BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: ALEXANDER NORTON, JR., M.D., Respondent.	**Case No. 21-27350-1**

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, J.D., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Alexander Norton, Jr., M.D., (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the 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 medical doctor holding an active license to practice medicine in the State of Nevada (License No. 10491). Respondent was originally licensed by the Board on May 21, 2003.

2. On September 25, 2017, Patient A[2] presented to Respondent for sexually transmitted disease (SDT) testing and a lesion near her rectum. Respondent conducted a physical examination and noted a small perianal lesion with no abnormal discharge and ordered the following laboratory tests: HIV 1/3 antigen/antibody, fourth generation with RFL, hepatitis plan, acute with reflex to confirm; sure swab (R), vaginosis/vaginitis plus and RPP (dx) with reflex titer and confirmation testing. Respondent, however, did not note the perianal lesion within the

[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 Rachakonda D. Prabhu, M.D., Mr. M. Neil Duxbury, and Victor M. Muro, M.D.

[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.

assessment section of Patient A's medical record. Respondent recorded the assessment code for vaginal discharge, yet the physical examination section stated there was no abnormal discharge found. Respondent did not note the plan for conducting a biopsy of Patient A's perianal lesion.

3. On October 2, 2017, Patient A presented for a pap smear test (PAPT), which was submitted along the GC/chlamydia/reflex HPV test to the laboratory. Subsequently, the PAPT results indicated atypical squamous cells of undermined significance (ASCUS). Respondent's gynecological examination described no abnormal finding and there was no note of the previously diagnosed perianal lesion, which was Patient A's main complaint on the first encounter with Respondent.

4. On October 9, 2017, Patient A returned to Respondent, who did not properly review Patient A's medical record prior this encounter and believed that Patient A was scheduled for an endometrial biopsy (EMB). Respondent performed that EMB[3] scheduled by his medical assistant. Immediately after the procedure, Patient A stated to Respondent that she was expecting to have an appointment/procedure to obtain a biopsy of the perianal lesion previously identified and documented by Respondent. Respondent investigated this confusion with his staff as to why the proper procedure (biopsy of the perianal lesion) for Patient A's medical confidion was not scheduled or performed. Respondent communicated with Patient A that the procedure he had just performed was in error and was not necessary for the diagnosis of her condition. Respondent did not document that he performed the EMB and coded Patient A's assessment for this encounter as abnormal uterine and vaginal bleeding and a high-grade squamous intraepithelial lesion of the cervix – none of the assessment codes were documented in any previous medical encounters with Patient A. Respondent noted Patient A's history of present illness noted a PAPT showing atypical cells of undetermined significance (ASCUS). Respondent failed to mention or document his assessment of Patient A's perianal lesion. Respondent did not document that he, in fact, performed the incorrect procedure upon Patient A and such procedure was performed in error and without Patient A's informed consent.

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[3] Endometrial biopsy was negative and Patient A did not have cancer.

COUNT I

NRS 630.301(4) (Malpractice)

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

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

7. 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.

8. 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 treating Patient A when: i) he failed to document Patient A's perianal lesion in the assessment section in the medical record; ii) he failed to establish and document a plan of treatment for the diagnosed lesion; iii) he failed to properly supervise his medical assistant, who scheduled the wrong medical procedure; iv) he failed to properly review Patient A's medical record before performing an invasive medical procedure; and v) when he performed the wrong medical procedure upon Patient A on October 9, 2017.

9. 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 Complete Medical Records)

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

11. 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 disciplinary action against a licensee.

12. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by i) failing to record of the perianal lesion in the assessment section; ii) by failing to document a plan to manage the lesion; and iii) by failing to ensure that he

and his staff generated and maintained accurate assessment codes and scheduling calendars within Patient A's medical records.

13. 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 what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this matter as outlined in NRS 622.400;

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

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

DATED this 14 day of July, 2021.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

ROBERT G. KILROY, J.D.
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Victor M. Muro, 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 14th day of July, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: V M Muro MD

VICTOR M. MURO, M.D.
Chairman of the Investigative Committee