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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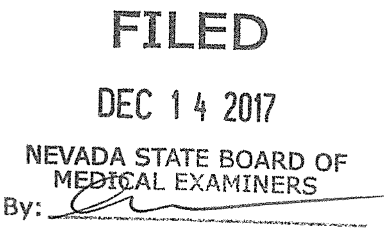
In the Matter of Charges and Complaint Against CHARLES P. VIRDEN, M.D., Respondent.	**Case No. 16-10736-2**



FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The above-entitled matter came on regularly for decision before the Nevada State Board of Medical Examiners (Board), on Friday, December 1, 2017, at the Renaissance Las Vegas Hotel, 3400 Paradise Road, Las Vegas, Nevada 89169, and by video conference at the Board's offices located at 1105 Terminal Way, Suite 301, Reno, Nevada, 89502, on the Complaint filed herein. Respondent Charles P. Virden, M.D. (Respondent) was present, and represented by counsel, Dominique A. Pollara, Esq. The adjudicating members of the Board participating in these Findings of Fact, Conclusions of Law, and Order (Final Order) were: Mr. M. Neil Duxbury; Ms. April Mastroluca; Dr. Aury Nagy; Dr. Michael C. Edwards; Dr. Weldon Havins. Dr. Wayne Hardwick recused himself due to a prior personal association with the Respondent. Henna Rasul, Esq., Senior Deputy Attorney General, served as legal counsel to the Board.

The Board, having received and read the Complaint and exhibits admitted in the matter, as well as the Synopsis of Record prepared by the hearing officer who presided over the hearing and the transcript of the hearing, proceeded to make a decision pursuant to the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), and NRS Chapter 233B.

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The Board, after due consideration of the record, evidence and law, and being fully advised in the premises, makes its FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER in this matter as follows:

FINDINGS OF FACT

I.

Respondent held a license to practice medicine in the State of Nevada issued by the Board at all relevant times.

II.

On May 17, 2016, the Investigative Committee filed the Complaint in this matter alleging Respondent violated the Medical Practice Act, specifically, alleging four counts of malpractice. Respondent was duly served with the Complaint on May 20, 2016. Respondent Answered the Complaint on July 6, 2016, and also filed a Notice of Defense, Request for Hearing and Notice of Special Defenses, which are part of the record. An Order for Prehearing Conference was filed on September 12, 2016, setting that conference for April 10, 2017, at 4:30 p.m., at the Board's offices at 1105 Terminal Way, Suite 301, Reno, Nevada 89502. A Prehearing Conference was held as ordered. Notice of Hearing was filed on September 12, 2016, noticing a hearing on the Complaint to be held on June 6 and 7, 2017, at 9:30 a.m., at the Board's offices at 1105 Terminal Way, Suite 301, Reno, Nevada 89502. Notice of Hearing and Order for Prehearing Conference were served on Respondent's attorney, Dominique A. Pollara, Esq. On June 6 and 7, 2017, a hearing was held before an appointed hearing officer on the allegations contained within the Complaint. Respondent was represented by counsel, Dominique A. Pollara, Esq. The Investigative Committee (IC) was represented by Aaron Bart Fricke, Esq., and Jasmine Mehta, Esq. On November 9, 2017, Respondent was provided the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees.

III.

The Complaint alleges four counts of malpractice relating to Respondent's treatment of Patients A and B. Count I alleges malpractice in Respondent's failure to perform with reasonable care when performing a blepharoplasty on Patient A, which failure caused a corneal laceration to

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Patient A's right eye. Count II alleges malpractice in Respondent's failure to promptly examine or refer Patient A to a specialist who could treat the injury. Count III alleges malpractice in Respondent's failure to perform with reasonable care when performing a blephoraplasty on Patient B, which failure caused a corneal laceration to Patient B's right eye. Count IV alleges malpractice in Respondent's failure to promptly examine or refer Patient B to a specialist who could treat the injury.

IV.

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 was disclosed in the Patient Designation that was served upon Respondent along with a copy of the Complaint.

V.

On or about April 13, 2012, Respondent performed a blepharoplasty on Patient A.

VI.

Respondent caused Patient A to suffer a laceration of the cornea on her right eye, which is a complication which should not have occurred had Respondent used reasonable care, skill, and knowledge ordinarily used under these circumstances.

VII.

Respondent failed to use reasonable care, skill, and knowledge ordinarily used under the circumstances to avoid damage to the eye when performing a blepharoplasty on Patient A.

VIII.

As a 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 failure caused serious injury to Patient A.

IX.

Respondent failed to use reasonable care, skill, and knowledge ordinarily used under the circumstances by failing to properly and promptly examine, diagnose or refer Patient A to a specialist who could treat the injury.

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X.

As a result of Respondent's failure to properly and promptly examine, diagnose or refer Patient A to a specialist who could treat the injury, Patient A suffered a delay in treatment and was placed in greater danger of further injury.

XI.

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 was disclosed in the Patient Designation that was served upon Respondent along with a copy of the Complaint.

XII.

On December 28, 2012, Respondent performed a blepharoplasty on Patient B.

XIII.

Respondent caused Patient B to suffer a laceration of the cornea on her right eye, which is a complication which should not have occurred had Respondent used reasonable care, skill, and knowledge ordinarily used under these circumstances.

XIV.

Respondent failed to use reasonable care, skill, and knowledge ordinarily used under the circumstances to avoid damage to the eye when performing a blepharoplasty on Patient B.

XV.

As a 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 failure caused serious injury to Patient B.

XVI.

Respondent failed to use reasonable care, skill, and knowledge ordinarily used under the circumstances by failing to properly and promptly examine, diagnose or refer Patient B to a specialist who could treat the injury.

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XVII.

As a result of Respondent's failure to properly and promptly examine, diagnose or refer Patient B to a specialist who could treat the injury, Patient B suffered a delay in treatment and was placed in greater danger of further injury.

XVIII.

The Board finds by a preponderance of the evidence that Respondent violated NRS 630.301(4) as alleged in Count I of the Complaint, as Respondent failed to use reasonable care, skill, and knowledge ordinarily used under the circumstances to avoid damage to the eye when performing a blepharoplasty on Patient A.

XIX.

The Board finds by a preponderance of the evidence that Respondent violated NRS 630.301(4) as alleged in Count II of the Complaint, as Respondent failed to use reasonable care, skill, and knowledge ordinarily used under the circumstances by failing to properly and promptly examine, diagnose or refer Patient A to a specialist who could treat the injury.

XX.

The Board finds by a preponderance of the evidence that Respondent violated NRS 630.301(4) as alleged in Count III of the Complaint, as Respondent failed to use reasonable care, skill, and knowledge ordinarily used under the circumstances to avoid damage to the eye when performing a blepharoplasty on Patient B.

XXI.

The Board finds by a preponderance of the evidence that Respondent violated NRS 630.301(4) as alleged in Count IV of the Complaint, as Respondent failed to use reasonable care, skill, and knowledge ordinarily used under the circumstances by failing to properly and promptly examine, diagnose or refer Patient B to a specialist who could treat the injury.

XXII.

The Board has reviewed the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees, and the Board finds them to be the actual fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings

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against Respondent, and finds them to be reasonable based on: (1) the abilities, training, education, experience, professional standing and skill demonstrated by Board staff and attorneys; (2) the character of the work done, its difficulty, its intricacy, its importance, the time and skill required, the responsibility imposed and the prominence and character of the parties where, as in this case, they affected the importance of the litigation; (3) the work actually performed by Board's attorneys and staff, and the skill, time and attention given to that work, and; (4) the product of the work and benefits to the Board and the people of Nevada that were derived therefrom.

XXIII.

If any of the foregoing Findings of Fact is more properly deemed a Conclusion of Law, it may be so construed.

CONCLUSIONS OF LAW

I.

The Board has jurisdiction over Respondent and the Complaint, and an adjudication of this matter by the Board members as set forth herein is proper.

II.

Respondent was timely and properly served with the Complaint, and all notices and orders in advance of the hearing and adjudication thereon, in accord with NRS and NAC Chapters 630, NRS Chapter 233B, and the requirements of due process.

III.

NRS 630.301(4) provides that malpractice is an act, among others, that constitutes grounds for the Board to initiate disciplinary action.

IV.

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

V.

The Board concludes that Respondent has violated NRS 630.301(4) as alleged in Counts I, II, III and IV of the Complaint and, accordingly, is subject to discipline pursuant to NRS 630.352.

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VI.

The Board finds that, pursuant to NRS 622.400, it may recover from Respondent reasonable attorneys' fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent as it hereby enters this Final Order finding that Respondent has violated the Medical Practice Act, which the Board has the authority to enforce.

VII.

If any of the foregoing Conclusions of Law is more properly deemed a Finding of Fact, it may be so construed.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and good cause appearing therefore,

IT IS HEREBY ORDERED that:

1. Respondent shall be issued a public reprimand.
2. Respondent shall pay a fine of $2,500 within one hundred eighty (180) days of this Order.
3. Respondent shall reimburse the Board the reasonable costs and expenses actually incurred in the investigation and prosecution of this case in the amount of $25,986.66, which amount Respondent shall pay within one hundred eighty (180) days of this Order.

Dated this 14th day of December, 2017.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

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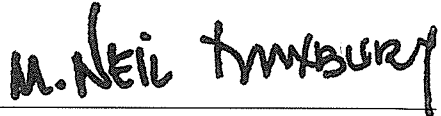
CERTIFICATION

I certify that the foregoing is the full and true original FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER on file in the office of the Board of Medical Examiners in the matter of CHARLES P. VIRDEN, M.D., Case no. 16-10736-2.

I further certify that Rachakonda D. Prabhu, M.D., is the President of the Nevada State Board of Medical Examiners and that full force and credit is due to his official acts as such; and that the signature to the foregoing ORDER is the signature of said Rachakonda D. Prabhu, M.D.

IN WITNESS THEREOF, I have hereunto set my hand in my official capacity as Secretary-Treasurer of the Nevada State Board of Medical Examiners.



M. Neil Duxbury, Secretary-Treasurer
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