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**BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF NEVADA**

\* \* \* \* \*

**In the Matter of Charges and )  
)  
Complaint Against )  
)  
VAN R. BOHMAN, M.D., )  
)  
Respondent. )**

**Case No. 13-10038-1**

**FILED**  
**MAR 22 2013**  
**NEVADA STATE BOARD OF**  
**MEDICAL EXAMINERS**  
By: 

**COMPLAINT**

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), composed at the time of filing of Theodore B. Berndt, M.D., Chairman, Valerie J. Clark, BSN, RHU, LUTCF, Member, and Michael J. Fischer, M.D., Member, by and through Erin L. Albright, Esq., Deputy General Counsel for the Board and attorney for the IC, having a reasonable basis to believe that Van R. Bohman, M.D. (Respondent), violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively "Medical Practice Act"), hereby issues its formal Complaint, stating the IC's charges and allegations as follows:

**FACTUAL BACKGROUND**

1. Respondent is currently licensed in active status (License No. 6760), and has been licensed by the Board since June 5, 1993, pursuant to the provisions of the Medical Practice Act.

2. At all times alleged herein, Patient A was a twenty-three (23) year old female pregnant with triplets, Babies A – C. Patient A's true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with a copy of this Complaint.

///

1           3.       On or about December 10, 2009, Patient A was admitted with frequent contractions  
2 to Summerlin Hospital for preeclampsia workup and the administration of betamethasone for fetal  
3 lung maturity.

4           4.       Patient A was an in-patient at Summerlin Hospital from December 10, 2009  
5 through January 5, 2010. She was being treated for antepartum management of preterm labor  
6 contractions, preeclampsia and monitoring of her triplets growth and fetal well-being.

7           5.       On or about January 5, 2010, at approximately 2:45 a.m., Patient A was  
8 diaphoretic, pale and experiencing severe pain and pressure in her abdomen and pelvis.

9           6.       On or about January 5, 2010, at approximately 4:00 a.m., Respondent performed a  
10 biophysical profile ("BPP") for each triplet, which was documented as eight (8) out of eight (8)  
11 for each fetus. The fetal monitor indicated a lack of reactivity for Baby A and Baby B coupled  
12 with the presence of late decelerations. The fetal monitor indicated that there was tachycardia in  
13 Baby C. Despite the lack of reactivity for Babies A and B and the tachycardia in Baby C,  
14 Respondent ordered the fetal monitors removed and reapplied at 6:00 a.m.

15           7.       On or about January 5, 2010, at approximately 7:05 a.m., the fetal monitors were  
16 nonreactive for all three (3) fetuses and tachycardic at times for Babies B and C. From  
17 approximately 7:28 a.m. until 10:18 a.m., Baby A was not tracing and Baby A's heart rate was  
18 absent variability with no and/or late decelerations. At approximately 7:45 a.m. and 8:20 a.m.,  
19 Baby B was not tracing. At approximately 8:30 a.m., the status of the fetal heart rates for all three  
20 (3) babies was changed from Category I to Category II.

21           8.       On January 5, 2010, at approximately 9:05 a.m., nursing staff telephonically  
22 informed Respondent of Patient A's condition. Respondent advised the nursing staff to telephone  
23 Dr. Vo, Patient A's primary care physician. At approximately 9:07 a.m., nursing staff left a voice  
24 message for Dr. Vo regarding Patient A, which was not returned. At approximately 9:28 a.m.,  
25 nursing staff again telephoned Dr. Vo. Dr. Vo was informed of Patient A's status and was advised  
26 that he should assess Patient A as soon as possible.

27           9.       On January 5, 2010, from approximately 9:12 a.m. until 10:18 a.m., Baby A was  
28 not tracing.



1           17. Respondent also failed to use the reasonable care, skill or knowledge ordinarily  
2 used under similar circumstances when he, as outlined above, failed to communicate with Dr. Vo  
3 regarding Patient A's status.

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

6   **COUNT II**

7   **(Records Violation)**

8           19. All of the allegations in the above paragraphs are hereby incorporated as if fully set  
9 forth herein.

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

13          21. Respondent failed to maintain accurate and/or complete medical records relating to  
14 the diagnosis, treatment and care of Patient A when he wrote numerous untimed and/or illegible  
15 entries into Patient A's medical records and/or failed to document that he re-evaluated Patient A  
16 or the fetal monitor recordings after 4:00 A.M. on January 5, 2010.

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

19           **WHEREFORE**, the IC prays:

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

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

25           3. That the Board determine the sanctions it will impose if it finds Respondent  
26 violated the Medical Practice Act;

27           4. That the Board make, issue and serve on Respondent, in writing, its findings of  
28 fact, conclusions of law and order, which shall include the sanctions imposed; and

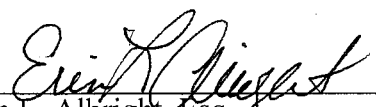
OFFICE OF THE GENERAL COUNSEL  
Nevada State Board of Medical Examiners  
1105 Terminal Way #301  
Reno, Nevada 89502  
(775) 688-2559

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

DATED this 22<sup>nd</sup> day of March, 2013.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

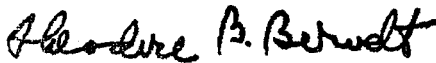
By:   
Erin L. Albright, Esq.  
Deputy General Counsel  
Attorney for the Investigative Committee

VERIFICATION

1 STATE OF NEVADA )  
2 : ss.  
3 COUNTY OF WASHOE )

4 Theodore B. Berndt, M.D., hereby deposes and states under penalty of perjury under the  
5 laws of the state of Nevada that he is the Chairman of the Investigative Committee of the  
6 Nevada State Board of Medical Examiners that authorized the foregoing Complaint against the  
7 Respondent herein; that he has read the foregoing Complaint; and that based upon information  
8 discovered during the course of the investigation into a complaint against Respondent, that he  
9 believes the allegations and charges in the foregoing Complaint against Respondent are true,  
10 accurate and correct.

11 Dated this 22<sup>nd</sup> day of March, 2013.

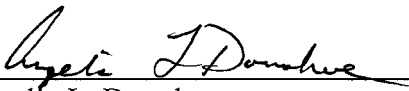
12  
13   
14 Theodore B. Berndt, M.D.

**CERTIFICATE OF MAILING**

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 22<sup>nd</sup> day of March 2013; I served a filed copy of the COMPLAINT, PATIENT DESIGNATION and FINGERPRINT INFORMATION via USPS e-certified return receipt mail to the following:

Van Bohman, M.D.  
5761 S. Fort Apache  
Las Vegas, NV 89148

Dated this 22<sup>nd</sup> day of March, 2013.

  
\_\_\_\_\_  
Angelia L. Donohoe  
Legal Assistant