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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

* * * * *

In the Matter of Charges and Complaint Against

ALI DANA, M.D.,

Respondent.

Case No. 16-37541-1

FILED
AUG 2 5 2016
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ______

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Ali Dana, M.D. (Respondent), a licensed physician in Nevada. After investigating this matter, the IC has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act).

The IC alleges the following facts:

1. Respondent is currently licensed in an inactive status (License No. 13550), and has been licensed by the Board since June 9, 2010 pursuant to the provisions of the Medical Practice Act.

2. Previous to the preparation of this Complaint, the Board solicited the services of an independent medical expert (IME), a nephrologist, to review the conduct of the Respondent and render an opinion regarding whether Respondent through his acts and omissions violated the Medical Practice Act.

3. At the time of the incidents alleged herein, Patient was being treated by Respondent. Her true identity is not disclosed in this Complaint to protect her identity, but her

[1] The Investigative Committee of the Nevada State Board of Medical Examiners is composed of Board members Theodore B. Berndt, M.D., Wayne Hardwick, M.D., and Mr. M. Neil Duxbury.

identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

4. On January 7, 2012, at approximately 3:00 a.m., Patient ingested a bottle of Aspirin (ASA). After approximately four to six (4-6) hours of nausea and vomiting, finally resulting in black vomitus, Patient notified her mother and was driven to the hospital.

5. On January 7, 2012, at approximately 10:00-10:30 a.m., Patient was seen in triage, and she was under the care of another physician.

6. On January 7, 2012, Respondent, a nephrologist, treated Patient, between 12:35 and 1:00 p.m., when he was assigned to the case and notified that he was the admitting and the consulting physician for Patient following a case discussion with the emergency room (ER) physician.

7. On January 7, 2012, at 12:42 p.m., Patient's ASA level was drawn pursuant to the ER physician order. The results of this test were called to Respondent.

8. On January 7, 2012, at 5:06 p.m., Patient was seen and examined by Respondent, who did not write orders as to when the blood work was to be drawn, did not write orders requesting that Patient's arterial blood gas (ABG) be measured, did not write orders regarding the timing for repeated measurements of the Patient's ABG, did not write a start time for the blood draws to measure the Patient's ASA levels, did not write orders for electrolyte determination or updated assessment of renal function and did not write orders to follow fluid intake or output.

9. On January 7, 2012, at 5:50 p.m., Respondent was notified of Patient's respiratory difficulties and then Respondent ordered the contracted dialysis nurse from Davita be called to the hospital to provide hemodialysis. He also ordered the "on-call" nephrologist to place a femoral vein dialysis catheter. Respondent also informed this nephrologist of the need for immediate dialysis. The on-call nephrologist confirmed the need for immediate dialysis. The Patient's blood pressure was not recorded.

10. On January 7, 2012, at 6:15 p.m., another physician (not the Respondent) ordered intravenous (IV) Ativan and Haldol be administered to the Patient to address the Patient's level of anxiety and distress.

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11. On January 7, 2012, at 7:52 p.m., IV blood pressure lowering medications were given, but once again, no blood pressure recordings were found in the Patient's chart.

12. On January 7, 2012, at 8:00 p.m., the contracted dialysis nurse from Davita arrived to perform the hemodialysis approximately two and a half hours (2.5 hrs.) after Respondent initially ordered dialysis.

13. On January 7, 2012, at 8:15 p.m., Patient was experiencing asystolic cardiac arrest and coded; at 9:18 p.m., the Patient was declared dead.

14. The Board's IME found that Respondent's care and treatment of Patient constituted malpractice. He stated that despite the fact that Respondent was a consulting physician, he was the "captain of the ship" in the management of complex intoxications involving fluid, electrolytes and kidney considerations for Patient.

15. The IME opined that a nephrologist needs to pay attention to detail and must frequently personally monitor the patient to ensure all bases are covered. Respondent failed to act as the "captain of the ship" for Patient care and treatment.

16. The IME opined that "the standard of care would be that once Respondent was contacted and 'case discussed' that his involvement began and that all orders from that point forward were part of his responsibility, including review and modification (if indicated) of prior orders."

17. The IME opined that there should have been an order for strict monitoring of intake and output of body fluids to guide and assess fluid volume status to prevent fluid overload.

18. The IME opined that there should have been orders for frequent blood electrolyte levels so abnormalities or sub-optimal levels could be corrected.

19. The IME opined that potassium replacement should have been started much earlier.

20. The IME opined that more frequent ABGs should have been performed to allow regulation of medication to achieve the desired target levels of pH of over 7.5 to enhance removal of ASA by the kidneys.

21. The IME opined that more frequent blood ASA levels should have been performed to allow careful tracking as to the progress of ASA removal from the system.

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22. Based upon the foregoing, the IC charges Respondent with the following violations of the Medical Practice Act.

COUNT I
(NRS 630.3062 (Medical Records Violation))

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

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

25. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patient when he failed to document the nature, intensity and course of treatment for Patient's ASA overdose condition.

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

COUNT II
(NRS 630.301 (Malpractice))

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

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

29. 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.

30. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when Respondent i) failed to act as the "captain of the ship" for Patients care and treatment, ii) failed to instruct or order for the strict monitoring of intake and output of bodily fluids to guide and assess fluid volume status to prevent fluid overload, iii) failed to instruct or order for frequent blood electrolyte levels so abnormalities or sub-optimal levels could be corrected, iv) failed to timely start potassium replacement, v) failed to perform more frequent ABGs to allow regulation

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of medication to achieve the desired target levels of pH of over 7.5 to enhance removal of ASA by the kidneys, vi) failed to perform more frequent blood ASA levels to allow careful tracking as to the progress of ASA removal from the system.

31. 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 25th day of August, 2016.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________
Jasmine K. Mehta
Deputy General Counsel for the Investigative Committee of the Nevada State Board of Medical Examiners

By: ______________________
Robert G. Kilroy, Esq.
General Counsel
Attorney for the Investigative Committee

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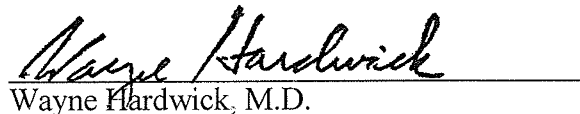
VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Wayne Hardwick, M.D., hereby deposes and states under penalty of perjury under the laws of the State of Nevada that he is the Chair of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against Respondent herein; that he has read the foregoing Complaint; and 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 26th day of August, 2016.



Wayne Hardwick, M.D.

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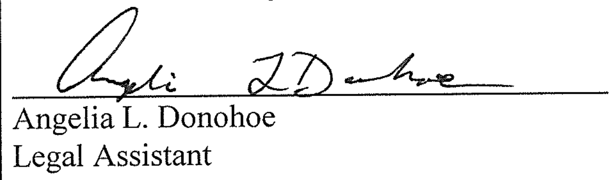
CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 26th day of August 2016; I served a file stamp copy of the COMPLAINT, along with a copy of the PATIENT DESIGNATION & Fingerprint information, by mailing via USPS e-certified return receipt mail to the following:

Ali Dana, M.D.
1200 West Gonzales Rd.
Oxnard, CA 93036

Dated this 26th day of August, 2016.



Angelia L. Donohoe
Legal Assistant

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