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Battlefield Medicine, DNR Directives and Ventilator Allocation in the Wake of the Coronavirus Pandemic

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Winston Churchill once said, "[t]hings are not always right because they are hard, but if they are right one must not mind if they are also hard."

How does one define "right" and "hard" during the current pandemic and the care allocation decisions which must be made?

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Overview

Worldwide there are more than 1 million confirmed cases related to the Coronavirus COVID-19 disease,[1] which was declared a pandemic by the World Health Organization on March 11, 2020.[2] Just as HIV is the virus which leads to the end disease AIDS, the SARS-CoV-2 virus leads to the infectious disease coronavirus disease COVID-19.[3] "In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). The most recently discovered coronavirus causes coronavirus disease COVID-19."[4]

The COVID-19 pandemic is certainly not the first in recent memory. For instance, the cholera pandemic of 1817 had spread worldwide.[5] Additionally, according to the Centers for Disease Control and Prevention (CDC), there were four pandemics between 1918 and 2018: 1918 influenza (H1N1);[6] 1957-1958 influenza A (H2N2) (aka Asian Flu);[7] 1968 influenza A (H3N2);[8] and 2009 novel influenza A (H1N1).[9] However, a significant difference between most of the prior pandemics and COVID-19 is the changes in triage protocols as a result of advancements in medical care and technology, as well as the emergence of Do Not Resuscitate (DNR) orders in the 1970s.

COVID-19 is raising issues around the globe regarding the application of battlefield medicine, the allocation of resources (i.e., ventilators and equipment) and the invocation of universal DNR orders. Interestingly, there is an intersection between mass casualty response, allocation of resources and DNR orders. This article will address battlefield triage medicine, allocation of resources (specifically ventilators) and DNR orders in relation to the COVID-19 pandemic.

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MISSION STATEMENT

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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.

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Battlefield Triage

"Pandemic disease is arguably one of the greatest threats to global stability and security."[10] Italy was forced to make extraordinary decisions regarding COVID-19 weeks before the United States and implement battlefield triage as the number of cases reached over 10,000 on March 11, 2020.[11] "Effective mass casualty response is founded on the principle of *triage*, the system of sorting and prioritizing casualties based on the tactical situation, mission, and available resources."[12] Triage can be further explained as follows:

A mass casualty scenario is a place where entropy could reign supreme; however, triage provides stability and order. During a mass casualty, the allocation of resources, as well as the assessment time of the injuries, is vital to mitigating loss of life. Not everyone needs to be resuscitated. Those victims should be diverted into the appropriate medical treatment or surgical area.

There are four general categories of triage: immediate, delayed, minimal and expectant. These categories are based on the severity of injury and the timeframe for significant treatment in order to avoid death or major disability.

- **Immediate (threatened loss of limb; multiple extremity amputations; uncontrolled hemorrhage; etc.)**: these individuals are the most critical, with the greatest chance of survival, unlike those who are expectant.
- **Delayed (blunt or penetrating torso injuries without signs of shock**; **fracture; survivable burns; etc.):** this group needs surgery but they can wait to undergo the treatment without a significant threat to loss of life or limb. Typically, sustaining treatment in the form of antibiotics, fracture stabilization, pain relief and gastric decompression is required.
- **Minimal (abrasions**; **low degree burns; small bone fractures; etc.)**: nursing staff can handle these individuals and they should be detoured away from the main medical treatment facility.
- **Expectant (no vital signs**; **transcranial gunshot wounds; etc.):** although these types of casualties should not be abandoned, there should be a separate area where they can be monitored an assessed, while the greater resource allocation should go to those whose injuries have a greater chance of recovery.[13]

Appreciating that triage is used in military medicine, as well as every day in emergency rooms and during mass casualties such as the Mandalay Bay shooting,[14] how can battlefield triage be utilized in the COVID-19 pandemic? In relation to the medical decision-making process, physicians are always expected to consider the following when rendering care, especially when resources are limited. In determining whether particular procedures or treatments should be included in the adequate level of healthcare, the following ethical principles should be considered:

1. degree of benefit (the difference in outcome between treatment and no treatment),
2. likelihood of benefit,
3. duration of benefit,
4. cost, and
5. number of people who will benefit (referring to the fact that a treatment may benefit the patient and others who come into contact with the patient, as with a vaccination or antimicrobial drug).[15]

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These elements are in keeping with concept of evidence-based medicine. Evidence-based medicine:

> [i]s the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected ... in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care.[16]

Appreciating that while no situation where battlefield triage is being deployed on a mass scale is ideal, having a framework in place can enable more individuals to live because resources are deployed to those with the greatest likelihood of survival.

Allocation of Resources

COVID-19 has stressed resources in the United States and throughout the world. Hospitals in the United States and manufacturers are continuing to report equipment shortages (i.e., ventilators[17] and personal protective equipment (PPE)).[18] "Adequate production and distribution of both types of equipment are crucial to caring for patients during the pandemic."[19] Therefore, a decision-making process needs to be made on both macro and micro levels in relation to resource allocation.

Resource allocation has been described as "the distribution of resources – usually financial – among competing groups of people or programs."[20] In healthcare, three distinct levels of decision-making are associated with decision-making in the context of resource allocation:

- Level 1: allocating resources to healthcare versus other social needs;
- Level 2: allocating resources within the healthcare sector; and
- Level 3: allocating resources among individual patients.[21]

At Level 1, which addresses macro-level considerations, the issue of resource allocation is fundamentally a brutal trade-off – "inducing massive economic suffering in order to save human lives."[22] The trade-offs between social needs and healthcare require tough decisions. Once those decisions have been made by leaders on a federal, state and local level, with the input of participants from a variety of industries and public health officials, then the step of allocating resources within the healthcare sector can begin.

Level 2, which addresses resource allocation between different providers, is a contentious matter that is discussed multiple times a day in the media. "What am I going to do with 400 ventilators when I need 30,000?" New York's Governor posited at a March 24, 2020 press conference.[23] Additionally, there are tensions between the federal government and a variety of state governments regarding PPE.[24]

Level 3 requires medical professionals to allocate the available resources among individual patients. This is where battlefield medicine and triage are used to assess who has the best chance of survival, based on a variety of factors. The American Medical Association's (AMA) Council on Ethical and Judicial Affairs published *Opinion 2.03 – Allocation of Limited Medical Resources.*[25] Opinion 2.03 sets forth three major obligations in relation to physicians who are practicing in a situation where resources are limited or rationed.

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First, a physician must act in the best interest of the patient in light of the circumstances.[26] Second, "[d]ecisions regarding the allocation of limited medical resources among patients should consider only ethically appropriate criteria relating to medical need."[27] Third, to the extent possible, a physician must remain a patient advocate.[28] In relation to the third obligation, one must bear in mind that patients have "the right to be informed of the reasoning" behind the allocation decision.[29]

The second obligation is particularly germane to the COVID-19 pandemic in relation to having a battlefield triage framework in place, which enables the greatest number of people to survive. Kidney dialysis, which is used during the treatment of end-stage renal disease (ESRD) may be illustrative, as it was once a rationed resource.[30] Prior to 1972, dialysis was viewed as experimental, and there were many more ESRD patients needing treatment than dialysis machines or available funds.[31] "There was a public outcry based on the inherent injustice of dialysis allocation, and the federal government responded with Public Law (P. L.) 92-603 in 1972. P. L. 92-603 established the U.S. ESRD program, mandating Medicare coverage for dialysis patients, regardless of age or ability to pay."[32] Note that dialysis supplies and other medical and surgical supplies were not always single-use, disposable items. With appropriate sterilization and cleaning, some items can be reused.

Throughout the evolution of utilizing dialysis for ESRD, four bioethical principles have been applied differently based upon changing considerations related to technology, resource limitations and societal values.[33] These four bioethical principles – beneficence, nonmaleficence, autonomy and justice – should be considered when setting the framework for battlefield triage and allocating resources during the COVID-19 pandemic. The framework needs to be established beforehand, so that a universal application can occur. As a potential result, scarce resources can be deployed and utilized more effectively.

Do Not Resuscitate (DNR) Orders

"A do not resuscitate order is an advance directive that is to be followed when a person's heart or breathing stops and they are unable to communicate their wishes to refuse treatment that could allow them to die."[34] In other words, a DNR order requires that the patient not be resuscitated under certain circumstances.

These laws vary on a state-by-state basis, so it is crucial to check the laws of that particular state when drafting a DNR order. For example, in Texas, the law for in-hospital DNR orders tightened considerably. Prior to April 2018, it was possible for a physician to enter a DNR order without the consent of either the patient or the surrogate decision maker.[35] Now, physicians need to make certain that patients meet the criteria. Otherwise, a risk of criminal liability is present.

What about the notion of unilateral DNR orders? The seminal case addressing right-to-die decisions is *Cruzan v. Director, Missouri Department of Health*.[36] The Court held that the United States Constitution does not forbid Missouri to require that evidence of an incompetent's wishes to withdraw life-sustaining treatment.[37] The Court also opined that "[m]ost state courts have based a right to refuse treatment on the common law right to informed consent, *see, e.g., In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, or on both that right and a constitutional privacy right, *see, e.g., Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417. In addition to relying on state constitutions and the common law, state courts have also turned to state statutes for guidance, *see, e.g., Conservatorship*

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of Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840. However, these sources are not available to this Court, where the question is simply whether the Federal Constitution prohibits Missouri from choosing the rule of law which it did."

But perhaps the Court's statement that has the most relevance to DNR orders and the COVID-19 pandemic is that:

> [t]he State may also properly decline to make judgments about the "quality" of a particular individual's life, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual. It is self-evident that these interests are more substantial, both on an individual and societal level, than those involved in a common civil dispute.[38]

Arguably, the notion of "these interests are most substantial, both on an individual and societal level, than those involved in a common civil dispute" is a cornerstone of resource allocation, battlefield triage and the rights of an individual during a pandemic.[39] On March 25, 2020, *The Washington Post* published an article, *Hospitals consider universal do-not-resuscitate orders for coronavirus patients*, which stated that the basis of these conversations are based on risk management and resource allocation.[40] "Northwestern Memorial Hospital in Chicago has been discussing a do-not-resuscitate policy for infected patients, regardless of the wishes of the patient or their family members – a wrenching decision to prioritize the lives of the many over the one."[41] If an appropriate battlefield triage framework, specific to COVID-19 is implemented, is such a drastic measure – universal DNR orders – necessary and is it in violation of the United States Constitution, as well as individual state constitutions?

On March 28, 2020, *The Atlantic* published an article, *The Curve is Not Flat Enough*, which acknowledged that hospitals are "poised to face the kind of life-and-death decisions that industrialized countries typically encounter only in times of war and natural disaster:"[42]

> Under usual circumstances, a person with a dangerous, infectious respiratory disease such as COVID-19 requires special precautions in a hospital. Everyone who enters the patient's room—even to ask how they're doing or to pick up a lunch tray—is required to don a fresh gown, gloves, and a mask. If the worker must get in close contact with the patient, the mask has to be an N95 respirator, and a face shield is required to guard the eyes. Without exception, every piece of this gear must be discarded in a biohazard dispenser upon leaving the room. An errant mask or glove or gown, coated in virus, can become lethal.[43]

Usual circumstances are not the reality for many providers, especially those in the "hot spots" (i.e., New York, New Orleans, Miami, Chicago), with the United States leading the world in COVID-19 diagnoses and deaths.[44] "But without more widespread testing and basic protective equipment, the problem will be less the number of ventilators, and more the number of health-care workers available to operate them. The United States has entered its coronavirus rationing era, and the kind of medical care many people are used to isn't going to be available all the time."[45]

This is why it may be helpful to utilize battlefield triage to minimize the misuse of precious and scarce resources without resorting to universal DNR orders.

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While battlefield triage does not eliminate the fact that many lives will be lost, at least it is possible to minimize the loss in a realistic and respectful manner. "Advance directives guide healthcare providers to listen to and respect patients' wishes regarding their right to die in circumstances when cardiopulmonary resuscitation is required, and hospitals accredited by The Joint Commission are required to have a do-not-resuscitate (DNR) policy in place."[46] The Joint Commission has specifications on National Quality Measures related to advanced directives and advance care planning, which require notation in a patient's medical record.[47] DNR orders are a part of everyday life in clinical medicine and hospital operations. But, universal DNR orders were proposed to apply to anyone who has the virus regardless of the associated symptoms.[48]

There is no perfect solution to the issue of having a greater number of patients who have the same need while a limited number of providers and equipment exist. Applying battlefield triage, along with evidence-based decision making, these proposed principles should be considered in relation to COVID-19, in the following order:

1. Assess the situation on a country-wide, local and provider-to-patient basis and accept that people will die;
2. With the guidance of physicians from a variety of specialties, as well as public health officials and professionals, set universal criteria for treatment (immediate, delayed, minimal, expectant) in relation to the symptoms and stage of COVID-19 with which each individual presents; and
3. Flag patients who have a DNR directive, which was executed by a patient ahead of time. Although the Joint Commission requires that hospitals have policies and procedures in place to address this, it appears as though these directives would be disregarded if a universal DNR order is implemented for anyone with COVID-19, regardless of their symptoms, stage of the disease and other factors.

Note that as The Department of Health and Human Services' Office for Civil Rights (OCR) has signaled, age cannot be the basis of withholding care, as OCR indicated that not providing access to ventilators by the elderly constitutes a civil rights violation.[49] Using a battlefield triage model based on evidence-based medicine, providers have to take into account the totality of the person's medical factors and the likelihood of survival. For instance, an 80-year old who plays golf and only has Type 2 diabetes would be considered healthier and have a better chance of survival than a 30-year old heroin addict.

Conclusion

The reality is that the number of patients infected with COVID-19 far outnumber the medical personnel and supplies that are available to treat them, which triggers the application of a pre-determined mass casualty/battlefield triage and treatment protocols specific to COVID-19. This unfortunately requires gut-wrenching decisions related to both the allocation of resources and the application of DNR orders. It's important that individual rights are considered during this process, as well as Constitutional considerations and realizing that with equipment being utilized instead of mouth-to-mouth resuscitation, a universal DNR order may be an extreme measure. Everyone with COVID-19 would not be resuscitated – is that realistic, ethical and/or legal? That is what a universal DNR order may do.

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This article opened with a thought-provoking quote from Winston Churchill: "Things are not always right because they are hard, but if they are right one must not mind if they are also hard." How does one define "right" and "hard" during the current pandemic and the care allocation decisions which must be made? Reasonable people would agree that the aforementioned decisions that have to be made are hard. The right course of action is to save as many individuals as possible with the resource constraints that are "in play" at any given time. This means facing the stark reality that not everyone is going to be saved.

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[1] Johns Hopkins, *Coronavirus COVID-19*, https://coronavirus.jhu.edu/map.html (last visited Apr. 2, 2020).
[2] World Health Organization, *WHO Director-General's opening remarks at the media briefing on COVID-19* (Mar. 11, 2020), https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.
[3] Centers for Disease Control and Prevention, *Situation Summary*, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html (last visited Apr. 1, 2020).
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[5] World Health Organization, *Global epidemics and impact of cholera*, https://www.who.int/topics/cholera/impact/en/ (last visited Mar. 30, 2020). "Throughout history, populations all over the world have sporadically been affected by devastating outbreaks of cholera. Records from Hippocrates (460-377 BC) and Galen (129-216 AD) already described an illness that might well have been cholera, and numerous hints indicate that a cholera-like malady was also known in the plains of the Ganges River since antiquity."
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[13] *Id*.
[14] Tim Craig, 'Something we would see in a war zone': Military surgeons on the wounds they treated in Las Vegas, The Washington Post (Oct. 5, 2017), https://www.washingtonpost.com/news/post-nation/wp/2017/10/05/something-we-would-see-in-a-war-zone-military-surgeons-on-the-wounds-they-treated-in-las- vegas/?utm_term=.9fa52afe757d.

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[16] *See* Sackett D.L., Rosenberg, W. M., Gray, J. A., Haynes, R.B., Richardson, W.S., *Evidence based medicine: What it is and what it isn't,* BMJ (Jan. 13, 1996); 312 (7023):71–2. doi: 10.1136/bmj.312.7023.71.
[17] U.S. Food and Drug Administration, 42 CFR 868.5895, *Continuous ventilator*, https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=868.5895 (defining this Class II device as "[a] continuous ventilator (respirator) is a device intended to mechanically control or assist patient breathing by delivering a predetermined percentage of oxygen in the breathing of gas. Adult, pediatric, and neonatal ventilators are included in this generic type of device."). Importantly, a continuous ventilator is distinguishable from a multi-function one, which was approved in 2018 by the U.S. Food and Drug Administration through the 510(k) process for durable medical equipment (DME). Known as VOCSN, it's a device that combines five respiratory therapies: ventilation, oxygen, cough, suction and nebulization. *See* 83 Fed. Reg. 34304 (Sept. 10, 2018). On April 3, 2020, CMS announced that "Medicare's multi-function ventilator policy applies to beneficiaries who are prescribed and meet the medical necessity coverage criteria for a ventilator and at least one of the four additional functions (namely, oxygen concentrator, cough stimulator, suction pump, and nebulizer). HCPCS code E0467 is used to describe multi-function ventilators. **This article informs DME suppliers that effective immediately, you may provide and bill for multi-function ventilators described by code E0467 as an upgrade in situations where beneficiaries only meet the coverage criteria for a ventilator."** [emphasis in the original**]** *See* https://www.cms.gov/files/document/se20012.pdf (Apr. 3, 2020).
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[24] *Id*.
[25] *See* https://journalofethics.ama-assn.org/article/ama-code-medical-ethics-opinions-allocating-medical-resources/2011-04 (last visited Apr. 2, 2020).
[26] *Id*.
[27] *Id*.
[28] *Id*.
[29] *Id*.
[30] *See* https://www.kidney.org/sites/default/files/v36b_a4.pdf (last visited Apr. 2, 2020).
[31] *Id*.
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[35] *See* https://capitol.texas.gov/tlodocs/851/billtext/pdf/SB00011F.pdf#navpanes=0 (last visited Apr. 1, 2020). Notably, S.B. 11 does not apply to an out-of-hospital DNR order.
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[41] *Id*.
[42] *See* https://www.theatlantic.com/health/archive/2020/03/coronavirus-forcing-american-hospitals-ration-care/609004/.
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[44] *Id*.
[45] *Id*.
[46] Sumrall, W. D. et al., *Do Not Resuscitate, Anesthesia, and Perioperative Care: A Not So Clear Order*, Ochsner J., pp. 176-179 (Summer 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4896664/.
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About the Authors

Rachel V. Rose advises clients on healthcare, cybersecurity and *qui tam* matters. Ms. Rose also teaches bioethics at Baylor College of Medicine. She has been consecutively named by *Houstonia Magazine* as a Top Lawyer (Healthcare), the National Women Trial Lawyer's Top 25 and the National Trial Lawyers Top 100.

Lance H. Rose, MHA, MS, LFACHE, is a retired hospital chief executive officer, who began his healthcare career serving in the United States Navy during Vietnam, where, first-hand, he experienced the application of battlefield medicine. Mr. Rose has served on numerous boards, including the American Hospital Association's Regional Policy Board. He also taught as an adjunct professor at The Pennsylvania State University.

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

What in the Heck is a POLST?

By Guest Author: Curtis Brown, MD, FACEP

WHO:

Old age is not necessarily a determining factor for a POLST, although the majority of POLSTs are completed for the elderly. The criterion is if the patient's provider would not be surprised should the patient pass away within one year. Patients who are near the end of a life-limiting disease process, terminally ill or frail would greatly benefit from a POLST.

WHAT:

The POLST is a Provider Order for Life-Sustaining Treatment form. Provider is defined in the State of Nevada as either a physician, APRN (advanced practice registered nurse) or PA (Physician Assistant). Look at it as both a legal document and a portable medical order that allows patients to express their wishes for current and future medical care when they no longer possess capacity. Capacity is determined by their provider at the time of the completion of the POLST and is their ability to understand and communicate their health care preferences for options in this medical order. If the patient is able to express their wishes, the POLST is not necessary. Think of the POLST as what the patient wants done now.

WHEN:

The POLST is filled out by the patient and their health care provider, who must sign the form in order for it to be legal. The medical care provider must determine a patient's capacity at the time of the POLST signing. If the patient lacks capacity, then the AGENT (Durable Power of Attorney) or guardian or health care surrogate may help fill out and sign the POLST. It is best addressed while the patient is still able to communicate their personal wishes and help in the decision-making process. It must be signed by their health care provider to be a valid legal order. The POLST can be modified or updated by the patient and their health care provider since patients' conditions change over time.

WHERE:

Your POLST should be with you at all times. Common practice is to place the POLST on the refrigerator door or next to their bed. This is where the EMS (emergency medical service) providers are trained to look, and it should be easily seen by EMS providers. In a care facility, it should be in the medical record and in a place easily identifiable to caregivers and EMS providers in case of an emergency.

WHY:

Too many people receive care at the end of life that is not consistent with their values. The POLST helps avoid this by determining whether a patient wants to receive more aggressive treatment, some intermediated measures or comfort-focused care. The POLST allows patients to communicate their desired health care treatment currently and in the future in the event they no longer have the ability to do so on their own. This includes treatments they do and do not want to receive.

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POLST vs. DNR (Do Not Resuscitate) vs. AD (Advanced Directive):

A POLST is a medical order that is valid in any setting.

A DNR order is only valid in a healthcare facility.

An AD is a legal document, not a medical order, so it cannot be followed by healthcare personnel such as EMS unless a provider writes a medical order to stop resuscitation. EMS must initiate CPR even in the presence of an AD stating the patient does not want CPR because an AD is not a medical order, it is a legal document.

DNR orders are used in circumstances when a patient has lost their pulse, is not breathing or is near death and can no longer communicate.

The POLST is much more than just a DNR order. It can provide guidance for health care providers to follow, including whether or not a patient wanted full, partial or comfort care only. These decisions can include, but are not limited to the use of IV fluids, antibiotics, feeding tubes, intubation and placement on ventilators, or even whether or not a patient wants to be hospitalized or placed into the ICU (intensive care unit).

CONCLUSION:
POLST forms are not required but are extremely helpful to insure the patient's wishes are fulfilled at or near the end of their life. Not only does the POLST direct the care of the patient, but it also helps family, friends and medical health care providers understand the wishes of the patient when they can no longer communicate.

Disclaimer: The opinions expressed in the 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.

NEVADA PHYSICIAN WELLNESS COALITION (NPWC)

Mission & Background:

The mission of the Northern Nevada Physician Wellness Coalition (NNPWC) is to "address the devastation and negative community impact of physician burnout and suicide. " It was formed by 3 physicians in Reno, NV, following the suicide of a colleague, and out of recognition of the need to approach physician wellness in a proactive, non-punitive, humanistic manner. Also recognized was the need to make resources accessible to physicians' families. It is also referred to as "Nevada Physician Wellness Coalition" (NPWC) in acknowledgment of the issue's statewide impact.

Described as a national public health crisis, physician burnout is highly prevalent, with over 50% of practicing physicians reporting feeling depressed or having signs of professional burnout. The suicide rate for physicians is 4 times the national average, and suicide is the second leading cause of death among medical trainees. The reasons for the escalation in physician burnout and suicide are numerous and multi-factorial. Complicating any path toward stabilization of the problem is the fact that physicians do not self-report burnout, and are reluctant to seek help for mental health issues due to social stigma and out of fear of reprisal from licensure boards or employers.

About NPWC

NPWC is led by a passionate, dedicated group of mostly-physician volunteer Board of Directors and key advisors from all the major sectors of health care in Nevada. With this team, and the help of our community stakeholders and community-at-large, NPWC is poised to raise much-needed awareness regarding physician burnout and suicide, become a confidential resource for our local physicians and their families, and ultimately serve as the new paradigm for approaching physician un-wellness.

NPWC delivers programs that provide outreach, education, and supportive resources to physicians and their families to intervene at all stages of burnout and to prevent suicide. We have a Physician and Family Resource line which is a non-urgent, non-crisis phone line that is staffed by local psychologists with expertise in physician stress. Calls are answered within 24 hours with the purpose of linking physicians, partners, and family members to needed resources. Calls are free and confidential.

We also have on-going programming currently featuring a monthly Speaker Series with experts from around the country.

To find out more about the NPWC go to: https://nevadaphysicianwellnesscoalition.com

WHOM TO CALL IF YOU HAVE QUESTIONS

Management: Edward O. Cousineau, JD
Executive Director

Sarah A. Bradley, JD, MBA
Deputy Executive Director

Donya Jenkins
Finance Manager

Administration: Laurie L. Munson, Chief

Legal: Robert Kilroy, JD
General Counsel

Licensing: Lynnette L. Daniels, Chief

Investigations: Ernesto Diaz, Chief

2020 BME MEETING & HOLIDAY SCHEDULE

January 1 – New Year's Day
January 20 – Martin Luther King, Jr. Day
February 17 – Presidents' Day
March 6 – Board meeting
May 25 – Memorial Day
June 5 – Board meeting
July 3 – Independence Day (observed)
September 7 – Labor Day
September 11 – Board meeting
October 30 – Nevada Day
November 11 – Veterans' Day
November 26 & 27 – Thanksgiving Day & Family Day
December 4 – Board meeting (Las Vegas)
December 25 – Christmas

Nevada State Medical Association
5355 Kietzke Lane
Suite 100
Reno, NV 89511
775-825-6788
http://www.nvdoctors.org

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

Washoe County Medical Society
5355 Kietzke Lane
Suite 100
Reno, NV 89511
775-825-0278 phone
775-825-0785 fax
http://www.wcmsnv.org

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy, Ste. 206
Reno, NV 89521
775-850-1440 phone
775-850-1444 fax
http://bop.nv.gov/
pharmacy@pharmacy.nv.gov

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Ste. 210
Henderson, NV 89074
702-732-2147 phone
702-732-2079 fax
www.bom.nv.gov

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

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.

DISCIPLINARY ACTION REPORT

ANDERSON, Clinton, PA-C (PA1203)
Las Vegas, Nevada

Summary: Alleged malpractice and failure to maintain appropriate medical records relating to his treatment of a patient.

Charges: One violation of NAC 630.380(1)(f) [malpractice]; one violation of NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient].

Disposition: On August 26, 2020, the Board accepted a Settlement Agreement by which it found Mr. Anderson violated NAC 630.380(1)(f) and NRS 630.3062(1)(a), as set forth in the Complaint, and imposed the following discipline against him: Mr. Anderson's license to practice medicine in the State of Nevada was revoked, with said revocation immediately stayed and Mr. Anderson's license placed on probation for a period of time not less than 12 months, but up to 24 months, pending the completion of the following probationary terms: (1) public reprimand; (2) total fines in the amount of $4,000.00; (3) 10 hours of continuing medical education (CME), in addition to his statutory CME requirements for licensure in Nevada; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

AWAD, Ayman N., M.D. (8060)
Lake Havasu City, Arizona

Summary: Disciplinary action taken against Dr. Awad's medical license in Arizona and conviction of an offense involving moral turpitude.

Charges: One violation of NRS 630.301(3) [disciplinary action taken against his medical license in another state]; one violation of NRS 630.301(11)(g) [conviction of an offense involving moral turpitude].

Disposition: On September 11, 2020, the Board found Dr. Awad violated NRS 630.301(3) and NRS 630.301(11)(g), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $500.00 fine; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

FAKHOURI, Ibrahim T., M.D. (14038)
Henderson, Nevada

Summary: Alleged failure to adequately supervise a physician assistant.

Charges: Six violations of NAC 630.230(1)(i) [failure to adequately supervise a physician assistant].

Disposition: On September 11, 2020, the Board accepted a Settlement Agreement by which it found Dr. Fakhouri violated NAC 630.230(1)(i) (6 counts), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $2,500.00 fine; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

FLEISHER, Charles W., M.D. (8351)
Las Vegas, Nevada

Summary: Alleged failure to maintain appropriate medical records relating to his treatment of a patient.

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

Disposition: On September 11, 2020, the Board accepted a Settlement Agreement by which it found Dr. Fleisher violated NRS 630.3062(1)(a), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) his license to practice medicine in the State of Nevada shall be placed in "Inactive" status; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter, with the order for reimbursement of fees and costs stayed until such time as he applies for a change of licensure status from "Inactive" to "Active."

HAYES, Amy S., M.D. (8308)
Carson City, Nevada

Summary: Alleged malpractice, failure to maintain appropriate medical records relating to her treatment of a patient, and engaging in conduct in violation of standards of practice established by regulation of the Board of Medical Examiners.

Charges: One violation of NRS 630.301(4) [malpractice]; one violation of NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; one violation of NRS 630.306(1)(b)(2) [engaging in conduct which the Board has determined is a violation of the standards of practice established by regulation of the Board].

Disposition: On September 11, 2020, the Board found Dr. Hayes violated NRS 630.301(4), as set forth in Count I of the Complaint, and imposed the following discipline against her: (1) public reprimand; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Counts II and III of the Complaint were dismissed with prejudice.

LEE, Ben H., M.D. (17977)
Los Angeles, California

Summary: Disciplinary action taken against Dr. Lee's medical license in Colorado and alleged failure to timely report said disciplinary action 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(1)(k) [failure to report in writing, within 30 days, disciplinary action taken against him by another state].

Disposition: On September 11, 2020, the Board accepted a Settlement Agreement by which it found Dr. Lee violated NRS 630.301(3) and NRS 630.306(1)(k), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $250.00 fine; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

MANLEY, Gary L., PA-C (PA1209)
Las Vegas, Nevada

Summary: Disciplinary action taken against Mr. Manley's medical license by the Nevada State Board of Osteopathic Medicine and alleged failure to timely report said disciplinary action to the Nevada State Board of Medical Examiners.

Charges: One violation of NRS 630.301(3) [disciplinary action taken against his medical license by another licensing board]; one violation of NRS 630.306(1)(k) [failure to report in writing, within 30 days, disciplinary action taken against him by another licensing board].

Continued from page 15

Disposition: On September 11, 2020, the Board accepted a Settlement Agreement by which it found Mr. Manley violated NRS 630.301(3), as set forth in Count I of the First Amended Complaint, and imposed the following discipline against him: (1) public reprimand; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count II of the First Amended Complaint was dismissed with prejudice.

MANLEY, Gary L., PA-C (PA1209)
Las Vegas, Nevada

Summary: Alleged malpractice, failure to maintain appropriate medical records relating to his treatment of two patients, and engaging in conduct in violation of standards of practice established by regulation of the Board of Medical Examiners.

Charges: Two violations of NRS 630.306(1)(b)(2) [engaging in conduct which the Board has determined is a violation of the standards of practice established by regulation of the Board]; two violations of NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; two violations of NRS 630.301(4) [malpractice].

Disposition: On September 11, 2020, the Board accepted a Settlement Agreement by which it found Mr. Manley violated NRS 630.306(1)(b)(2) (2 counts), NRS 630.3062(1)(a) (2 counts) and NRS 630.301(4) (2 counts), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) 20 hours of live, in-person continuing medical education; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

SHAH, Dhaval J., M.D. (12305)
Las Vegas, Nevada

Summary: Alleged malpractice and failure to maintain appropriate medical records relating to his treatment of two patients.

Charges: Two violations of NRS 630.301(4) [malpractice]; one violation of NRS 630.301(4) [malpractice – respondeat superior]; two violations of NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; one violation of NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient – respondeat superior].

Disposition: On August 26, 2020, the Board accepted a Settlement Agreement by which it found Dr. Shah violated NRS 630.301(4) (2 counts) and NRS 630.3062(1)(a) (3 counts), as set forth in the Complaints, and imposed the following discipline against him: (1) revocation of Dr. Shah's license to practice medicine in the State of Nevada, and he may not apply for reinstatement of a medical license for a period of one year; (2) public reprimand; (3) total fines in the amount of $10,000.00; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count I of the Complaint in Case No. 19-32539-01 was dismissed with prejudice.

STUMPF, Paul M., M.D. (7081)
Reno, Nevada

Summary: Alleged failure to maintain appropriate medical records relating to his treatment of a patient and engaging in conduct in violation of standards of practice established by regulation of the Board of Medical Examiners.

Charges: One violation of NRS 630.306(1)(b)(2) [engaging in conduct which the Board has determined is a violation of the standards of practice established by regulation of the Board]; one violation of NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient].

Disposition: On September 11, 2020, the Board accepted a Settlement Agreement by which it found Dr. Stumpf violated NRS 630.306(1)(b)(2), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) 4 hours of continuing medical education (CME), in addition to his statutory CME requirements for licensure; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count II of the Complaint was dismissed with prejudice.

★ ★ ★

Public Reprimands Ordered by the Board

September 8, 2020

Clinton Anderson, PA-C
c/o Johnathon Fayeghi, Esq.
Sklar Williams PLLC
410 S. Rampart Boulevard, Suite 350
Las Vegas, NV 89145

**Re: In the Matter of Charges and Complaint Against Clinton Anderson, PA-C
BME Case No. 20-36612-1**

Mr. Anderson:

On August 26, 2020, 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 the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Administrative Code 630.380(1)(f) (Count I) and Nevada Revised Statute 630.3062(1)(a) (Count II), as set forth in the Complaint. For the same, your license to practice medicine was revoked, with said revocation immediately stayed, and your license placed on probation for a period of time not less than 12 months, but up to 24 months, pending the completion of probationary terms set forth in the Agreement. The Board ordered that you shall take ten (10) hours of continuing medical education (CME) on medical ethics and professionalism within three (3) months in addition to any CME requirements that are regularly imposed upon you as a condition of licensure in the State of Nevada. You shall pay a fine of $4,000; you shall receive a public reprimand; and you shall pay the costs and expenses incurred in the investigation and prosecution of this case.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 14, 2020

Ayman Nicolas Awad, M.D.
c/o Christina M. Alexander, Esq.
Hutchison & Steffen, PLLC
10080 West Alta Drive, Suite 200
Las Vegas, NV 89145

**Re: In the Matter of Charges and Complaint Against Ayman Nicolas Awad, M.D.
BME Case No. 20-10721-1**

Dr. Awad:

On September 11, 2020, 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 the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated one count of Nevada Revised Statute (NRS) 630.301(3), Disciplinary Action by Another State Medical Board (Count I), and one count of NRS 630.301(11)(g), Conviction of an Offense Involving Moral Turpitude (Count II). For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter, pay a fine of $500.00 and be publicly reprimanded.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 14, 2020

Ibrahim Fakhouri, M.D.
c/o Todd Weiss, Esq.
John Cotton & Associates, Ltd.
7900 West Sahara Avenue, Suite 200
Las Vegas, NV 89117

**Re: In the Matter of Charges and Complaint Against Ibrahim Fakhouri, M.D.
BME Case No. 20-38677-1**

On September 11, 2020, 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 the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated six counts of Nevada Administrative Code 630.230(1)(i), Failure to Adequately Supervise Physician Assistant. For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter, pay a fine of $2,500.00, and be publicly reprimanded.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 14, 2020

Charles Wayne Fleisher, M.D.
c/o Jill M. Chase, Esq.
Lewis Brisbois Bisgaard & Smith LLP
6385 South Rainbow Blvd., Suite 600
Las Vegas, NV 89118

**Re: In the Matter of Charges and Complaint Against Charles Wayne Fleisher, M.D.
BME Case No. 20-11931-1**

Dr. Fleisher:

On September 11, 2020, 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 the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated one count of Nevada Revised Statute 630.3062(1)(a), Failure to Maintain Proper Medical Records. For the same, your license to practice medicine in

Continued from page 17

the State of Nevada shall be placed in an inactive status. You may apply for a change of status and petition the Board to allow you to resume the practice of medicine provided you have paid the costs and expenses related to the investigation and prosecution of this matter, and you shall be publicly reprimanded.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 14, 2020

Amy Sue Hayes, M.D.
c/o Edward J. Lemons, Esq.
Lemons, Grundy & Eisenberg
6005 Plumas Street, Third Floor
Reno, NV 89519

Re: In the Matter of Charges and Complaint Against Amy Sue Hayes, M.D.
BME Case No. 20-11777-1

Dr. Hayes:

On September 11, 2020, 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 the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated one count of Nevada Revised Statute 630.301(4), Malpractice (Count I). Counts II and III shall be dismissed with prejudice. For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter, and be publicly reprimanded.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 14, 2020

Ben Huon Lee, M.D.
3680 Wilshire Boulevard, #202
Los Angeles, CA 90010

Re: In the Matter of Charges and Complaint Against Ben Huon Lee, M.D.
BME Case No. 19-48498-1

Dr. Lee:

On September 11, 2020, 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 the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated one count of Nevada Revised Statute (NRS) 630.301(3), Out-of-State Discipline Imposed (Count I) and NRS 630.306(1)(k), Failure to Report (Count II). For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter, pay a fine of $250.00 and be publicly reprimanded.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 14, 2020

Gary Manley, PA-C
c/o Todd Weiss, Esq.
John Cotton & Associates, Ltd.
7900 West Sahara Avenue, Suite 200
Las Vegas, NV 89117

Re: In the Matter of Charges and Complaint Against Gary Manley, PA-C
BME Case No. 20-36618-1

Mr. Manley:

On September 11, 2020, 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 First Amended Complaint filed against you in the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated one count of Nevada Revised Statute (NRS) 630.301(3), Disciplinary Action by Another State Medical Board (Count I). Count II is dismissed. For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter and be publicly reprimanded.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 14, 2020

Gary Manley, PA-C
c/o Todd Weiss, Esq.
John Cotton & Associates, Ltd.
7900 West Sahara Avenue, Suite 200
Las Vegas, NV 89117

Re: In the Matter of Charges and Complaint Against Gary Manley, PA-C
BME Case No. 20-36618-2

Mr. Manley:

On September 11, 2020, 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 the aforementioned case.

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In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated two counts of Nevada Revised Statute (NRS) 630.306(1)(b)(2), Violation of Standards of Practice (Counts I & IV); two counts of NRS 630.3062(1)(a), Failure to Maintain Proper Medical Records (Counts II & V); and two counts of NRS 630.301(4), Malpractice (Counts III & VI). For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter, be publicly reprimanded, and you shall take 20 hours of live, in-person continuing medical education related to best practices in the prescribing of controlled substances.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 8, 2020

Dhaval Jasvantbhai Shah, M.D.
c/o Johnathon Fayeghi, Esq.
Sklar Williams PLLC
410 S. Rampart Boulevard, Suite 350
Las Vegas, NV 89145

Re: In the Matter of Charges and Complaint Against Dhaval Shah, M.D.
BME Case Nos. 19-32539-01 and 20-32539-1

Dr. Shah:

On August 26, 2020, 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 BME Case Nos. 19-32539-01 (Complaint One) and 20-32539-1 (Complaint Two).

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Count II of Complaint One, Nevada Revised Statute (NRS) 630.3062(1)(a). Count I of Complaint One shall be dismissed with prejudice. The Board also found you violated all counts of Complaint Two, NRS 630.301(4), as set forth in Counts I and III, and NRS 630.3062(1)(a), as set forth in Counts II and IV. The Board ordered that your license shall be immediately revoked; pursuant to NRS 622A.410(1), you may not apply for a new license to practice medicine for a period of one (1) year; you shall pay a fine of $10,000; you shall receive a public reprimand; and you shall pay the costs and expenses incurred in the investigation and prosecution of these cases.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

September 14, 2020

Paul Stumpf, M.D.
c/o Edward J. Lemons, Esq.
Lemons, Grundy & Eisenberg
6005 Plumas Street, Suite 300
Reno, NV 89519

Re: In the Matter of Charges and Complaint Against Paul M. Stumpf, M.D.
BME Case No. 20-10382-1

Dr. Stumpf:

On September 11, 2020, 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 the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated one count of Nevada Revised Statute (NRS) 630.306(1)(b)(2), Violation of Standards of Practice Established by Regulation (NAC 630.210, Failure to Timely Seek Consultation with Another Provider of Health Care in a Difficult Case). Count II is dismissed with prejudice. For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter, be publicly reprimanded, and you shall take four hours of continuing medical education (CME) related to the subject matter of best practices for medicine consultations in difficult and demanding cases, in addition to any CME requirements that are regularly imposed upon you as a condition of licensure in the State of Nevada.

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,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

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NEVADA STATE BOARD OF MEDICAL EXAMINERS
9600 Gateway Drive
Reno, NV 89521