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 CHARLES P. VIRDEN, M.D., Respondent.	**Case No. 16-10736-2**

FILED
MAY 17 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 Charles P. Virden, 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 active status (License No. 7420), and has been licensed by the Board since May 18, 1995. At all times alleged herein, Respondent was licensed in an active status by the Board pursuant to the provisions of the Medical Practice Act.

PATIENT A

2. Patient A was a 51-year-old female at the time of the events at issue. Her true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners is composed of Board members Beverly A. Neyland, M.D., Rachakonda D. Prabhu, M.D., and Ms. Sandy Peltyn.

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3. On or about April 13, 2012, Patient A presented to Renown Regional Medical Center, in Reno, Nevada. Respondent performed an upper and lower blepharoplasty with laser resurfacing of her lower eyelids.

4. Prior to the surgery, Patient A had no visual acuity problems or other problems with her eyes.

5. Respondent did not note any complications or problems in the operative report. Respondent did not use globe protection or an eyeshield to protect the eyes during the procedure.

6. Immediately after surgery, in recovery, Patient A noticed vision problems in her right eye. While in recovery, she notified a nurse of this problem.

7. Respondent did not examine Patient A after surgery, nor prior to discharging her home.

8. Approximately 24 or 48 hours after the surgery, Patient A received a call from Respondent, during which she informed him that she was experiencing vision problems in her right eye, and wanted him to examine it. However, Respondent did not examine her eye, and instead said that she would be fine and he would see her at her first postoperative visit.

9. Three days after the aforementioned surgery, on April 16, 2012, Patient A saw Respondent for her first postoperative visit. She expressed concern about still having blurriness in her vision in her right eye. He examined her eye at that time for the first time but "could not see anything," according to his records. He prescribed Maxitrol and closed the patient's eye with a patch.

10. On April 18, 2012, Patient A returned for another postoperative visit for suture removal. She expressed concern that her vision was still blurry in her right eye. Respondent believed she had a bit of corneal abrasion. Because Respondent did not have the equipment to further investigate or stain the cornea, Respondent immediately referred her to an ophthalmologist.

11. The same day, April 18, 2012, the ophthalmologist examined Patient A and diagnosed her with an ocular laceration with prolapsed or exposure of intra ocular tissue. The ophthalmologist scheduled surgery for the next day to repair the injury.

12. Patient A now suffers with permanent visual disturbance of light, halo formation, residual scarring of the cornea, loss of tissue of the iris, and a sector cataract at the point of injury. Patient A will require further surgery on her cornea and a cataract removal with lens placement in the future.

PATIENT B

13. Patient B was a 55-year-old female at the time of the events at issue. Her true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

14. On December 28, 2012, Patient B presented to Respondent at the Summit Surgery Center in Reno, Nevada for a bilateral upper lid blepharoplasty.

15. Prior to the surgery, the patient had no visual acuity problems or other problems with her eyes.

16. Respondent did not note any complications or problems in the operative report. Respondent did not use globe protection or an eyeshield to protect the eye during the procedure.

17. At Patient B's first postoperation examination on January 2, 2013, she did not mention any problems with her vision or with pain in her eyes. Puffy eyelids were noted, but no other problems.

18. On January 11, 2013, Patient B called Respondent's office and left a message complaining of blurred vision and pain in her right eye.

19. On January 16, 2013, Respondent examined Patient B and diagnosed corneal edema and prescribed a Medrol Dosepack.

20. On January 21, 2013, Patient B again called Respondent's office and complained that she could not see out of her right eye. Respondent referred her to an optometrist, who referred her to an ophthalmologist.

21. On January 23, 2013, the ophthalmologist diagnosed her with a corneal laceration with iris incarceration and performed emergency surgery to repair the injury.

22. Patient B still suffers from distorted vision in her right eye, intermittent nausea, and she must wear a rigid gas-permeable contact lens which she finds uncomfortable.

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COUNT I

(Malpractice - Failure to Perform With Reasonable Care When Performing Operation Patient A - NRS 630.301(4))

23. NRS 630.301(4) provides that malpractice is an act, among others, that constitutes grounds for initiating disciplinary action.

24. Malpractice is defined as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances." NAC 630.040.

25. The standard of care in cases such as Patient A's is to use either corneal protectors or to exercise special care with sharp instruments used near the eye.

26. Respondent did not use corneal protectors or other eye protection during part of the procedure. The patient suffered a laceration of the cornea, a complication which ordinarily should not occur during this type of procedure.

27. Respondent failed to use reasonable care, skill, or knowledge ordinary used under the circumstances by failing to use corneal protectors, or to exercise adequate care or skill to avoid damage to the eye when performing the procedure without eye globe protection.

28. As a direct result of Respondent's failure to use reasonable care, skill, or knowledge ordinarily used in the circumstances, Patient A suffered a laceration of her cornea, which required emergency surgery to address. She still suffers from scarring of the cornea, visual disturbances such as halo formation, and a cataract which will require future surgery and lens placement.

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

COUNT II

(Malpractice - Failure to Promptly Examine or Refer Patient Patient A - NRS 630.301(4))

30. NRS 630.301(4) provides that malpractice is an act, among others, that constitutes grounds for initiating disciplinary action.

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31. Malpractice is defined as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances." NAC 630.040.

32. The standard of care when a patient complains of eye pain or blurriness in vision is to examine the cornea with Flourescein staining, or to refer the patient to a specialist promptly.

33. Patient A complained of vision problems in her right eye immediately after surgery, and at her first postop exam, three days after surgery.

34. Respondent did not examine her eye with Flourescein staining, nor did he immediately refer her to a specialist. Instead, he assumed that she had a bit of corneal abrasion and he prescribed Maxitrol and closed her eye with a patch.

35. Patient A complained again two days later, at which point Respondent referred her to an ophthalmologist, who performed emergency surgery the next day to repair the injury.

36. As a direct result of Respondent's failure to use reasonable care, skill, or knowledge ordinarily used in the circumstances, Patient A was not correctly diagnosed until five days after surgery. Had Respondent promptly referred her to a specialist, she likely would have received treatment more quickly and experienced a better outcome.

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

COUNT III

(Malpractice - Failure to Perform With Reasonable Care When Performing Operation Patient B - NRS 630.301(4))

38. NRS 630.301(4) provides that malpractice is an act, among others, that constitutes grounds for initiating disciplinary action.

39. Malpractice is defined as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances." NAC 630.040.

40. The standard of care in such cases is to use either corneal protectors or to exercise special care with sharp instruments used near the eye.

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41. Despite a very similar injury occurring to another patient (Patient A) approximately six to eight months earlier, Respondent did not use corneal protectors or other eye protection during part of the procedure. Patient B suffered a laceration of the cornea, a complication which ordinarily should not occur during this type of procedure.

42. Respondent failed to use reasonable care, skill, or knowledge ordinary used under the circumstances by failure to use corneal protectors, or to exercise adequate care or skill to avoid damage to the eye when performing the procedure without eye globe protection.

43. As a direct result of Respondent's failure to use reasonable care, skill, or knowledge ordinarily used in the circumstances, Patient B suffered a laceration of her cornea, which required emergency surgery to address. She still suffers from scarring of the cornea, visual disturbances, occasional nausea, and must wear a rigid contact she finds uncomfortable.

44. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.301(4).

COUNT IV

(Malpractice - Failure to Promptly Examine or Refer Patient to a Specialist Patient B - NRS 630.301(4))

45. NRS 630.301(4) provides that malpractice is an act, among others, that constitutes grounds for initiating disciplinary action.

46. Malpractice is defined as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances." NAC 630.040.

47. The standard of care when a patient complains of eye pain or blurriness of vision is to examine the cornea with Flourescein staining, or to refer the patient to a specialist promptly.

48. Patient B complained of pain and blurriness in her right eye on January 11, 2013.

49. Despite the fact that a very similar injury occurred to another patient undergoing a similar procedure approximately six to eight months prior, Respondent did not examine Patient B until January 16, 2013. At that time he diagnosed corneal edema and prescribed a Medrol Dosepack, but did not refer her to an ophthalmologist.

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50. Patient B complained again of pain and vision problems on January 21, 2013. Respondent then referred her to an optometrist, who examined her and referred her to an ophthalmologist.

51. The ophthalmologist saw Patient B on January 23, 2013, and diagnosed a corneal laceration with iris incarceration. He performed emergency surgery later that day to repair the injury.

52. As a direct result of Respondent's failure to use reasonable care, skill, or knowledge ordinarily used in the circumstances, Patient B was not correctly diagnosed until approximately 3.5 weeks after surgery. Had Respondent promptly referred her to a specialist, she likely would have received treatment more quickly and experienced a better outcome.

53. 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 upon the Respondent, in writing, its findings of fact, conclusions of law and order, which shall include the sanctions imposed; and

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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 13 day of May, 2016.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Kevin Benson, Esq.
Deputy General Counsel for the Board
Attorney for the Investigative Committee

By: _____
Robert Kilroy, Esq.
General Counsel for the Board
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

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

Dated this 17th day of May, 2016.

Beverly A. Neyland, M.D.

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 17th day of May 2016; I served a file stamp copy of the COMPLAINT & PATIENT DESIGNATION, by mailing via USPS e-certified return receipt mail to the following:

Charles P. Virden, M.D.
960 Caughlin Crossing N., Ste. 100
Reno, NV 89519

Dated this 17th day of May, 2016.

Angelia L. Donohoe
Legal Assistant

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