leg numbness, pain, insomnia or any other symptom that would justify increasing Patient D's prescription.

38. Further, on the same date, Patient D's urine drug screen tested negative for all substances, demonstrating that Patient D was not taking his medications as prescribed. Despite this test result, Respondent failed to counsel or discharge Patient D from his practice.

39. On or about February 1, 2011, Patient D presented to Respondent. During this appointment, Patient D's blood pressure was 147/95, indicating the patient was suffering from hypertension.

40. On or about April 28, 2011, Patient D presented to Respondent. During this appointment, Patient D's blood pressure was 153/105, indicating the patient was suffering from hypertension.

41. Patient D's medical records lack any documentation and/or evidence demonstrating that Respondent informed Patient D of the markedly elevated blood pressure readings on either February 1, 2011 or April 28, 2011.

42. Patient D's medical records lack any documentation and/or evidence demonstrating that Respondent ordered diagnostic testing regarding the elevated blood pressure readings on either February 1, 2011 or April 28, 2011.

43. Patient D's medical records lack any documentation and/or evidence demonstrating that Respondent treated Patient D's hypertension on either February 1, 2011 or April 28, 2011.

44. Patient D's medical chart lacks documentation regarding the nature and intensity of the patient's pain, the effect of pain on the patient's ability to function and the presence of recognized medical indications for the use of controlled substances.

F. Respondent's Care and Treatment of Patient E

45. Patient E was ten (10)-year-old female at the time the incidents in questioned commenced. Her true identity is not disclosed in this Complaint to protect her identity, but her

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identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

46. Patient E suffered from Type I Diabetes.

47. On or about September 16, 2000, Patient E presented to Respondent for a well check. Respondent reviewed Patient E's lab results that showed a critically elevated glucose level of two hundred eighty-four (284), an elevated calcium level of ten point eight (10.8), a decreased sodium level of one hundred twenty-nine (129) and a mean cell volume of seventy-five point one (75.1). Patient E's medical chart lacks documentation and/or evidence demonstrating that Respondent diagnosed and/or treated the critically elevated glucose level.

48. On or about September 30, 2000, Patient E presented to Respondent for a follow-up appointment. Respondent ordered lab work repeated on Patient E. The lab results showed a critically elevated glucose level of five hundred and three (503), a critically low carbon dioxide level of twelve (12), a glycohemoglobin of thirteen point one percent (13.1%) and a sodium level of one hundred thirty (130). Patient E's anion gap was elevated at twenty-seven (27). These results clearly demonstrated that Patient E was in metabolic acidosis caused by diabetic ketoacidosis. Despite these lab results, Respondent failed to refer Patient E to an endocrinologist.

49. Respondent prescribed Patient E Avandia, which is not approved by the Federal Drug Administration for use in patients with Type I Diabetes.

50. On or about December 4, 2007, Patient E underwent lab work. The lab results showed an extremely elevated glycohemoglobin level of fourteen point six percent (14.6%). During this appointment, Patient E complained of mood swings. Based on this information, Respondent diagnosed Patient E with Attention Deficit Disorder (ADD) without performing any psychological testing or referring Patient E to a psychologist. Further, Patient E's medical chart lacks any documentation and/or evidence, either subjective or objective, supporting Respondent's diagnosis.

51. Respondent prescribed Patient E Adderall and Geodon for her mood swings, without first determining whether Patient E's mood swings resulted from her extremely elevated glycohemoglobin levels.

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52. Further, Patient E's medical chart lacks any documentation and/or evidence demonstrating that Respondent was monitoring and/or managing Patient E's Type I Diabetes.

G. Respondent's Care and Treatment of Patient F

53. Patient F was a thirty-two (32)-year-old male at the time the incidents in question commenced. His true identity is not disclosed in this Complaint to protect his identity, but his identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

54. On or about March 8, 2010, Patient F established with Respondent as his pain management specialist. Patient F had a history of lumbar back pain, AADD, insomnia and Bipolar Disorder. Patient F's medical chart lacks documentation demonstrating that Respondent performed a family history, social history or past medical history on Patient F. Respondent failed to request Patient F's prior medical records. Respondent also failed to document Patient F's prior narcotic use through the PMP.

55. On or about July 19, 2010, Patient F submitted to a urine drug screen. Patient F's urine tested positive for the illicit drug commonly known as PCP. Patient F's medical chart lacks documentation and/or evidence demonstrating that Respondent counseled Patient F regarding this positive test or discharged Patient F from his practice due to this positive test.

56. The majority of the progress notes in Patient F's medical chart appear to be cloned, as the chief complaint and plan is exactly the same on each note.

57. The majority of the urine drug screens in Patient F's medical chart are not signed by the donor, the collector and/or Respondent.

58. Patient F's medical chart lacks documentation regarding the nature and intensity of the patient's pain, the effect of pain on the patient's ability to function and the presence of recognized medical indications for the use of controlled substances.

H. Respondent's Care and Treatment of Patient G

59. Patient G was a twenty-four (24)-year-old male at the time the incidents in question commenced. His true identity is not disclosed in this Complaint to protect his identity, but his

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identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

60. On or about May 4, 2010, Patient G established with Respondent as his pain management specialist. Patient G had a history of lumbar back pain, right jaw pain and anxiety. Patient G's medical chart lacks documentation demonstrating that Respondent performed a family history, social history or past medical history on Patient G. Respondent failed to request Patient G's prior medical records. Respondent also failed to document Patient G's prior narcotic use through the PMP.

61. Respondent failed to document in Patient G's medical chart that other treatment modalities or adjuvant therapies were considered, tried and failed prior to prescribing Patient G narcotic medications.

62. Patient G's medical chart demonstrates that Patient G was suffering from hypertension on July 29, 2010, September 30, 2010 and November 1, 2010. Patient G's medical chart lacks any documentation and/or evidence demonstrating that Respondent diagnosed and treated Patient G's hypertension on said dates.

63. The urine drug screens performed on Patient G by Respondent are inconsistent with Patient G's prescribed medications. For example, on September 30, 2010, Patient G's urine drug screen tested negative for opiates, even though Patient G was still being prescribed opiates by Respondent. There is no documentation and/or evidence in Patient G's medical chart demonstrating that Respondent counseled and/or discharged Patient G regarding the results of said test.

64. The majority of the urine drug screens in Patient G's medical chart are not signed by the donor, the collector and/or Respondent.

65. Patient G's medical chart lacks documentation regarding the nature and intensity of the patient's pain, the effect of pain on the patient's ability to function and the presence of recognized medical indications for the use of controlled substances.

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I. **Respondent's Care and Treatment of Patient H**

66. Patient H was a twenty-eight (28)-year-old female at the time the incidents in question commenced. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

67. On or about April 13, 2010, Patient H established with Respondent as her pain management specialist. Patient H had a history of arthralgia anxiety and Obsessive Compulsive Disorder. Patient H's medical chart lacks documentation demonstrating that Respondent performed a family history, social history or past medical history on Patient H. Respondent failed to request Patient H's prior medical records. Respondent also failed to document Patient H's prior narcotic use through the PMP.

68. On or about August 6, 2010, Patient H had a witnessed grand mal seizure and was hospitalized. Patient H was started on Dilantin. The neurology consult recommended Patient H's medication changed from Dilantin to Vimpat due to the patient's age and busy lifestyle. However, Patient H's medication was not changed at that time.

69. On or about August 10, 2010, Patient H presented to Respondent for follow-up after her hospitalization. Patient H's blood pressure during this visit was elevated at 169/105. Without performing lab work or referring the patient for a second neurology opinion, Respondent discontinued Patient H's Dilantin and started Patient H on Tegretol. Further, Patient H's medical chart lacks documentation and/or evidence demonstrating Respondent diagnosed and/or treated Patient H's elevated blood pressure.

70. The majority of the progress notes in Patient H's medical chart appear to be cloned, as the chief complaint and plan is exactly the same on the notes.

71. Patient H's medical chart lacks documentation regarding the nature and intensity of the patient's pain, the effect of pain on the patient's ability to function and the presence of recognized medical indications for the use of controlled substances.

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COUNT I
(Medical Records Violation – Eight Counts)

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

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

74. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patients A through H when he failed to document the nature and intensity of the patients' pain, the effect of pain on the patients' ability to function, and the presence of recognized medical indications for the use of controlled substances.

75. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patients A through H when he failed to document that other treatment modalities or adjuvant therapies had been considered.

76. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patients A through H when he failed to document that he had obtained the patients' prior medical records from prior treating physicians and the patients' prior narcotic use through the PMP.

77. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patients A through H when he failed to document that he performed a family history, social history or past medical history on Patients A through H.

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

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COUNT II
(Malpractice – Eight Counts)

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

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

81. 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.

82. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient A when he failed to confirm Patient A's AADD diagnosis; failed to obtain Patient A's prescription records from the PMP prior to prescribing Patient A controlled substances; failed to further evaluate and/or order diagnostic testing of the four (4)-centimeter mass on Patient A's liver; failed to treat Patient A's nonmalignant pain with other modalities and/or adjuvant therapies prior to prescribing Patient A controlled substances and/or dangerous drugs; failed to order diagnostic testing and/or imaging to determine the etiology of Patient A's pain; failed to prescribe controlled substances and/or dangerous drugs in accordance with the law; and failed to counsel and/or discharge Patient A after Patient A tested positive for illicit drugs.

83. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient B when he failed to obtain Patient B's prescription records from the PMP prior to prescribing Patient B controlled substances; failed to treat Patient B's nonmalignant pain with other modalities and/or adjuvant therapies prior to prescribing Patient B controlled substances and/or dangerous drugs; failed to order diagnostic testing and/or imaging to determine the etiology of Patient B's pain; failed to diagnose and/or treat Patient B's hypertension; failed to prescribe controlled substances and/or dangerous drugs in accordance with the law; and failed to counsel and/or discharge Patient B after Patient B tested positive for illicit drugs.

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84. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient C when he failed to obtain Patient C's prescription records from the PMP prior to prescribing Patient C controlled substances; failed to treat Patient C's nonmalignant pain with other modalities and/or adjuvant therapies prior to prescribing Patient C controlled substances and/or dangerous drugs; failed to order diagnostic testing and/or imaging to determine the etiology of Patient C's pain; failed to monitor Patient C's Tegritol levels; failed to monitor Patient C's white blood counts; failed to monitor Patient C's renal functions; failed to diagnose and/or treat Patient C's hypertension; and failed to prescribe controlled substances and/or dangerous drugs in accordance with the law.

85. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient D when he failed to obtain Patient D's prescription records from the PMP prior to prescribing Patient D controlled substances; failed to treat Patient D's nonmalignant pain with other modalities and/or adjuvant therapies prior to prescribing Patient D controlled substances and/or dangerous drugs; failed to order diagnostic testing and/or imaging to determine the etiology of Patient D's pain; failed to diagnose and/or treat Patient D's hypertension; failed to prescribe controlled substances and/or dangerous drugs in accordance with the law; and failed to counsel and/or discharge Patient D after Patient D's urine drug test results did not conform to his prescriptions.

86. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient E when he failed to monitor Patient E's Type I Diabetes; failed to diagnose and/or treat Patient E's critically elevated glucose level; failed to refer Patient E to an endocrinologist; failed to obtain Patient E's prescription records from the PMP prior to prescribing Patient E controlled substances; failed to treat Patient E's nonmalignant pain with other modalities and/or adjuvant therapies prior to prescribing Patient E controlled substances and/or dangerous drugs; failed to order diagnostic testing and/or imaging to determine the etiology of Patient E's pain;

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failed to recognize the patient's complaints resulted from her critically elevated glycohemoglobin levels; and failed to prescribe controlled substances and/or dangerous drugs in accordance with the law.

87. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient F when he failed to confirm Patient F's diagnosis of AADD, insomnia and Bipolar Disorder; failed to obtain Patient F's prescription records from the PMP prior to prescribing Patient F controlled substances; failed to treat Patient F's nonmalignant pain with other modalities and/or adjuvant therapies prior to prescribing Patient F controlled substances and/or dangerous drugs; failed to order diagnostic testing and/or imaging to determine the etiology of Patient F's pain; failed to counsel and/or discharge Patient F after Patient F's urine drug test results did not conform to his prescriptions; and failed to prescribe controlled substances and/or dangerous drugs in accordance with the law.

88. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient G when he failed to confirm Patient G's diagnosis of lumbar back pain, right jaw pain and anxiety; failed to obtain Patient G's prescription records from the PMP prior to prescribing Patient G controlled substances; failed to treat Patient G's nonmalignant pain with other modalities and/or adjuvant therapies prior to prescribing Patient G controlled substances and/or dangerous drugs; failed to order diagnostic testing and/or imaging to determine the etiology of Patient G's pain; failed to counsel and/or discharge Patient G after Patient G's urine drug test results did not conform to his prescriptions; failed to diagnose and treat Patient G's hypertension; and failed to prescribe controlled substances and/or dangerous drugs in accordance with the law.

89. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient H when he failed to confirm Patient H's diagnosis of Arthralgia, anxiety and Obsessive Compulsive Disorder; failed to obtain Patient H's prescription records from PMP prior to prescribing Patient H controlled substances; failed to treat Patient H's nonmalignant pain with

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other modalities and/or adjuvant therapies prior to prescribing Patient H controlled substances and/or dangerous drugs; failed to order diagnostic testing and/or imaging to determine the etiology of Patient H's pain; failed to diagnose and treat Patient H's hypertension and failed to prescribe controlled substances and/or dangerous drugs in accordance with the law.

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

COUNT III
(Unlawful Administration, Dispensing or Prescribing of Controlled Substances – Eight Counts)

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

92. NRS 630.306(3) provides that administering, dispensing or prescribing any controlled substance, or any dangerous drug, to others except as authorized by law is grounds for initiating discipline against a licensee.

93. As demonstrated by, but not limited to, the above-outlined facts, Respondent prescribed controlled substances and/or dangerous drugs in violation of the law when he failed to determine the etiology of pain for Patients A through H; failed to obtain the prescription record from the PMP for Patients A through H prior to prescribing Patients A through H controlled substances and/or dangerous drugs; failed to treat the nonmalignant pain of Patients A through H with other modalities and/or adjuvant therapies prior to prescribing controlled substances and/or dangerous drugs; failed to perform urine drug testing on Patients A through H, and failed to discharge and/or counsel patients whose urine drug screen results did not conform to their prescribed medications.

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

COUNT IV
(Practicing Beyond the Scope of Training – Eight Counts)

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

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96. NRS 630.306(5) provides that practicing or offering to practice beyond the scope permitted by law or performing services that the licensee knows or has reason to know that he is not competent to perform or which are beyond the scope of his or her training is grounds for initiating disciplinary action against a licensee.

97. Respondent's specialty is internal medicine, not pain management. As demonstrated by, but not limited to, the above-outlined facts, Respondent was prescribing controlled substances and/or dangerous drugs to patients without first determining the etiology of the patients' pain and considering other modalities and/or adjuvant therapies prior to prescribing the patients controlled substances and/or dangerous drugs. Further, as demonstrated by, but not limited to, the above-outlined facts, Respondent was practicing beyond the scope permitted by law and/or was performing services that were beyond the scope of his training.

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

COUNT V

(Continual Failure to Exercise the Skill or Diligence or Use the Methods Exercised by Physicians in the Same Specialty or Field – Eight Counts)

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

100. NRS 630.306(7) provides that the continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for initiating discipline against a licensee.

101. Respondent's specialty is internal medicine, not pain management. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to exercise the skill or diligence or use the methods exercised by physicians in the same specialty or field when he prescribed controlled substances and/or dangerous drugs to Patients A through H without first obtaining a prescription drug profile for each patient from the PMP prior to prescribing each patient controlled substances and/or dangerous drugs, without determining the etiology of each patient's pain, without considering other modalities and/or adjuvant therapies prior to prescribing

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each patient controlled substances and/or dangerous drugs and without referring patients to necessary specialists, like endocrinologists and psychologists.

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

COUNT VI

(Conduct that Violates the Standards of Practice – Eight Counts)

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

104. NRS 630.306(2)(b) provides that if the licensee engages in any conduct that is a violation of the standards of practice established by regulation of the Board is grounds for initiating disciplinary action against the licensee.

105. NAC 630.185 provides that NAC 630.185 to 630.230, inclusive, set forth the standards of practice established by the Board.

106. NAC 630.230(k) provides that a licensee shall not engage in the practice of writing prescriptions for controlled substances to treat acute pain or chronic pain in a manner that deviates from the policies set forth in the *Model Policy for the Use of Controlled Substances for the Treatment of Pain* adopted by reference in NAC 630.187.

107. As demonstrated by, but not limited to, the above-outlined facts, Respondent prescribed controlled substances and/or dangerous drugs in violation of the law when he failed to determine the etiology of pain for Patients A through H, failed obtain the prescription record from the PMP for Patients A through H prior to prescribing Patients A through H controlled substances and/or dangerous drugs, failed to treat the nonmalignant pain of Patients A through H with other modalities and/or adjuvant therapies prior to prescribing controlled substances and/or dangerous drugs, failed to perform urine drug testing on Patients A through H, and failed to discharge and/or counsel patients whose urine drug screen results did not conform to their prescribed medications.

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

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

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);

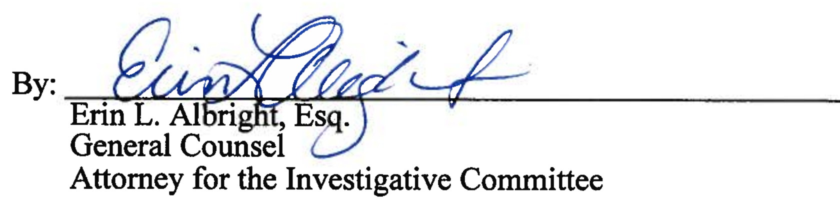
3. That the Board determine the sanctions it will impose if it finds Respondent violated the Medical Practice Act;

4. That the Board make, issue and serve on Respondent, in writing, its findings of fact, conclusions of law and order, which shall include the sanctions imposed; and

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

DATED this 13th day of February, 2014.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ______________________
Erin L. Albright, Esq.
General Counsel
Attorney for the Investigative Committee

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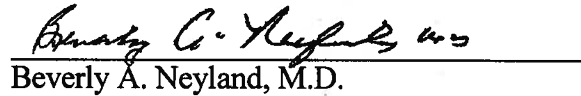
VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Beverly A. Neyland, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that she is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against the Respondent herein; that she has read the foregoing Complaint; and that based upon information discovered during the course of the investigation into a complaint against Respondent, she believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

Dated this 13th day of February, 2014.



Beverly A. Neyland, M.D.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
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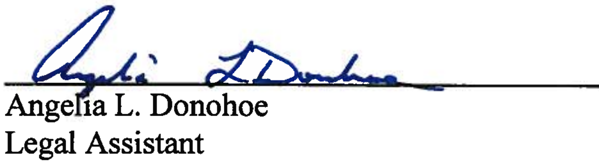
CERTIFICATE OF SERVICE

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 13th day of February 2014; I served a filed copy of COMPLAINT, PATIENT DESIGNATION & FINGERPRINT INFORMATION, via USPS e-certified mail to the following:

John A. Hunt, Esq.
500 South Rancho Dr., Ste. 17
Las Vegas, NV 89106-4847

Dated this 13th day of February, 2014.



Angelia L. Donohoe
Legal Assistant

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