THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against ROBERT WATSON, M.D., Respondent.	**Case No. 18-12823-1**

FILED
OCT 31 2018
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 Robert Watson, M.D. (Respondent), a physician licensed 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's license, No. 9076, active since July 12, 1999, was issued pursuant to the Medical Practice Act.

2. Patient A's 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.

3. On June 26, 2013, Patient A, who was a 56-year-old female, presented to Renown Emergency Room (ER) complaining of abdominal pain. The ER evaluation included a CT scan of her abdomen, which revealed a small bowel obstruction (SBO) with multiple dilated loops of bowel with multiple air fluid levels consistent with a mechanical SBO. A general surgery consult was requested with white blood cell (WBC) count of 12,200.

4. Between June 27, 2013, thru June 29, 2013, her laboratory results indicated an increase in hemoglobin and hematocrit. Additionally, Patient A indicated having a 7/10 to 8/10

[1] The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), at the time this formal Complaint was authorized for filing, was composed of Board members Rachakonda D. Prabhu, M.D., Ms. Sandy Peltyn and Beverly Neyland, M.D.

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pain scale, for which narcotics were prescribed and administered.

5. On June 28, 2013, Patient A reported to her nurse that she was having bad pain that evening. Subsequently, following the administration of additional pain medicine, Patient A went to have another CT scan (2nd CT Scan), which was ordered and was available to Respondent when he encountered Patient A at 0948 on June 29, 2013.

6. On June 29, 2013, the notes at 0800 indicate Patient's A increasing pain, which required an additional increase in narcotics (dilaudid & morphine every 4 hours) and she subsequently become drowsy. At 0948, the results of the 2nd CT Scan revealed progression of the SBO with marked inflammation of the pelvic bowel segment, which progressed into loop fluid ascites and mesenteric edema, and these results were available to be reviewed by Respondent, but he did not review such at that time.

7. On June 29, 2013, the notes at 1500 indicated Respondent's first encounter with Patient A and his notes reflect that she was clinically stable and scheduled for surgery the following morning.

8. On June 29, 2013, the notes at 1700 indicate the continued use of the previously prescribed pain medications.

9. Between the late night of June 29, 2013, and the morning of June 30, 2013, Patient A's condition deteriorated to such a state that she had to be transferred to the ICU (Intensive Care Unit) with aggressive resuscitation measures implemented. At this time, Respondent was notified and he decided to proceed to perform surgery upon the patient the next day. Respondent did not note or acknowledge the increased pain medications nor did he review the 2nd CT Scan according to his medical charts. Respondent believed there was no need to proceed to surgery on the 29th of June, despite having Patient A's medications increased for pain and a SBO and having this 2nd CT Scan show the progression of the SBO with marked inflammation of edematous pelvic bowel segment with progressed interloop fluid, along with the radiologist also stating "ischemia within the small bowel loop cannot be excluded." Respondent opted to schedule surgery for the next day despite the aforementioned medical information.

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10. On June 30, 2013, Patient A required bowel resection for ischemic bowel and later developed respiratory failure, sepsis, and renal failure. Patient A's serum lactate level, at 0504, was at an elevated 3.01 level when she was transferred into the ICU.

11. Previous to the preparation of this Complaint, the Board solicited the services of an independent medical expert (IME) to review Patient A's medical records and the care provided to such patient by Respondent.

12. This IME opined that Respondent's care of Patient A violated the Medical Practice Act due to his acts and omissions when rendering care to this patient.

Count I

(Malpractice)

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

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

15. 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.

16. 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: (a) failed to recognize the fact that the patient was in a state of increased pain and increased narcotic medications; (b) failed to review the second CT Scan at the time of Respondent's first encounter with Patient A and subsequently prior to surgery; (c) failed to properly review all of the medical charts and ordered tests; (d) failed to perform the necessary procedure earlier, which could have occurred had Respondent not failed to perform (a) thru (c) due to the 2nd CT Scan indications and the increased use of pain medications with an SBO conditions which should have been a warning sign to Respondent prior to Patient's dire conditions of respiratory failure, sepsis, and renal failure at the time Respondent decided to proceed with surgery.

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

Count II

(Failure to Maintain Complete Medical Records)

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

19. NRS 630.3062(1)(a) 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.

20. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he: (a) failed to recognize the fact that the patient was in a state of increased pain and increased narcotic medications, (b) failed to review the second CT Scan at the time of Respondent's first encounter with Patient A and subsequently prior to surgery, (c) failed to properly review all of the medical charts and ordered tests, (d) failed to perform the necessary procedure earlier, which could have occurred had Respondent not failed to perform (a) thru (c), due to the 2nd CT Scan indications and the increased use of pain medications with an SBO condition which should have been a warning sign to Respondent prior to Patient's worsen conditions of respiratory failure, sepsis, and renal failure at the time Respondent decided to proceed with surgery.

21. 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 Nevada State Board of Medical Examiners 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 Nevada State Board of Medical Examiners set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Nevada State Board of Medical Examiners determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

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4. That the Nevada State Board of Medical Examiners make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 30 day of October, 2018.

INVESTIGATIVE COMMITTEE OF
THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Robert Kilroy, Esquire
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

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

DATED this 30th day of October, 2018.

D Prabhu Rachakonda MD

Rachakonda D. Prabhu, M.D.
Chairman, Investigative Committee
Nevada State Board of Medical Examiners

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 31st day of October 2018, I served a filed copy of the formal COMPLAINT, PATIENT DESIGNATION and fingerprint information, via U.S. Mail to the following:

Edward J. Lemons
Lemons, Grundy & Eisenberg
6005 Plumas Street, Third Floor
Reno, Nevada 89519

Dated this 31st day of October, 2018.

Sheri L. Quigley
Legal Assistant

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