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

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against ROBERT W. WATSON, M.D., Respondent.	**Case No. 15-12823-1**

FILED
FEB 13 2015
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., Board General Counsel and attorney for the IC, having a reasonable basis to believe that Robert W. Watson, 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:

1. Respondent is currently licensed in active status (License No. 9076), and has been so licensed by the Board since July 12, 1999, pursuant to the provisions of the Medical Practice Act.

2. Patient A was a forty-eight (48)-year-old female at the time of the incidents in question. Her 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 this Complaint.

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3. Patient A was admitted to St. Mary's Hospital on September 9, 2010, with diverticular disease complicated by the development of an abscess adjacent to the affected sigmoid colon.

4. On September 10, 2010, Respondent discussed the various treatment options with Patient A. After this discussion, Patient A agreed to undergo a colorectal anastomosis.

5. On September 13, 2010, Respondent performed a colorectal anastomosis on Patient A.

6. Post operatively, Patient A began passing green enteric fluid from her vagina.

7. On September 24, 2010, a different physician performed an exploratory laparotomy. During this subsequent surgery, it was discovered that the physician assistant who assisted Respondent placed the circular staple device in Patient A's vagina instead of the rectum, leading to a direct colovaginal anastomosis instead of a colorectal anastomosis.

8. Respondent's failure to recognize the fact that the physician assistant's placement of the staple device was incorrect prior to stapling the anastomosis constitutes malpractice.

COUNT I

(Malpractice)

9. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

10. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

11. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

12. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he failed to recognize the fact that the physician assistant placed the staple device in the wrong location prior to stapling the anastomosis.

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

WHEREFORE, the Investigative Committee prays:

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

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

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

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

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

DATED this 13th day of February, 2015.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

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

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

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

Dated this 13th day of February, 2015.

Theodore B. Berndt

Theodore B. Berndt, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 13th day of February 2015; I served a filed copy of COMPLAINT & PATIENT DESIGNATION via USPS certified return receipt mail to the following:

Robert W. Watson, M.D.
75 Pringle Way Ste 1002
Reno, NV 89502

Dated this 13th day of February, 2015.

Angelia L. Donohoe
Legal Assistant

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