THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against LIBBY KRISTAL, M.D., Respondent.	Case No. 19-40909-1 FILED MAR 28 2019 NEVADA STATE BOARD OF MEDICAL EXAMINERS By:

COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this formal Complaint (Complaint) against Libby Kristal, M.D. (Respondent), a licensed physician in Nevada. After investigating this matter, the IC[1] 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 was licensed by the Board, pursuant to the provisions of the Medical Practice Act, on October 23, 2013, and is currently licensed in active status (License No. 15023).

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 September 18, 2014, Patient A presented to Respondent for a left eye cataract surgery. Patient A was given eye drops in the pre-operation stage and she was informed that her surgery was imminent, but she remained in this pre-op stage for at least four hours. There is no documentation within the medical records indicated for this four-hour delay. Subsequently, Respondent began this procedure and inserted a new lens in Patient A's left eye. This surgery was performed with complications of a posterior capsular rupture, vitreous loss and the placement of an anterior chamber lens implant.

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[1] At the time filing of the Complaint was approved, the IC was composed of Wayne Hardwick, M.D., Chairman, Mr. M. Neil Duxbury, and Aury Nagy, M.D.

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4. On September 23, 2014, Respondent's notes indicate that she (Respondent) was unable to remove the entirety of the lens cortex but "did not feel there was any nuclear material remaining."

5. From September 18, 2014, to approximately the end of October 2014, Respondent saw Patient A for six surgical follow-ups. Respondent's complaints included floaters, eye pain, and it was found that on these repeated examinations that Patient A's left eye had an elevated intraocular pressure, corneal edema and intraocular inflammation to a degree greater than normally seen following a cataract surgery. This elevated intraocular pressure rise was significant and required the use of multiple medications, including eye drops and an oral agent, acetazolamide (Diamox). This inflammation was severe enough to necessitate an increase in the potency and frequency of the topical steroid drops above what is usually required during the post-operative period of cataract surgery. Finally, after approximately five weeks after the initial surgery, Respondent referred Patient A to a retina specialist, who subsequently diagnosed retained nuclear lens fragments and scheduled an urgent surgery for the removal of the debris (from Respondent's surgery). Respondent's notes indicate "No Data" under the "Fundus" heading for all of the examinations conducted postoperatively upon Patient A's eye.

6. 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 medical care provided to such patient by Respondent. This IME opined that Respondent's medical care of Patient A violated the Medical Practice Act due to her acts and omissions when rendering care to Patient A. Further, the IME opined that Respondent's care was below the standard of care when she failed todiagnose the retained nuclear material in Patient A's left eye and failed to act diligently with the findings of increased intraocular pressure and increased inflammation postoperatively. These aforementioned findings should have alerted Respondent to the presence of retained nuclear material and should have prompted her to examine the vitreous and fundus of the patient postoperatively. Additionally, the IME opined that in the instance of a complicated cataract surgery with a posterior capsular rupture and vitreous prolapse requiring an automated anterior vitrectomy, a surgeon should be on heightened alert for signs and symptoms of retained

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nuclear material. The IME noted the literature [*American Journal of Ophthalmology*, published in 2008, entitled "Clinical Predicators and Outcomes of Pars Plana Vitrectomy for Retained Lens Material After Cataract Extraction"] indicates a common knowledge standard of the signs and symptoms associated with retained nuclear material following cataract surgery.

Count I

(Malpractice)

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

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

9. 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.

10. 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 rendering medical services to Patient A because Respondent failed to adequately perform postoperative examinations and failed to diagnose retained lens fragments in the operated eye, which caused delays in having Patient A receive the timely and appropriate care to fix her left eye.

11. 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)

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

13. 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.

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14. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document her actions when she treated Patient A, whose medical records were not timely, legible, accurate, or complete.

15. 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 her and give her notice that she 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);

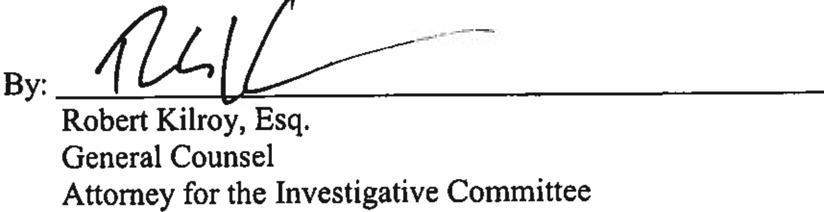
3. That the Board determine what sanctions to impose if it finds and concludes that there has been a violation or violations of the Medical Practice Act committed by Respondent;

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 28th day of March, 2019.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ______________________
Robert 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 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 28th day of March, 2019.

INVESTIGATIVE COMMITTEE OF THE NEVADA
STATE BOARD OF MEDICAL EXAMINERS

Wayne Hardwick, M.D., Chairman

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 9th day of April, 2019, I served a filed copy of the formal COMPLAINT, via USPS e-certified, return receipt mail to the following:

Libby Kristal, M.D.
Siems Lasik & Eye Center
8230 W. Sahara Avenue, #111
Las Vegas, NV 89117

Dated this 9th day of April, 2019.

Sheri L. Quigley
Sheri L. Quigley, Legal Assistant

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