OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(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	**Case No. 19-32539-01**
DHAVAL JASVANTBHAI SHAH, M.D.,	FILED JUL 12 2019 NEVADA STATE BOARD OF MEDICAL EXAMINERS By:
Respondent.	

COMPLAINT

The Investigative Committee (IC)[1] of the Nevada State Board of Medical Examiners (Board), by and through Jasmine K. Mehta, Esq., Deputy Executive Director and attorney for the IC, having a reasonable basis to believe that Dhaval Jasvantbhai Shah, M.D. (Respondent), violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and the Nevada Administrative Code (NAC) Chapter 630 (collectively Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a licensed medical doctor holding an active license to practice medicine in the State of Nevada (License No. 12305). Respondent was licensed by the Board on June 15, 2007.

2. Patient A was a 25-year-old female at the time of the incidents in question. Her name is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with a copy of this Complaint.

3. At the time of the events in question, Patient A had given birth to premature twins on or about May 11, 2013.

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[1]The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Wayne Hardwick, M.D., Chairman, Theodore B. Berndt, M.D., and Mr. M. Neil Duxbury.

4. Following discharge from the hospital, on or about May 18, 2013, Patient A presented to the emergency department with a fever of 101 degrees Fahrenheit. Patient A was discharged by a doctor other than Respondent with instructions to monitor her condition.

5. On May 23, 2013, Patient A presented with fever, was seen by a doctor other than Respondent, and was referred to another doctor for evaluation of possible mastitis. The physician to whom she was referred evaluated her for mastitis on or about May 29, 2013, and referred her to Respondent for an infectious disease evaluation.

6. On May 31, 2013, Respondent first saw Patient A, who complained of fever at that time. Patient A had an abdominal wound, which was not described in Respondent's physical exam. However, Respondent's medical records for Patient A show that the abdominal wound was cultured and ultimately grew an *Enterobacter cloacae* complex organism that was virtually sensitive to all drugs tested. At the time of her visit with Respondent on May 31, 2013, Patient A had already failed therapy with clindamycin and Augmentin. Respondent initially placed Patient A on linezolid plus metronidazole.

7. On June 4, 2013, Respondent switched Patient A's prescription to ciprofloxacin after the culture results were returned. A Computed tomography of Patient A's abdomen performed on June 3, 2013, showed a 9 x 3 x 4 centimeter fluid collection anterior and superior of the uterus. Respondent's impression at that time was that the patient's fever and abnormal lab results were a result of a postoperative wound infection with an intrapelvic abscess. According to Respondent's records at that time, Patient A had clear lungs on auscultation and no complaint of cough.

8. Patient A initially improved, but her fever returned. However, Respondent's medical record for Patient A's visit on June 12, 2013, says that Patient A "denies fever, weakness, fatigue, myalgia, malise (sp)." A repeat CT scan of Patient A's abdomen and pelvis showed that the fluid in Patient A's pelvis had resolved. Respondent placed her on intravenous ertapenem on June 12, 2013.

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9. On June 20, 2013, Patient A was admitted to the hospital with complaints of fever, weakness, dizziness and confusion. She was seen by another physician from Clinical Infectious Disease Specialists. He determined Patient A had a fever of unknown origin, but did not consider tuberculosis as part of the differential diagnosis.

10. From June 20, 2013, through June 28, 2013, Patient A was seen by Clint Anderson, a certified physician assistant supervised by Respondent, and by Respondent's business colleague, Asher Shahzad, M.D. During that time, several imaging studies and laboratory results should have prompted consideration of tuberculosis. Patient A's chest CTs from June 21, 2013, and June 30, 2013, showed fine reticular interstitial opacities, that, while not diagnostic of tuberculosis, are consistent with miliary tuberculosis, a potential cause of fevers of unknown origin. Magnetic resonance imaging (MRI) of Patient A's head and spine on June 23, 2013, and June 24, 2013, showed changes consistent with meningitis, and the leptomeninges enhancement on the June 24, 2013 MRI is more common with tuberculosis than with toxoplasmosis (which was considered), and should have been considered when presented with the MRI results.

11. Respondent saw Patient A on June 29, 2013 and June 30, 2013. It was not until June 30, 2013 that Respondent ordered a QuatiFERON-TB Gold In-Tube test to look for a latent tuberculosis infection. Before that test could be completed, Patient A was transferred to UCLA Medical Center on June 30, 2013.

12. On July 1, 2013, Patient A expired. An autopsy confirmed that Patient A had *Mycobacterium tuberculosis* complex.

COUNT I

NRS 630.301(4)

(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 for the purpose of NRS chapter 630 as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

16. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances, including but not limited to the conduct described herein, when he failed to consider tuberculosis in the differential diagnosis of Patient A's symptoms and/or treat Patient A for tuberculosis.

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

COUNT II

NRS 630.3062(1)(a)

(Failure to Maintain Timely, Legible, Accurate and Complete Medical Records)

18. 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.

19. Respondent's medical records on May 31, 2013 fail to document in his physical exam of Patient A that Patient A had had an abdominal wound from her caesarian section. Respondent's medical records document on June 12, 2013, that Patient A denied her fever had returned, even though that was the reason for her patient visit, and the medical record later states that "Pt still have [sic] high grade fevers."

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

WHEREFORE, the IC 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);

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3. That the Board determine what sanctions to impose if it finds and concludes that there has been a violation or violations of the Medical Practice Act committed by Respondent;

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

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

DATED this 12 day of July, 2019.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Jasmine K. Mehta
Jasmine K. Mehta, Esq.
Deputy Executive Director
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 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 12th day of July, 2019.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Wayne Hardwick

Wayne Hardwick, M.D., Chairman

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 12th day of July, 2019, I served a filed copy of the formal COMPLAINT, via USPS e-certified, return receipt mail to the following:

Dhaval Jasvantbhai Shah, M.D.
2435 Fire Mesa Street, Suite 120
Las Vegas, NV 89128

Dated this 15th day of July, 2019.

Sheri L. Quigley

Sheri L. Quigley, Legal Assistant

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