BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against ERIK JON SIRULNICK, M.D., Respondent.	**Case No. 20-30471-1**

FILED
SEP 18 2020
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert Kilroy, Esq., General Counsel and attorney for the IC, having a reasonable basis to believe that Erik Jon Sirulnick, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 11522). Respondent was originally licensed by the Board on July 14, 2005.

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

3. On October 13, 2015, Patient A was admitted for a pacemaker lead change, lead extraction, and placement of an automatic implantable cardioverterdefibrillator. At approximately 11:45 p.m., Patient A was taken to the operating room (OR) and the aforementioned procedures were to be done by Respondent (main operator) and Dr. Kahn (co-operator as Respondent lacked privileges to perform extraction). Respondent kept a laser sheath located in the Patient A's right ventricle and

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Wayne Hardwick, M.D., Chairman, Mr. M. Neil Duxbury, and Aury Nagy, M.D.

placed a wire through the sheath into the right ventricle. Believing his procedure to be complete, Respondent left the OR. Upon Respondent returning to the OR, there were two other wires in Patient A's heart that inadvertently cannulated into a likely third space within the dissected media. Patient A's innominate artery was made friable by the laser removal, which could have exposed a flap of vulnerable tissue. Near the end of these procedures, Patient A's laser lead was removed and she became hypotensive. Subsequently, the dismissed (by the Respondent) cardiac surgeon was called back into the OR, and Patient A underwent a median stenotomy, which lasted several hours, in order to control the bleeding coming from what was identified as a large laceration on the underside of the left subclavian-innominate vein, superior vena cava, and the right atrium. This surgeon noted a right hemothorax, a fair amount of mediastinal hematoma encountered with free blood in the pericardial space, and free blood exited from the right atrium and the underside of the innominate vein. Patient A died shortly thereafter.

4. On October 14, 2015, the Clark County Nevada Coroner opined Patient A's death was caused by accident (therapeutic complication). Patient A died of exsuguination due to laceration of the subclavian vein, innominate vein, superior vena cava and right atrium, due to laser pacemaker lead extraction, due to pacemaker-dependent congestive heart failure and other significant contributing conditions, including hypotensive and atherosclerotic cardiovascular disease.

COUNT I

NRS 630.301(4) (Malpractice)

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

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

7. 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.

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8. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he provided medical services to Patient A.

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

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Complete Medical Records)

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

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

12. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete.

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

COUNT III

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

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

15. Violation of a standard of practice established by regulation of the Board is grounds for imitating disciplinary action pursuant to NRS 630.306(1)(b)(2).

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

17. Respondent failed to timely seek consultation with regard to Patient A's medical condition of hypotension and Respondent should have consulted with an appropriate care provider

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to address the doubtfulness of the diagnosis of this condition, and such a consultation would have confirmed or denied such a diagnosis.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes 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 20 day of September, 2020.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Robert Kilroy, Esq., General Counsel
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Mr. M. Neil Duxbury, 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 18th day of September, 2020.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

M. Neil Duxbury

M. Neil Duxbury, Chairman

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