NEVADA STATE BOARD OF MEDICAL EXAMINERS

NEWSLETTER

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Alzheimer's Association International Conference Research Update

Guest Contributor:
***Jacob R. Harmon**, Regional Director, Northern Nevada Alzheimer's Association*
Northern California and Northern Nevada

Alzheimer's disease is not just an aging issue, it is a public health crisis. There are more than 5 million Americans living with Alzheimer's or a related dementia, and a person living with Alzheimer's is three times more expensive to care for than a senior without. The cost to Medicare and Medicaid of caring for someone living with Alzheimer's disease was more than $140 billion last year. As baby boomers turn 65 at the rate of 40,000 a day, it is not difficult to see the looming healthcare crisis posed by Alzheimer's.

Alzheimer's research is of critical importance to proactively solving the Alzheimer's dilemma. New research into the causes of the disease, into methods for early detection, and into treatments that might slow the progression of the disease offers hope. The Alzheimer's Association International Conference (AAIC) is the world's largest gathering of leading researchers from around the world focused on Alzheimer's and other dementias. Held in Copenhagen, AAIC 2014 brought together approximately 4,000 leading experts and researchers from 75 countries around the world, and featured more than 1,700 scientific presentations, a few of which mentioned below offer particularly exciting insight.

FEATURED IN THIS ISSUE:

ALSO IN THIS ISSUE:

Potential for smell and eye tests in early detection of Alzheimer's

Two studies provided increasing evidence that the inability to correctly identify odors may indicate the development of cognitive impairment and Alzheimer's disease. Researchers in one study found that loss of brain cell function and worsened memory were associated with smell identification ability. Another study found that odor identification deficits were linked with an increased risk of transition from mild cognitive impairment (MCI) to Alzheimer's disease.

Two additional studies looked at possible eye tests to detect Alzheimer's. Preliminary results from one study suggest that there is a significant association between the level of beta-amyloid protein, the main component of Alzheimer's brain "plaques," in the brain and levels detected in the retina. In another study, researchers compared amyloid levels based on an eye lens test to amyloid plaque buildup estimates from brain positron emission tomography (PET) scans and were able to accurately differentiate those with Alzheimer's disease from those without it.

Largest study of brain tau PET imaging suggests scans' ability for early detection of dementia

Using a newly developed PET scan technology to "see" tau in the brains of living people, scientists found that study participants with higher levels of tau buildup in areas of the brain important to memory performed worse on memory tests over three years. The Alzheimer's Association says the findings demonstrate the potential value of tau PET scans in early detection of dementia and in identifying participants for Alzheimer's and dementia research studies. *Article continued on page 2*

MISSION STATEMENT

The Nevada State Board of Medical Examiners serves the state of Nevada by ensuring that only well-qualified, competent physicians, physician assistants, respiratory therapists and perfusionists receive licenses to practice in Nevada. The Board responds with expediency to complaints against our licensees by conducting fair, complete investigations that result in appropriate action. In all Board activities, the Board will place the interests of the public before the interests of the medical profession and encourage public input and involvement to help educate the public as we improve the quality of medical practice in Nevada.

Continued from front page

Lifestyle interventions may improve memory and thinking in middle-age and older adults

A two-year randomized controlled clinical trial showed that people who received nutritional guidance, physical exercise, cognitive training, social activities and management of heart health risk factors performed significantly better on a comprehensive scale of memory and thinking, and on specific tests of memory and executive function compared with people who received only regular health advice.

In a separate study, researchers found that participants who self-reported a higher levels of mental stimulation – such as reading, visiting museums, playing games like puzzles and cards – had higher test scores for memory and thinking challenges, such as planning, judgment and problem-solving. They also had greater volume in several brain regions involved in Alzheimer's disease.

Exercise in mid- and late-life associated with decreased risk of dementia

Two studies reported evidence that regular physical activity may reduce the risk of Alzheimer's and other dementias. In one study, researchers found that a history of moderate physical exercise in middle age was associated with a significantly decreased risk of mild cognitive impairment (MCI). In a second study, researchers found that light physical exercise in midlife and late life was associated with a decreased risk of MCI, as was vigorous physical exercise in midlife and moderate physical exercise in late life.

Late-onset high blood pressure could protect against dementia

While hypertension during midlife may increase risk for Alzheimer's and other dementias, there is emerging evidence that its association with dementia risk may change over time, and may instead help protect against dementia in people age 90 and over. Researchers followed older adults in the U.S. without dementia for up to 10 years and found that those with the onset of high blood pressure at age 80 to 89 had a significantly lower risk of developing dementia compared with participants with no history of high blood pressure. Those with the onset of hypertension at age 90 or older had even lower dementia risk.

Psychological intervention for caregivers may reduce anxiety and depression

A randomized controlled trial in the U.K. found that an eight-week psychological support program for family caregivers of people with dementia significantly reduced caregivers' anxiety and depression, and the impact lasted for two years. The support program included education about dementia, caregiver stress and where to get emotional support, and techniques for dealing with caregiving challenges

Diabetes drug associated with reduced risk of dementia

A study of a large German database of people age 60 or older who were free of Alzheimer's and other dementias found that long-term use of the diabetes drug pioglitazone may reduce incidence of dementia. Researchers at AAIC 2014 presented the study, which examined more 145,712 subjects over six years. Results suggest that reduced risk of dementia was significantly associated with use of pioglitazone. Researchers noted one possible theory is the drug's ability to suppress neuroinflammation.

Additional abnormal protein, TDP-43, found in brains of people with Alzheimer's

Researchers identified that an abnormal protein, known as TDP-43, may play an important role in Alzheimer's disease along with two previously identified proteins. Researchers examined the brains of 342 people identified after death as having Alzheimer's-related changes for the presence, amount and distribution of TDP-43. More than half the brains had TDP-43. In addition, people with TDP-43 were ten times more likely to have been cognitively impaired at death than subjects without it. The scientists speculate that TDP-43 may help explain why some people have Alzheimer's changes in their brain, but do not experience dementia.

In addition to the exciting biomedical research that is being done, the fight against Alzheimer's is being fought every day by the nearly 40,000 families in Nevada living with Alzheimer's disease. The Alzheimer's Association is not only the largest non-profit funder of Alzheimer's research in the world, but also offers individualized supportive services to families living with Alzheimer's or a related dementia throughout Nevada. Please call the ***24/7 Helpline*** at 1-800-272-3900 with any questions or for information about dementia care services in Nevada.

Contact:
Jacob R. Harmon, *Regional Director, Northern Nevada Alzheimer's Association - Northern California and Northern Nevada*
Email: jharmon@alz.org ***Phone:*** (775) 786-8061 ***Fax:*** (775) 786-1920
24/7 Helpline*:* (800) 272-3900

Disclaimer: The opinions expressed in the Guest Contributor's article are those of the author, and do not necessarily reflect the opinions of the Board members or staff of the Nevada State Board of Medical Examiners.

BOARD MEMBER NEWS

Sandy Peltyn Joins Board of Medical Examiners

Governor Brian Sandoval has appointed Sandy Peltyn as the new public member of the Board, effective July 1, 2014.

Since 2004, Ms. Peltyn has been the principal in charge of Business Development/Marketing, Political Affairs and Community Relations for DeSimone Consulting Engineers. Working with her husband, the late structural engineer, Roger Peltyn, for twenty years in the same capacity, they were able to secure many of Las Vegas' biggest projects, including the Wynn Las Vegas, Ceasar's Palace Hotel, Venetian Hotel, Paris Hotel and Thomas & Mack Center.

Ms. Peltyn also serves on the Executive Board and the Foundation Board of St. Rose de Lima/Dignity Health and has been appointed by President Barack Obama to serve as one of 24 commissioners to perform feasibility studies to bring to life the first ever museum of the American Latino under the umbrella of the Smithsonian Institute.

With a nearly 35 year history of community service, cultural activities and humanitarian work, Ms. Peltyn has served Nevada and Las Vegas with distinction. In 2002, Governor Kenny Guinn appointed Ms. Peltyn to the Board of Directors for Independent Nevada Doctors (IND), serving as Chair of the Community Outreach Committee and Head of Public Relations. Ms. Peltyn established the Foundation for Excellence and Distinction in 2005 and through proceeds garnered from the annual Senoras of Excellence/Senores of Distinction Awards Gala, has presented more than 600 scholarships for higher education in Nevada. Ms. Peltyn's most recent awards include: Epicurean Club Woman of the Year, The College of Southern Nevada Woman of the Year, The Hispanic of the Year Award for the Latin Chamber of Commerce and Volunteer of the Year Award presented by the Juvenile Diabetes Foundation.

Ms. Peltyn was born in San Juan, Puerto Rico, where she attended Inter American University, majoring in Humanities, with a minor in Music. She has performed throughout the world as a singer, hosting and producing two award-winning television shows in Puerto Rico and a talk show in New York.

Board Elects New Officers

On 5 September 2014, the Board of Medical Examiners voted to retain its current leadership by re-electing its three officers for another yearly cycle. Dr Michael Fischer, Carson City, was retained as President; Dr. Theodore Berndt, Reno, was retained as Vice President; and Ms Valerie Clark, Reno, was retained as Secretary-Treasurer. The three officer positions comprise the Board's Executive Committee, which acts to review administrative, limited budget, and personnel matters not subject to the open meeting law, between Board meetings.

BOARD MEMBERS

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NOTIFICATION OF ADDRESS CHANGE, PRACTICE CLOSURE AND LOCATION OF RECORDS

Pursuant to NRS 630.254, all licensees of the Board are required to "maintain a permanent mailing address with the Board to which all communications from the Board to the licensee must be sent." A licensee must notify the Board in writing of a change of permanent mailing address within 30 days after the change. Failure to do so may result in the imposition of a fine or initiation of disciplinary proceedings against the licensee.

Please keep in mind the address you provide will be viewable by the public on the Board's website.

Additionally, if you close your practice in Nevada, you are required to notify the Board in writing within 14 days after the closure, and for a period of 5 years thereafter, keep the Board apprised of the location of the medical records of your patients.

An Interview with Anthony J.G. Alastra, M.D., FAANS

A Neurosurgeon Discusses Medical Devices, Malpractice & High-Risk Patients

Guest Author: Rachel V. Rose, JD, MBA

Spine surgery is considered one of the most lucrative areas in the practice of medicine and is performed by either a neurosurgeon or an orthopaedic surgeon. Kyphoplasty or vertebroplasty, which are procedures where a type of cement is injected into the vertebral body to restore its integrity, are sometimes performed by radiologists and neuroradiologists. Yet, with high returns comes high-risk for both the physician and the hospital. Hence, there is a need for discussion around the issues these specialists face.

Dr. Alastra is a board-certified neurosurgeon in New York City, who did his residencies at Vanderbilt University and New York University. His perspectives on various issues includes: a surgeon's risk threshold on utilizing a newly-approved device or being involved in pre-market approval testing, medical malpractice insurance considerations, deciding what treatment options to provide patients; and operating on high-risk patients – just to name a few.

RR: How did you choose neurosurgery as a specialty?

AA: I was always interested in neuroscience ever since my time in college. I entered medical school with the intention of pursuing a neuroscience-related specialty. I found that I excelled in surgical sciences and was fascinated with surgical care, surgical technique and practice, and surgical practice. Together, this made neurosurgery the obvious choice. Once I was able to explore the world of neurosurgery in medical school—I was hooked.

RR: Dr. Alastra, would you please provide us with a synopsis of your practice's case mix?

AA: I am a general practice neurosurgeon with fellowship training in endovascular neurosurgery as well as a focus on minimally-invasive spinal surgery. With my partners, we see the gamut of neurosurgical disease, but my focus is on neurosurgical vascular disorders such as cerebral aneurysms, stroke, etc. and on degenerative spine conditions (which is the majority of a general neurosurgeon's practice). I spend usually about 25% of my time on vascular issues, 10% on general neurosurgery such as tumors, shunts, etc., and 65% on spinal conditions.

RR: What is your thought process for determining your risk threshold before operating on a certain patient type, utilizing a newly-FDA-approved device, or becoming involved in a clinical trial?

AA: My thought process always begins with a thorough review of the situation from two perspectives: The first is, "What is the goal of the planned trial or new device?" The second is: "What is the impact on my practice of neurosurgery?" When looking at devices or trials, one can become clouded by the concept of novelty—everything that is new must be cool or great or better and corporate and scientific America are great at exploiting this. But asking this question really forces you to look past corporate marketing and scientific hype and evaluate a product or trial for what it is: A useful new tool or a trial set up to answer a valid question versus a reinvention of the wheel with a novel tweak, or a trial made to validate this—consider trials made not to "show improved outcomes," but made only "to show no increase harm versus standard care." When looking at the impact on practice, what this means is: If I adopt said product or treatment, am I going to get any use out of it for my patients, are my patients going to see the real benefits? And that is different from me seeing the benefits—that should not and never be part of the evaluation protocol. In the end, thorough and discriminating review of the scientific literature should always be performed, but one has to understand the background debates in the field surrounding said product(s) and/or goals of the medical community regarding trial outcomes. Oftentimes, I will listen in on debates at our national/international society meetings and then ask some of the larger players in these debates what the underlying issues are, and that often helps in deciding what and how I use new products, get involved with trials, or participate in new product evaluations.

RR: Can you explain the decision-making process for selecting a particular procedure or course of treatment?

AA: Surgeons generally are aggressive or conservative. I am a conservative surgeon. I look at things from the standpoint of I treat patients as I would want myself or my family to be treated. Sometimes we tend to use CT scans or MRI scans to treat and forget to evaluate the patient as a whole. They work, they may not work; they have expectations -

Continued from page 4

sometimes appropriate, sometimes inappropriate. They have competing goals - sometimes appropriate sometimes not, sometimes secondary-gain issues. Most of the time, people are sincere and just want to feel better. Sometimes people have no choices with their diagnosis and their treatment is well circumscribed. I generally look to sort out all of these issues while evaluating the patient for the initial problem. Once I feel a patient is a surgical candidate—meaning they have exhausted conservative therapies (when appropriate), and I feel surgical intervention can be beneficial and the patient can deal with the ramifications of surgery both medically and psychosocially, then I decide on a surgical plan(s) (sometimes there is more than one surgical option). I then have a long discussion with the patient regarding the surgical plan(s), going over what I feel are the important issues to decide upon. Then, once we discuss these issues, I decide on the appropriate surgery and then we discuss the risk/benefits/expectations/courses, etc. When deciding on a particular treatment, it is important to have confidence in the overall plan for the patient, as well as plans in the future should things not turn out like one wants. Also, most neurosurgical procedures are tried and true, with newer ones just being tweaks and refinements of older techniques, so confidence on these comes with experience and practice. I usually reserve the newest techniques or procedures for the "perfect patient"—free of confounding factors that could make my own practice and perfection of newer techniques less prone to misstep or the natural error of humanity. Once you are confident of a technique in your hands on the best of patients, you will be better able to deal with it on a less than perfect patient. I try to avoid the natural urge of surgeons to be overcome by their own egotistical tendencies to 'bite off more than they can chew.' Personally, I think the surgeon who knows the most or is the most technically skilled is the one who also understands his or her own limitations and factors that into their practice. Keeping up to date on 'best practice guidelines' and noting what other surgeons do when attending national meetings or reviewing medical literature also helps in understanding where surgical trends are going, but I still feel the ultimate decision is between the surgeon and the patient for elective procedures.

RR: Many state medical boards, including Nevada, see an increase in the number of complaints against doctors who treat high-risk patients. From your perspective, what are the best ways to mitigate both a complaint and a malpractice lawsuit in this patient population? For example, informed consent, full disclosure, and knowing that the patient's family fully understands the risks.

AA: Several issues here: High-risk is a vague term applied vaguely and inconsistently across the medical spectrum. This could refer to severe comorbidities that make anesthesia for elective surgery high-risk for a complication such as heart attack, stroke, pulmonary issues, or even death. In this case, it essentially comes down to a team approach between all the necessary physicians to determine if surgery can be safely performed, and if so, how, and then with appropriate team management post-operatively. Sometimes this needs to be done at a center that has the best experience with high-risk patients of this sort. The most important issue with these patients is to have a candid discussion with these patients as to their high-risk and to have them understand that even in the best of surgical outcomes, high-risk patients have a higher chance of bad overall outcomes, if they didn't they wouldn't be high-risk. Many times, patients don't understand this.

High-risk also could mean high-risk for treatment failure—meaning the chances of success of treatment by a surgical procedure are low. Example: multilevel lumbar fusion for treatment of chronic back pain. Another: Craniotomy for high-grade glial origin brain tumors. Both are impacted more by the disease process than the surgical intervention, and both have poor functional success rates. This doesn't mean a patient should avoid surgery or not consider surgery (sometimes all other options have failed them), but you cannot expect even the best surgery to reverse a course of disease that has a relentless progressive course that has yet to be cured or reversed. Sometimes we can achieve some level of control, but many times surgery is just a way to delay the inevitable. Patients need to understand their disease processes better and be educated on what is an appropriate possible outcome—especially in high-risk for treatment failure surgeries—before undergoing surgery. Too many times patients are expecting to be 'cured' of their disease, when the only option for them with or without surgery is better 'control' or 'management' of the disease. This especially gets lost when patients 'doctor shop' - going from one M.D. to the next 'shopping' for the best outcome, as opposed

Continued from page 5

to getting numerous opinions. Unfortunately, our profession is rife with docs ready to tell you that only 'they' can treat your problem, and 'they' are the best at such and such, and 'they' can cure you or rid you of your back pain. I am still waiting to meet 'this' doc, because that doc does not exist.

Lastly, is the concept of high-risk specialists: These can often be the truly most experienced surgeon in an area with many years of experience in high-risk surgery and often get many referrals from their peers. Usually, they are in the larger academic institutions or high-volume hospitals. These are the docs we want and should encourage and usually they are great at explaining issues such as high-risk to their patients. Sometimes, though, specialists who take on high-risk patients or treatments use the concept of high-risk as an excuse to perform whatever surgery they want and guise poor outcomes as "well, it was high-risk from the start, so you can't complain if you have a poor outcome; you had no other choice; no one else would touch you…" I wouldn't let that type of person operate on me, and I would never give someone that type of argument. Patients always have options. That surgeon just didn't give you the option of "not a surgical candidate."

Most malpractice cases (when there isn't true malpractice, i.e. error) come down to two things: lack of understanding of potential surgical complications and outcomes from the start at the informed consent and decision-making process, and lack of management of post-operative care issues with respect to the patient's expectations even in a picture-perfect surgical scenario.

RR: How do you and your group evaluate medical malpractice insurance?

AA: Unfortunately, we don't evaluate them much. We have few choices. It is the med-mal (medical malpractice) that evaluates us for the most part and then, sets a price for coverage depending on how much (over-coverage) or how little (state minimum requirements) we want to insure ourselves for. Then we have to find a way to pay that price. Most of the time we look at past years, trends in payouts over the group and then figure a coverage need from that and then shop for coverage. In New York, there are limited med-mal companies allowed to operate in the state and hospitals have restrictions on which ones they will allow as coverage for private physicians, so essentially it is a loose monopoly not subject to supply-and-demand economic forces.

RR: Are you discovering that medical malpractice insurance does not cover certain types of procedures?

AA: Not really here in New York. More to point are medical insurers not willing to pay for certain procedures. But that is well known for years across the board. Essentially, I have not come across a physician who was told by a med-mal insurer he/she would not be covered for a certain procedure. I think it is more of a hospital's responsibility to restrict a physician's ability to perform said procedure. That type of restriction I have heard of before. Now if it comes to a hospital's attention via a med-mal company, I wouldn't be surprised, but I have no firsthand knowledge to it actually happening.

RR: Do you consult with any medical device companies?

AA: I have a relationship with Medtronic Sofamor Danek for consulting and educational activities as well as consulting and evaluation activities with Spine Frontier.

RR: What changes have you seen in the spine surgery industry over the past 10 years?

AA: The continued trend towards minimally-invasive spinal surgery continues to be the force driving the spine surgery industry, as well as better biologics for arthrodesis. These two are the main focus on the industry right now.

RR: What advice would you give physicians who refer to either neurosurgeons or orthopaedic surgeons for spine procedures?

AA: Many times there are restrictions imposed by insurance companies for referrals, but if you have a choice, then use that choice and vet out your local practitioners. Some spine specialists do better in one area than another or with a certain demographic or type of patient than others. Don't hesitate to ask them questions regarding their philosophy of care or about a particular disease entity and its treatment, not just the treatment of your particular referral. Docs who wine-and-dine you but, then, don't send you letters regarding your referrals or updates on progress may not necessarily

Continued from page 6

be the best spine surgeons around. Most importantly, ask your patients what they thought of the doctor. If you feel a patient needs a referral to a spine specialist that is out of the area of your usual general spine practitioner, don't be afraid to call for a recommendation or to discuss the case and educate yourself. If you are told by a patient that he or she needs a spine procedure that you have never heard of, the web and PubMed are great resources for study, and then call the surgeon and try to learn what they want to do and why.

Anthony J.G. Alastra, M.D., FAANS, is a board-certified neurosurgeon who has been in private practice for over a decade with Healthcare Associates in Medicine, PC in Staten Island, New York. He also holds academic appointments as a Clinical Assistant Professor of Neurosurgery with the New York University School of Medicine and New York University Langone Medical Center. Dr. Alastra has authored various articles and book chapters on a variety of clinical conditions. Prior to entering private practice, Dr. Alastra served as Chief Resident at Vanderbilt University's Department of Neurological Surgery and did a fellowship in Interventional Neuroradiology at the New York University Medical Center. He holds a BS from Johns Hopkins University and an M.D. from Case Western Reserve University School of Medicine. He is currently licensed in New York and New Jersey.

About the Author

Rachel V. Rose, JD, MBA is a Principal with Rachel V. Rose – Attorney at Law, PLLC located in Houston, TX. Ms. Rose holds an MBA with minors in healthcare and entrepreneurship from Vanderbilt University, and a law degree from Stetson University College of Law, where she graduated with various honors, including the *National Scribes Award* and *The William F. Blews Pro Bono Service Award*. Ms. Rose is licensed in Texas. Currently, she is Vice Chair of Publications for the Federal Bar Association's Corporations and Associations Counsel Division, the Co-editor of the American Health Lawyers Association's *Enterprise Risk Management Handbook for Healthcare Entities* (2nd Edition) and Vice Chair of the Book Publication Committee for the Health Law Section of the American Bar Association and Co-author of the ABA's publication, *The ABCs of ACOs*. Ms. Rose is an Affiliated Member with the Baylor College of Medicine's Center for Medical Ethics and Health Policy. She can be reached at: rvrose@rvrose.com.

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HHS Announces Nearly $212 Million in Grants to Prevent Chronic Disease

Funded in part by the Affordable Care Act, grants focus on preventing tobacco use, obesity, diabetes, heart disease, and stroke

Health and Human Services Secretary Sylvia M. Burwell announced nearly $212 million in grant awards to all 50 states and the District of Columbia to support programs aimed at preventing chronic diseases such as heart disease, stroke and diabetes. Funded in part by the Affordable Care Act, the awards will strengthen state and local programs aimed at fighting these chronic diseases, which are the leading causes of death and disability in the United States, and help lower our nation's health care costs.

A total of 193 awards are being made to states, large and small cities as well as counties, tribes and tribal organizations, and national and community organizations, with a special focus on populations hardest hit by chronic diseases. The Centers for Disease Control and Prevention will administer the grants.

"These grants will empower our partners to provide the tools that Americans need to help prevent chronic diseases like heart disease, stroke, and diabetes," said Secretary Burwell. "Today's news is important progress in our work to transition from a health care system focused on treating the sick to one that also helps keep people well throughout their lives."

The goals of the grant funding are to reduce rates of death and disability due to tobacco use, reduce obesity prevalence, and reduce rates of death and disability due to diabetes, heart disease, and stroke.

"Tobacco use, high blood pressure and obesity are leading preventable causes of death in the United States," said CDC Director Tom Frieden, M.D., M.P.H. "These grants will enable state and local health departments, national and community organizations, and other partners from all sectors of society to help us prevent heart disease, cancer, stroke and other leading chronic diseases, and help Americans to live longer, healthier, and more productive lives."

This is one of many ways the Affordable Care Act is improving access to preventive care, and coverage for people with pre-existing conditions. Under the Affordable Care Act, 76 million Americans with private health insurance have gained access to preventive care services without cost-sharing, and issuers can no longer deny coverage to anyone because of a pre-existing condition.

Chronic diseases are responsible for 7 of 10 deaths among Americans each year, and they account for more than 80 percent of the $2.7 trillion our nation spends annually on medical care.

For state-by-state lists of funding awards visit: http://www.cdc.gov/chronicdisease/about/2014-foa-awards.htm.

Contact: HHS Press Office (202) 260-6342 ***Note:*** All HHS press releases, fact sheets and other materials available at: http://www.hhs.gov/news.

Suggested Safeguards to Improve Prescription Writing

By: Jerry C. Calvanese, M.D.

Frequently we have had physicians and physician assistants appear before the Board to address controlled substance prescribing issues. In an effort to curb these appearances and to protect the health care professional and the public, below are some important suggestions and safeguards:

Protect Prescriptions

- Protect access to prescription pads.
- Keep prescriptions pads in a locked office and/or locked drawer and limit access to the area.
- Lock and restrict access to all dispensing facilities in the office.

Writing Prescriptions

- Limit the number of pills prescribed.
- Limit refills.
- Do not write multiple prescriptions for the same opiate with advanced dates.
- Write out the number of pills to be dispensed.
- Utilize electronic prescriptions instead of paper, when possible.
- Maintain the same health care provider in a group setting, oversee patient care and write the prescription for controlled substances and chronic pain, when possible.

Adherence to strict prescribing policy

- Safeguard medical license and DEA number.
- Only use medical license number and DEA numbers as required by law.
- Specify photo ID should be presented for prescription before it is filled.
- Enforce strict "refill policies" and "lost prescription policies."
- Obtain unused opioid prescription bottle from patient when switching patient to a different opioid.
- Use state Prescribing Monitoring Program (PMP AWARxE) when available. This should be used before dispensing any controlled substance to a new chronic pain patient.

Nevada State Board of Pharmacy Prescription Monitoring Program (PMP AWARxE): http://bop.nv.gov/links/PMP/
For Administrative Assistance Email: pmp@pharmacy.nv.gov

DEA Final Rule Scheduling of Hydrocodone Combination Products Effective as of October 6, 2014

(WASHINGTON)–On Friday, August 22, 2014, the U. S. Drug Enforcement Administration (DEA) published in the *Federal Register* the Final Rule moving hydrocodone combination products (HCPs) from Schedule III to the more-restrictive Schedule II, as recommended by the Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS) and as supported by the DEA's own evaluation of relevant data. The *Federal Register* has made the Final Rule available for preview on its website at: http://go.usa.gov/mc8d.

This Final Rule imposes the regulatory controls and sanctions applicable to Schedule II substances on those who handle or propose to handle HCPs. It goes into effect October 6, 2014.

The Controlled Substances Act (CSA) places substances with accepted medical uses into one of four schedules, with the substances with the highest potential for harm and abuse being placed in Schedule II, and substances with progressively less potential for harm and abuse being placed in Schedules III through V. (Schedule I is reserved for those controlled substances with no currently accepted medical use and lack of accepted safety for use.) HCPs are drugs that contain both hydrocodone, which by itself is a Schedule II drug, and specified amounts of other substances, such as acetaminophen or aspirin.

"Almost seven million Americans abuse controlled-substance prescription medications, including opioid painkillers, resulting in more deaths from prescription drug overdoses than auto accidents," said DEA Administrator Michele Leonhart. "Today's action recognizes that these products are some of the most addictive and potentially dangerous prescription medications available."

When Congress passed the CSA in 1970, it placed HCPs in Schedule III even though it had placed hydrocodone itself in Schedule II. The current analysis of HCPs by HHS and the DEA shows they have a high potential for abuse, and abuse may lead to severe psychological or physical dependence. Adding nonnarcotic substances like acetaminophen to hydrocodone does not diminish its abuse potential. The many findings by the DEA and HHS and the data that support these findings are presented in detail in the Final Rule on the website. Data and surveys from multiple federal and non-federal agencies show the extent of abuse of HCPs. For example, Monitoring the Future surveys of 8th, 10th, and 12th graders from 2002 to 2011 found that twice as many high school seniors used Vicodin®, an HCP, nonmedically, as used OxyContin®, a Schedule II substance, which is more tightly controlled.

In general, substances placed under the control of the CSA since it was passed by Congress in 1970 are scheduled or rescheduled by the DEA, as required by the CSA and its implementing regulations, found in Title 21 of the Code of Federal Regulations. Scheduling or rescheduling of a substance can be initiated by the DEA, by the HHS Assistant Secretary of Health, or on the petition of any interested party. (Detailed information on the scheduling and rescheduling process can be found beginning on page 8 of *Drugs of Abuse* on the DEA's website at: http://www.justice.gov/dea/pr/multimedia-library/publications/drug_of_abuse.pdf.)

The rescheduling of HCPs was initiated by a petition from a physician in 1999. The DEA submitted a request to HHS for a scientific and medical evaluation of HCPs and a scheduling recommendation. In 2013, the U. S. Food and Drug Administration held a public Advisory Committee meeting on the matter, and the committee voted to recommend rescheduling HCPs from Schedule III to Schedule II by a vote of 19 to 10. Consistent with the outcome of that vote, in December of 2013 HHS sent such a recommendation to the DEA. Two months later, on February 27, the DEA informed Americans of its intent to move HCPs from Schedule III to Schedule II by publishing a Notice of Proposed Rulemaking in the *Federal Register*, outlining its rationale and the proposed changes in detail and soliciting public comments on the proposal, of which almost 600 were received. A small majority of the commenters supported the proposed change.

DEA Public Affairs Office: (202) 307-7977

Emergency Department Visits Linked to Zolpidem Overmedication Nearly Doubled

The estimated number of emergency department visits involving zolpidem overmedication (taking more than the prescribed amount) nearly doubled from 21,824 visits in 2005-2006 to 42,274 visits in 2009-2010, according to a new study by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The report also indicates that 68 percent of all zolpidem overmedication visits in 2010 involved females, the number of zolpidem overmedication emergency department visits for males increased 150 percent from 2005-2006 to 2009-2010 compared to an increase of 69 percent for females over the same time period.

In 2010 there were a total of 4,916,328 drug-related visits to emergency departments throughout the nation.

Other prescription drugs were involved in 57 percent of the emergency department visits involving zolpidem overmedication. These medications included benzodiazepines (26 percent) and narcotic pain relievers (25 percent). Alcohol was also combined with zolpidem in 14 percent of these hospital emergency department visits.

Zolpidem is an FDA-approved medication used for the short-term treatment of insomnia and is the active ingredient in the brand name sleep aid drugs Ambien®, Ambien CR®, Edluar®, and Zolpimist®. These drugs have been used safely and effectively by millions of Americans. However, in January 2013, the FDA responded to increasing numbers of reports of adverse reactions by requiring manufacturers of drugs containing zolpidem to reduce the recommended dose by half for females. The FDA also suggested that manufacturers reduce the recommended dose for men as well.

Side effects associated with the medication include daytime drowsiness, dizziness, hallucinations, agitation, sleep-walking, and drowsiness while driving. When zolpidem is combined with other substances, the sedative effects of the drug can be dangerously enhanced.

Overall, nearly half (47 percent) of zolpidem overmedication-related emergency department visits resulted in either a hospital admission or a transfer to another medical facility. About a quarter of these more serious cases involved admission to a critical or intensive care unit.

“Sleep aid medications can benefit patients, but they must be carefully used and monitored,” said SAMHSA Administrator Pamela S. Hyde. “Physicians and patients need to discuss the potential adverse reactions associated with any medication, and work together to prevent problems or quickly resolve any that may arise.”

SAMHSA has several major efforts underway to promote prevention and risk reduction regarding prescription drug related problems. For example, SAMHSA’s Strategic Prevention Framework - Partnerships for Success II (SPF-PFS II) grant program provides funding to communities throughout the nation for programs raising awareness about the problems of prescription drug misuse and abuse among persons aged 12 to 25. SAMHSA has also partnered with the National Council on Patient Information and Education on the “Not Worth the Risk – Even If It’s Legal” campaign. The partnership has developed and distributed educational and outreach messages to encourage parents to communicate with their teens on prescription drug abuse and misuse. These messages have been distributed to television, radio, and newspaper outlets across the nation.

The report entitled, *Emergency Department Visits for Attributed to Overmedication That Involved the Insomnia Medication Zolpidem* is based on findings from the 2005 to 2010 Drug Abuse Warning Network (DAWN) reports. DAWN is a public health surveillance system that monitors drug-related morbidity and mortality through reports from a network of hospitals across the nation.

The complete survey findings are available on the SAMHSA website at: http://samhsa.gov/data/2K14/DAWN150/sr150-zolpidem-2014.htm.
For more information about SAMHSA visit: http://www.samhsa.gov/
Media Contact: SAMHSA Press Office **Telephone:** (240) 276-2130

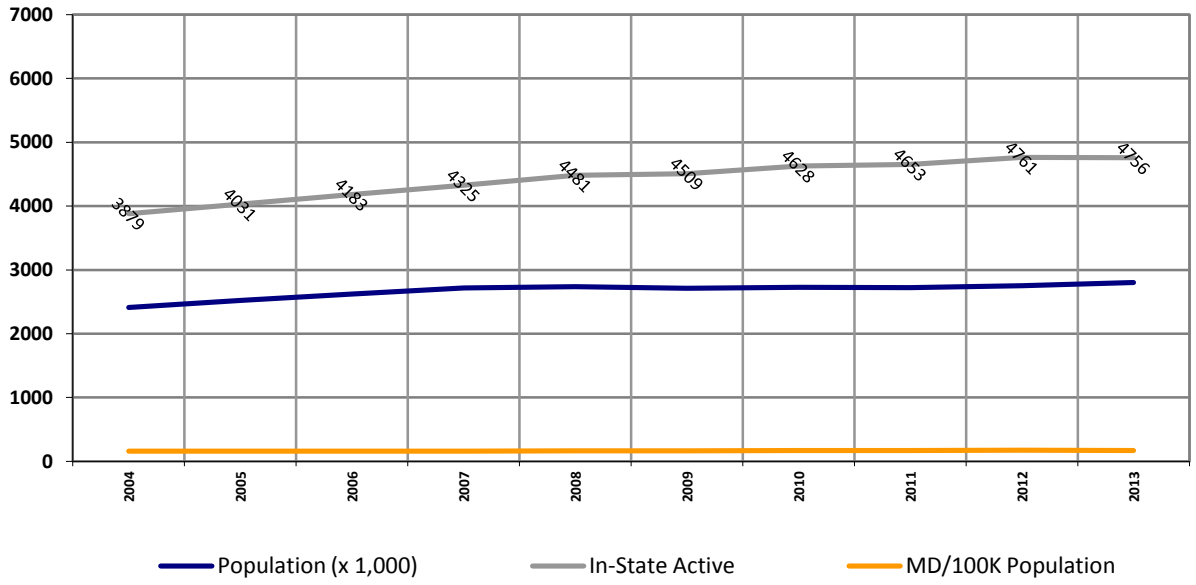
2013 ANNUAL REPORT HIGHLIGHTS

The Board licenses physicians, physician assistants, respiratory therapists and perfusionists. In 2013, the Board issued the following new licenses:

Practice	
Physicians	484
Physician Assistants	82
Respiratory Therapists	149
Perfusionists	9

In 2013, the ratio of physicians to 100,000 population* decreased slightly over the previous year. The following graph shows the growth of the state's population (measured in thousands so that the trend line will fit on the graph, and last reported at 2,800,967), the state's active, in-state physician population (in absolute numbers), and the ratio of physicians to population (measured as physician per 100,000 population). From 2004 through 2007, the ratio averaged between 159 and 161 physicians per 100,000. From 2008 through 2012, the ratio increased, averaging between 164 and 173. In 2013, the ratio was 170.

Comparison of Population With In-State Active Physicians



*Population statistics provided by the Nevada State Demographer, University of Nevada.

The physician licensure for active, in-state physicians in 2013 was 2.0% under 2012. The following table is a county-by-county breakdown of physician licenses for the last ten years. In 2013, Carson City, Churchill, Humboldt and Washoe Counties showed growth in their physician populations, four other counties remained static, and the remaining nine counties showed decreases in their physician populations.

Physician Licensure Counts (2004-2013)

County	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Carson City	141	143	144	140	142	143	151	158	152	164
Churchill	25	24	22	21	23	22	20	22	23	27
Clark	2578	2729	2850	2949	3060	3086	3186	3207	3305	3277
Douglas	82	79	82	93	97	85	84	87	89	80
Elko	41	42	41	41	46	45	46	48	41	40
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	1	0	1	1	1	1	0	0	1	0
Humboldt	6	6	7	9	9	10	9	10	11	12
Lander	3	3	2	2	2	3	3	2	2	2
Lincoln	2	1	1	1	2	2	2	2	2	2
Lyon	12	11	13	13	11	14	13	15	16	15
Mineral	6	6	5	6	5	6	6	5	6	5
Nye	23	20	18	19	17	16	15	16	14	13
Pershing	2	2	3	2	2	2	3	2	1	0
Storey	1	1	1	0	0	0	0	0	0	0
Washoe	944	952	981	1017	1056	1064	1081	1069	1088	1110
White Pine	12	12	12	11	8	10	9	10	10	9
In-State Active Status	**3879**	**4031**	**4183**	**4325**	**4481**	**4509**	**4628**	**4653**	**4761**	**4756**
Out-of-State Active Status	1206	1076	1388	1309	1655	1577	1888	1757	2084	1868
TOTAL ACTIVE STATUS	**5085**	**5107**	**5571**	**5634**	**6136**	**6086**	**6516**	**6410**	**6845**	**6624**
Inactive & Retired Statuses	898	833	834	776	760	781	770	758	748	818
TOTAL LICENSED (Active, Inactive & Retired Statuses)	**5983**	**5940**	**6405**	**6410**	**6896**	**6867**	**7286**	**7168**	**7593**	**7442**

The number of physician assistants grew by 3.8% in 2013. The locale of physician assistants trends similarly to the locale of physicians statewide, as is shown on the following table. In 2013, there was growth in Churchill, Clark, Douglas, Elko, Lyon, Mineral, Storey and Washoe Counties, with six counties remaining static and three counties showing a decrease.

Physician Assistant Licensure Counts (2004-2013)

County	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Carson City	9	12	14	15	15	14	13	16	17	14
Churchill	6	5	3	6	7	6	4	6	9	10
Clark	215	230	262	271	307	310	332	342	386	398
Douglas	4	8	10	15	15	10	11	9	12	16
Elko	3	3	7	7	6	5	5	5	7	9
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	1	0	1	1	1	1	1	1	1	1
Humboldt	1	1	1	1	1	0	0	0	0	0
Lander	1	1	1	1	1	1	0	1	2	1
Lincoln	1	1	2	3	2	3	3	3	3	3
Lyon	4	4	4	2	4	5	6	6	4	5
Mineral	1	1	1	1	1	1	1	2	2	3
Nye	7	10	10	6	10	6	7	4	4	2
Pershing	0	0	0	0	0	0	0	0	0	0
Storey	0	1	1	1	1	1	1	1	1	2
Washoe	48	61	71	76	83	82	91	91	104	109
White Pine	1	1	1	1	1	1	1	1	1	1
TOTAL ACTIVE STATUS	**302**	**339**	**389**	**407**	**455**	**446**	**476**	**488**	**553**	**574**

The number of respiratory therapists decreased by 3.0% in 2013. The largest decreases were in Clark and Washoe Counties, with five other counties showing slight decreases, three counties showing increases and seven counties remaining static.

Respiratory Therapist Licensure Counts (2004-2013)

County	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Carson City	11	9	10	9	10	12	12	12	13	12
Churchill	9	8	9	8	8	5	5	4	5	4
Clark	557	557	640	655	743	798	880	920	1006	982
Douglas	13	12	14	16	18	20	20	18	15	16
Elko	5	7	10	7	7	5	6	8	9	7
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	0	0	0	0	0	0	0	0	0	0
Humboldt	6	3	3	5	5	4	4	5	5	4
Lander	2	2	2	2	3	1	1	1	1	2
Lincoln	2	2	2	2	2	0	0	0	0	0
Lyon	19	19	19	19	20	16	18	15	16	15
Mineral	2	2	2	2	3	3	3	2	2	2
Nye	10	11	10	11	8	10	11	13	12	13
Pershing	0	0	0	0	0	0	0	0	0	0
Storey	1	1	1	0	1	0	0	0	0	0
Washoe	163	151	153	154	163	160	176	192	197	186
White Pine	3	3	3	2	2	3	4	3	3	3
TOTAL ACTIVE STATUS	**803**	**787**	**878**	**892**	**993**	**1037**	**1140**	**1193**	**1284**	**1246**

The number of perfusionists decreased by 19.4% in 2013. Those decreases were in Clark and Washoe Counties, with all other counties remaining static.

Perfusionist Licensure Count (2010-2013)*

County	2010	2011	2012	2013
Carson City	1	1	1	1
Churchill	0	0	0	0
Clark	20	19	25	20
Douglas	0	0	0	0
Elko	0	0	0	0
Esmeralda	0	0	0	0
Eureka	0	0	0	0
Humboldt	0	0	0	0
Lander	0	0	0	0
Lincoln	0	0	0	0
Lyon	0	0	0	0
Mineral	0	0	0	0
Nye	0	0	0	0
Pershing	0	0	0	0
Storey	0	0	0	0
Washoe	5	5	5	4
White Pine	0	0	0	0
TOTAL ACTIVE STATUS	**26**	**25**	**31**	**25**

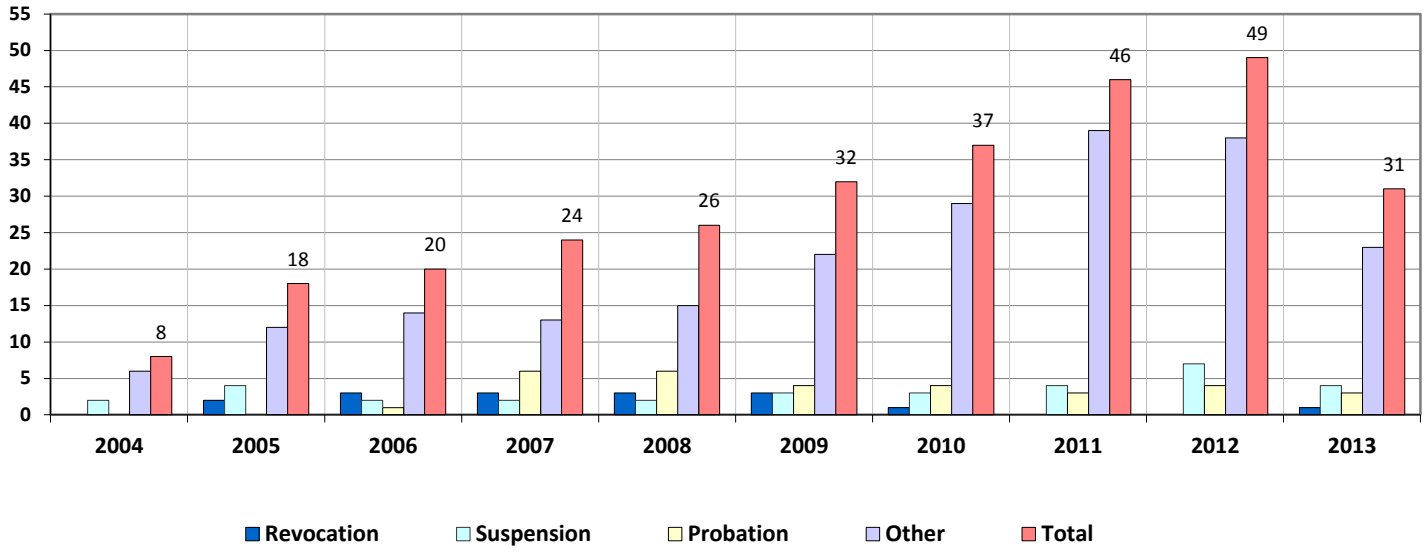
*In 2009, the Nevada State Legislature passed legislation requiring that all perfusionists must be licensed. No perfusionists were licensed by the Board prior to 2010.

COMPLAINTS, INVESTIGATIONS AND DISCIPLINE

The upward trend in complaints processed by the Board continued in 2013.

In 2013, the Board opened 657 investigations, closed 935 investigations (many of which, of course, originated in preceding years) and imposed 31 disciplinary actions against physicians. The graph below shows the number and types of discipline imposed by the Board regarding physicians for the last ten years.

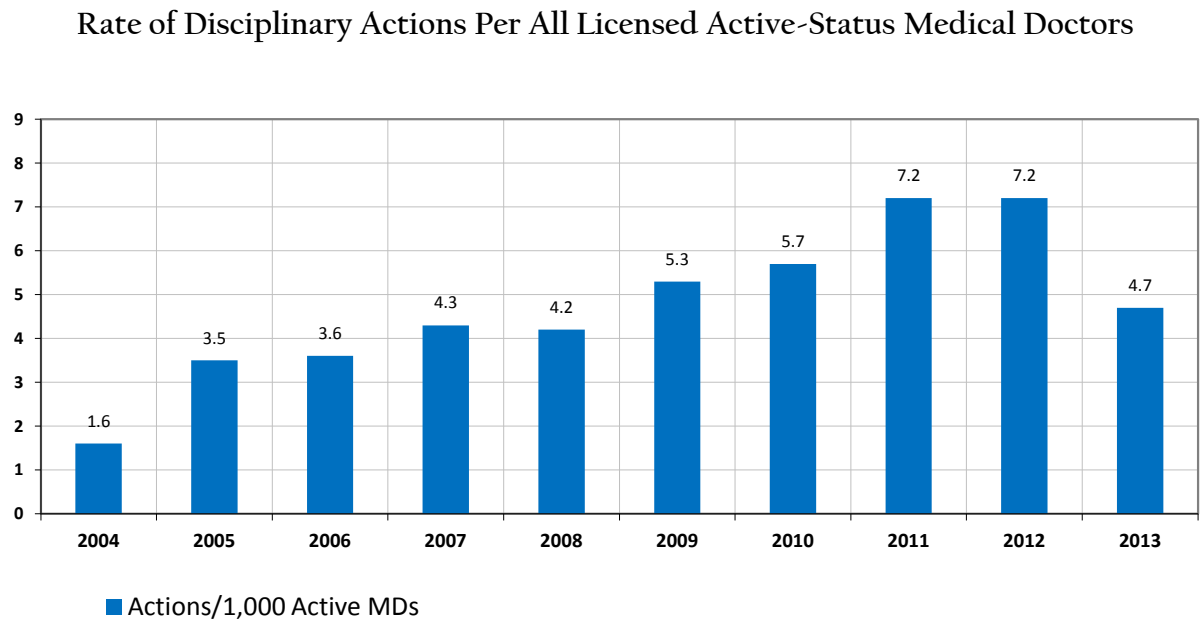
Disciplinary Actions Taken Against Medical Doctors*



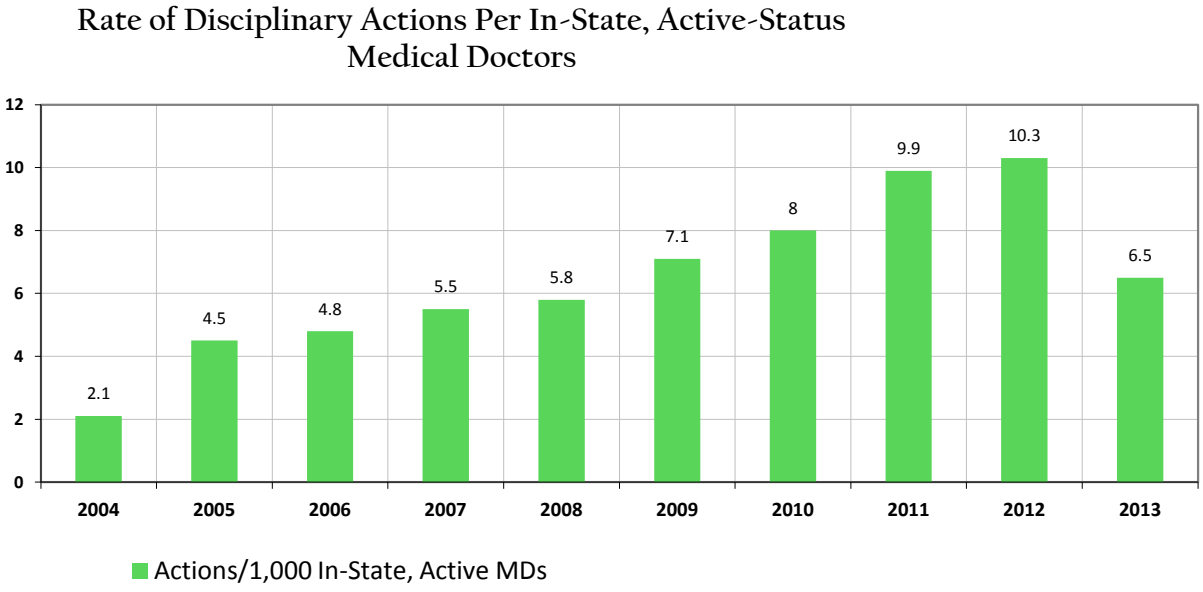
Note: "Other" actions include: Voluntary Surrender of License While Under Investigation, License Restriction, Public Reprimand, Licensure Denial, CME Ordered, Fine, Drug or Alcohol Treatment Program Ordered, and Competency Exam Ordered.

*Any discrepancy in these numbers from a report published by any other source is due to: (1) differences in verbiage or categorization; or (2) differences in the number of actions taken per practitioner.

The graph below shows the rate of disciplinary actions taken by the Board per 1,000 active-status licensed physicians for the last ten years.



The graph below shows the rate of disciplinary actions taken by the Board per 1,000 in-state, active-status, licensed physicians for the last ten years.



WHOM TO CALL IF YOU HAVE QUESTIONS

Management:	Douglas C. Cooper, CMBI Executive Director
	Edward O. Cousineau, J.D. Deputy Executive Director/Legal
	Donya Jenkins Finance Manager
Administration:	Laurie L. Munson, Chief
Legal:	Erin L. Albright, J.D. General Counsel
Licensing:	Lynnette L. Daniels, Chief
Investigations:	Pamela J. Castagnola, CMBI, Chief

2014 BME MEETING & HOLIDAY SCHEDULE

January 1 – New Year's Day holiday
January 20 – Martin Luther King, Jr. Day holiday
February 17– Presidents' Day holiday
March 7-8 – Board meeting
May 26 – Memorial Day holiday
June 6-7 – Board meeting
July 4 – Independence Day holiday
September 1 – Labor Day holiday
September 5-6 – Board meeting
October 31 – Nevada Day holiday
November 11 – Veterans' Day holiday
November 27 & 28 – Thanksgiving/family day holiday
December 5-6 – Board meeting
December 25 – Christmas holiday

Nevada State Medical Association
3660 Baker Lane #101
Reno, NV 89509
775-825-6788
http://www.nsmadocs.org website

Clark County Medical Society
2590 East Russell Road
Las Vegas, NV 89120
702-739-9989 phone
702-739-6345 fax
http://www.clarkcountymedical.org website

Washoe County Medical Society
3660 Baker Lane #202
Reno, NV 89509
775-825-0278 phone
775-825-0785 fax
http://www.wcmsnv.org website

Nevada State Board of Pharmacy
431 W. Plumb Lane
Reno, NV 89509
775-850-1440 phone
775-850-1444 fax
http://bop.nv.gov/ website
pharmacy@pharmacy.nv.gov email

Nevada State Board of Osteopathic Medicine
901 American Pacific Dr., Unit 180
Henderson, NV 89014
702-732-2147 phone
702-732-2079 fax
www.bom.nv.gov website

Nevada State Board of Nursing
Las Vegas Office
4220 S. Maryland Pkwy, Bldg. B, Suite 300
Las Vegas, NV 89119
702-486-5800 phone
702-486-5803 fax
Reno Office
5011 Meadowood Mall Way, Suite 300,
Reno, NV 89502
775-687-7700 phone
775-687-7707 fax
www.nevadanursingboard.org website

Unless otherwise noted, Board meetings are held at the Reno office of the Nevada State Board of Medical Examiners and videoconferenced to the conference room at the offices of the Nevada State Board of Medical Examiners/Nevada State Board of Dental Examiners, 6010 S. Rainbow Blvd., Building A, Suite 1, in Las Vegas.

Hours of operation of the Board are 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays.

DISCIPLINARY ACTION REPORT

AQUINO, Robert J., M.D. (13440)
Glen Head, New York

Summary: Disciplinary action taken against Dr. Aquino's medical license in New York.

Charges: One violation of NRS 630.301(3) [disciplinary action taken against his medical license in another state]; one violation of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute].

Disposition: On September 5, 2014, the Board accepted a Settlement Agreement by which it found Dr. Aquino violated NRS 630.301(3), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) suspension of license, with the suspension stayed and Dr. Aquino being placed on probation for a term to mirror his New York medical board probation, and continue until proof of successful termination of the New York medical board probation is provided to the Board; (2) public reprimand; (2) that he remain in compliance with all state and federal laws pertaining to the practice of medicine and the prescribing, administering or dispensing of any dangerous drugs or controlled substances; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter. Count II of the Complaint was dismissed.

GRACE, Brian E., M.D. (PA727)
Las Vegas, Nevada

Summary: Alleged failure to maintain appropriate medical records related to Mr. Grace's treatment of three patients.

Charges: Three violations of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient].

Disposition: On September 5, 2014, the Board accepted a Settlement Agreement by which it found Mr. Grace violated NRS 630.3062(1) (3 counts), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter.

RODRIGUEZ, Hector F., M.D. (11629)
Hemet, California

Summary: Reasonable belief that the health, safety and welfare of the public was at imminent risk of harm.

Statutory Authority: NRS 630.326(1) [risk of imminent harm to the health, safety or welfare of the public or any patient served by the physician].

Action Taken: On August 28, 2014, the Investigative Committee summarily suspended Dr. Rodriguez's license until further order of the Investigative Committee or the Board of Medical Examiners.

MARKS, Dana R., M.D. (9358)
Reno, Nevada

Summary: Reasonable belief that the health, safety and welfare of the public was at imminent risk of harm.

Statutory Authority: NRS 630.326(1) [risk of imminent harm to the health, safety or welfare of the public or any patient served by the physician].

Action Taken: On September 19, 2014, the Investigative Committee summarily suspended Dr. Marks's license until further order of the Investigative Committee or the Board of Medical Examiners.

MARTIN, Andrew S., M.D. (11416)
Las Vegas, Nevada

Summary: Reasonable belief that the health, safety and welfare of the public was at imminent risk of harm.

Statutory Authority: NRS 630.326(1) [risk of imminent harm to the health, safety or welfare of the public or any patient served by the physician].

Action Taken: On September 23, 2014, the Investigative Committee summarily suspended Dr. Martin's license until further order of the Investigative Committee or the Board of Medical Examiners.

SHARDA, Navneet N., M.D. (8200)
Las Vegas, Nevada

Summary: Alleged malpractice, failure to maintain appropriate medical records related to Dr. Sharda's treatment of multiple patients, and charging for visits to his office which did not occur and/or charging for services that were not rendered.

Charges: One violation of NRS 630.301(4) [malpractice]; two violations of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; one violation of NRS 630.305(1)(d) [charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient]; one violation of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute].

Disposition: On September 5, 2014, the Board accepted a Settlement Agreement by which it found Dr. Sharda violated NRS 630.3062(1) (2 counts), as set forth in Count I of the Complaint in Case No. 13-11856-1 and Count I of the Complaint in Case No. 13-11856-2, and imposed the following discipline against him: (1) public reprimand; (2) 12 hours of continuing medical education regarding medical records and/or ethics; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter. Count II of the Complaint in Case No. 13-11856-1 and Counts II and III of the Complaint in Case No. 13-11856-2 were dismissed.

SMITH, William D., M.D. (7897)
Las Vegas, Nevada

Summary: Alleged malpractice.

Charges: One violation of NRS 630.301(4) [malpractice].

Disposition: On September 5, 2014, the Board accepted a Settlement Agreement by which it found Dr. Smith violated NRS 630.301(4), as set forth in the Complaint, and imposed the following discipline against him: (1) $2,500 contribution to a medically-related, non-profit entity/organization; (2) 8 hours of continuing medical education regarding spinal surgery; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter.

TISBE, Carlos T., M.D. (10770)
Las Vegas, Nevada

Summary: Dr. Tisbe voluntarily surrendered his license to practice medicine in Nevada.

continued from page 17

Statutory Authority: NRS 630.240 [voluntary surrender of license].

Disposition: On September 5, 2014, the Board accepted Dr. Tisbe's voluntary surrender of his license to practice medicine in Nevada while under investigation.

VALENCIA, Arlyn M., M.D. (10340)
Las Vegas, Nevada

Summary: Reasonable belief that the health, safety and welfare of the public was at imminent risk of harm.

Statutory Authority: NRS 630.326(1) [risk of imminent harm to the health, safety or welfare of the public or any patient served by the physician].

Action Taken: On August 21, 2014, the Investigative Committee summarily suspended Dr. Valencia's license until further order of the Investigative Committee or the Board of Medical Examiners.

WESTFIELD, Kenneth C., M.D. (3953)
Las Vegas, Nevada

Summary: Disciplinary action taken against Dr. Westfield's medical licenses in Arizona and California, and alleged failure to report said disciplinary actions to the Nevada State Board of Medical Examiners.

Charges: One violation of NRS 630.301(3) [disciplinary action taken against his medical license in another state]; one violation of NRS 630.306(11) [failure to report in writing, within 30 days, disciplinary action taken against him by another state]; one violation of NRS 630.304(1) [obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement].

Disposition: On September 5, 2014, the Board accepted a settlement agreement by which it found Dr. Westfield violated NRS 630.301(3), as set forth in Count I of the First Amended Complaint and imposed the following discipline against him: (1) that he fully report all other outstanding state board actions to the Board; (2) reimbursement of the Board's fees and costs of investigation and prosecution.

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Public Reprimands Ordered by the Board

Robert Joseph Aquino, M.D.

September 9, 2014

Robert Joseph Aquino, M.D.
2 Copperfield Lane
Glen Head, NY 11545

Dr. Aquino:

On September 5, 2014, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 14-35576-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(3), any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by another state. For the same, your license to practice medicine shall be suspended, with said suspension stayed while on probation, the probation terms as outlined in the Agreement. You shall be publicly reprimanded, shall reimburse the Board the reasonable fees and costs incurred in the investigation and prosecution of this case within thirty (30) days of Board acceptance and approval, and you shall remain in compliance with all state and federal laws pertaining to the practice of medicine and the prescribing, administering or dispensing of any dangerous drugs or controlled substances. Count II of the Complaint shall be dismissed

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Brian E. Grace, PA-C

September 9, 2014

Brian E. Grace, PA-C
c/o Marie Ellerton, Esq.
2012 Hamilton Lane
Las Vegas, NV 89106

Mr. Grace:

On September 5, 2014, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement proposed between you and the Board's Investigative Committee in relation to the formal Complaint filed against you regarding Case Number 14-25576-1.

In accordance with its acceptance, the Board has entered an Order finding you guilty of a three-count violation of Nevada Revised Statute 630.3062(1). The Order also called for you to be publicly reprimanded and reimburse the Board the reasonable costs and expenses incurred in the investigation and prosecution of this case, which is to be paid to the Board within ninety (90) days of the acceptance of the Settlement Agreement.

It is now my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which also reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Navneet Sharda, M.D.

September 9, 2014

Navneet Sharda, M.D.
c/o L. Kristopher Rath, Esq.
Hutchison & Steffen
10080 West Alta Dr., Ste. 200
Las Vegas, NV 89145

Dr. Sharda:

On September 5, 2014, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaints filed against you in Case Number 13-11856-1 and Case Number 13-11856-2.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.3062(1) (two counts), failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient. For the same, you shall complete, in-person, twelve (12) hours of Continuing Medical Education regarding the subject of record keeping and/or ethics within one year of the Board's acceptance of the Agreement; receive a public reprimand and pay the fees and costs related to the investigation and prosecution of this matter within one year of the Board's acceptance of the Agreement.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144