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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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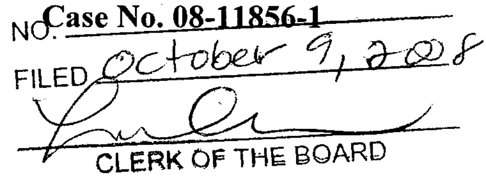
In The Matter of Charges and Complaint Against

NAVNEET SHARDA, M.D.,

Respondent.

Case No. 08-11856-1



COMPLAINT

The Investigative Committee of the Board of Medical Examiners of the state of Nevada, composed of Sohail U. Anjum, M.D., Chairman, and S. Daniel McBride, M.D., by and through Lyn E. Beggs, Deputy General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Navneet Sharda, M.D., hereinafter referred to as "Respondent," has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent is currently licensed in active status, and was so licensed by the Nevada State Board of Medical Examiners, hereinafter referred to as "the Board," pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes, at the time of the incidents in question.

2. Patient A was a seventy-four year old female at the time of the matter in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A had a history of atrial fibrillation, which eventually resulted in the implantation of a pacemaker in January of 2002.

4. During the workup of Patient A for the implantation of the pacemaker, her physician noted a mass in the left breast, which was determined to be cancerous.

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5. Patient A underwent a double mastectomy in August 2002 and the pathology report indicated poorly differentiated invasive ductal carcinoma with focal invasion of overlying skin and eleven left axillary lymph nodes demonstrated adenocarcinoma with perinodal extension.

6. Patient A was referred for a consultation with Respondent, which was performed on August 23, 2002, at which time he recommended radiation therapy. Patient A was in distress at Respondent's office and was later diagnosed with a pulmonary embolism and hospitalized so the initial consultation was not completed.

7. Patient A returned to Respondent on September 12, 2002 at which time her consultation was completed. In the medical records from this appointment, Respondent notes that Patient A did have a pacemaker.

8. Patient A began radiation therapy on September 17, 2002, however, Respondent did not fully investigate Patient A's pacemaker prior to beginning radiation therapy.

9. Respondent also did not review diagnostic studies prior to the beginning of radiation nor does he indicate in the medical records if he ever reviewed a bone scan and or a CT of the abdomen and pelvis, which is noted to exist on October 9, 2002.

10. Respondent did not have Patient A see a medical oncologist regarding the possibility of chemotherapy prior to beginning radiation therapy.

11. Patient A completed her radiation on November 6, 2002, but continued to see Respondent through 2003.

12. A biopsy performed on skin from Patient A's right cheek on November 1, 2002 was positive for cancer.

13. Patient A underwent radiation for skin cancer in 2003 and completed radiation therapy on August 27, 2003.

14. Respondent's medical records for Patient A are lacking in information and appear to be lacking in information regarding treatment that Patient A received.

15. Patient B was a seventy-six year old male at the time of the incidents in question. His true identity is not disclosed to protect his privacy, but his identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

16. Patient B presented to Respondent on November 6, 2002, after being referred by his physician after a chest x-ray and CT scan noted a suspicious nodule in his right upper lobe. Patient B also had a suspicious lesion in the right paratracheal region as well as other lesions.

17. Patient B underwent a biopsy, which was positive for small cell lung cancer and Patient B returned to Respondent on November 19, 2002 after the biopsy.

18. On November 19, 2002 Respondent noted in the medical records for Patient B that workup would continue with a CT of the head and abdomen and that radiation treatment would begin while Patient B made up his mind about chemotherapy.

19. Respondent's medical records for Patient B do not indicate that the CT scan was ever performed or reviewed prior to beginning radiation treatment.

20. An appointment was made with a medical oncologist for Patient B for November 22, 2002, however radiation treatment began before Patient had an opportunity to meet with the medical oncologist to discuss chemotherapy.

21. Respondent's medical records for Patient B are lacking information regarding the treatments that Patient B underwent and contains no information about the review of any further diagnostic studies.

22. Patient B did receive three doses of radiation using XRT modality, but discontinued his treatment and saw Respondent for the last time on November 21, 2002.

23. Respondent's medical records for Patient B are lacking in information and appear to be lacking in information regarding treatment that Patient A received.

24. Patient C was a sixty-three year old female at the time of the incidents in question. Her true identity is not disclosed to protect her privacy, but her identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

25. Patient C presented to Respondent on January 26, 2004, for continued follow-up care. Patient C had undergone a left mastectomy for cancer of the left breast six years prior and had been taking Tamoxifen for five years and had recently switched to Femara prior to seeing Respondent. Respondent performed a consultation and recommended that Patient C return in six months.

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26. Patient C returned on July 9, 2004 reporting of lower back pain for which she had undergone an MRI with showed moderate canal stenosis at the L3-L4 and L5 as well as some lumbar vertebral marrow signal changes.

27. Over the next several months, Patient C underwent several diagnostic studies including a bone scan, CT scans and a PET scan and saw Respondent several times complaining of increasing pain.

28. On December 4, 2004, Patient C underwent a CT scan performed at UMC which, indicated biapical pleural and parenchymal disease and some focal nodular thickening in the left apex and a PET scan subsequently performed indicated some abnormal soft tissue in the lung apices with abnormal hypermetabolic activity raising the question of carcinoma.

29. Patient C saw Respondent on March 10, 2005 at which time Respondent reviewed the CT scan and the results of the PET scan and indicated that lung cancer was very likely.

30. The medical records indicate that Patient C's husband indicated that a biopsy had not been performed by UMC due to high-risk concerns.

31. Patient C and her husband agreed for her to undergo radiation treatment using high doses of radiation and the IMRT modality instead of having rescans and the possibility of having thoracic surgery for a biopsy if the rescans indicated growth.

32. Patient C completed radiation therapy using dynamic arc IMRT on May 11, 2005 and according to Respondent, Patient C reported a significant reduction in pain towards the end of treatment.

33. Patient C did see Respondent again on June 10, 2005 reporting continued modest discomfort in the right supraclavicular area.

34. Patient C continued her care for her on-going pain with other providers.

35. Respondent's medical records for Patient C do not appear to be complete and are lacking information in regard to the radiation treatment that Patient C received and her continued complaints of pain.

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Count I

36. Nevada Administrative Code Section 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

37. Nevada Revised Statute Section 630.301(4) provides that malpractice is grounds for initiating disciplinary action against a licensee.

38. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he failed to appropriately investigate Patient A's pacemaker prior to beginning radiation therapy and thus violated Nevada Revised Statute Section 630.301(4).

39. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count II

40. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he failed to have Patient A speak with a medical oncologist to discuss chemotherapy and/or to investigate other treatment modalities prior to beginning radiation treatment, thus violating Nevada Revised Statute Section 630.301(4).

41. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count III

42. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he failed to review or consider the bone scan or the CT scan of Patient A's abdomen and pelvis before continuing with radiation therapy, thus violating Nevada Revised Statute Section 630.301(4).

43. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

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Count IV

44. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he ordered a CT scan but failed to review it prior to beginning radiation therapy on Patient B, thus violating Nevada Revised Statute Section 630.301(4).

45. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count V

46. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he referred Patient B for a medical oncology consult but began radiation treatment before the consultation was completed, thus violating Nevada Revised Statute Section 630.301(4).

47. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count VI

48. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he failed to obtain a biopsy on Patient C prior to beginning radiation treatment for suspected lung cancer and failed to follow up with her other health care providers to determine whether a biopsy was possible, thus violating Nevada Revised Statute Section 630.301(4).

49. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count VII

50. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he failed to refer Patient C for any consultations regarding any other possible treatment modalities prior to beginning radiation treatment, thus violating Nevada Revised Statute Section 630.301(4).

51. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

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Count VIII

52. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he used an excessive dose of radiation and in using IMRT when it was not necessary, in treating Patient C, thus violating Nevada Revised Statute Section 630.301(4).

53. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count IX

54. Nevada Revised Statute Section 630.306(7) provides that continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty of field is grounds for initiating disciplinary action against a licensee.

55. Respondent showed a continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty of field when he failed to contact any other treatment providers for Patients A, B and C prior to beginning radiation treatment on all three patients.

56. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count X

57. Respondent showed a continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty of field when he used treatment modalities that were not necessary in the treatment of Patients A, B and C and used excessive doses of radiation thus violation Nevada Revised Statute Section 630.306(7).

58. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

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Count XI

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

60. Respondent's medical records for Patients A, B and C and lacking in information regarding the radiation treatment provided to all three patients and is lacking in detail about the care of the patients.

61. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;

2. That the Nevada State Board of Medical Examiners give Respondent notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;

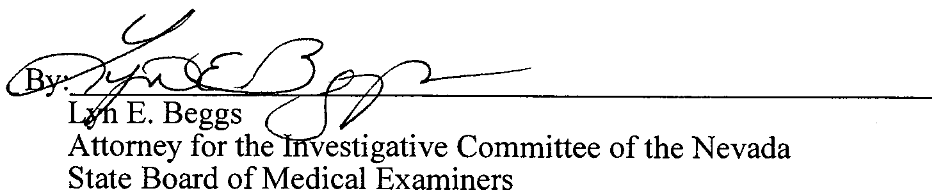
3. That the Nevada State Board of Medical Examiners determine what sanctions it will impose for the violation or violations committed by Respondent;

4. That the Nevada State Board of Medical Examiners make, issue and serve on Respondent its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 9th day of October, 2008.

INVESTIGATIVE COMMITTEE OF
THE NEVADA STATE BOARD OF MEDICAL EXAMINERS



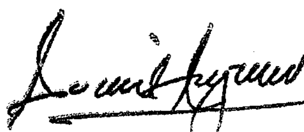
By: ______________________
Lyn E. Beggs
Attorney for the Investigative Committee of the Nevada
State Board of Medical Examiners

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

SOHAIL U. ANJUM, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate, and correct.

DATED this 9th day of October, 2008.



SOHAIL U. ANJUM, M.D.

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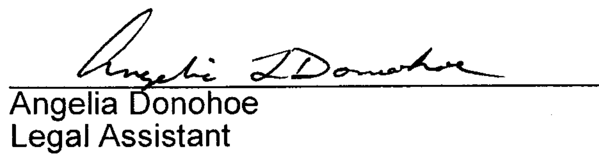
CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 9th day of October 2008, I served a file copy of the COMPLAINT, PATIENT DESIGNATION, NOTICE OF PREHEARING & HEARING and a copy of the APPOINTMENT LETTER, by mailing via USPS certified return receipt to the following:

Navneet Sharda, M.D.
3509 E. Harmon Ave.
Las Vegas, NV 89121

Dated this 9th day of October 2008.



Angelia Donohoe
Legal Assistant