BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: GUIDO ALBERT TORRES, M.D., Respondent.	**Case No. 21-7212-1**

FILED
MAR - 4 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., General Counsel and attorney for the IC, having a reasonable basis to believe that Guido Albert Torres, 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. 6294). Respondent was originally licensed by the Board on July 1, 1991.

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 March 7, 2016, Patient presented to Respondent for a preoperative visit, where she consented to the following medical procedures: laparscopy, hysteroscopy, and D & C, and was given a urine pregnancy test as ordered by Respondent. A review of the pre-operative History & Physicial Report, which the Respondent dictated on March 15, 2016, indicates that Respondent

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[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 Victor M. Muro, M.D., Chairman, Rachakonda D. Prabhu, M.D., and Ms. Sandy Peltyn.

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did not include information regarding, nor assessment of, Patient A's reproductive status prior to surgery.

4. On March 16, 2016, Respondent attempted to perform the aforementioned procedures at Spring Valley Hospital Medical Center. After performing a disgnostic laparoscopy, Respondent attempted several times to remove an endometrial mass without success. Respondent performed a endometrial curettage and the surgery ended. Despite previously ordering the pregnancy test during the preop visit, Respondent was not aware of Patient A's positive test results as he proceeded to perform the surgery upon Patient A. Subsequently to learning the positive pregnancy test, Respondent ordered a serum pregnancy test from the blood drawal at the pre-op visit. Respondent's History & Physicial Update form does not include any information regarding Patient A's reproductive status.

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.

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, because Respondent failed to assess her reproductive status prior to surgery despite ordering a pregnancy test.

9. 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

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. Therefore, Patient A's medical records were not timely, legible, accurate, and complete, because Respondent failed to appropriately document Patient A's reproductive status through acknowledgement of the positive pregnancy test and providing an assesstment within the medical records.

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 conditions and Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of this condition, and such a consultation would have confirmed or denied such a diagnosis.

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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 award fees and costs for the investigation and prosecution of this matter as outlined in NRS 622.400;

5. 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

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

DATED this 3 day of March, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Victor M. Muro, 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 3rd day of March, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: V M Muro MD
Victor M. Muro, M.D., Chairman