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

* * * * *

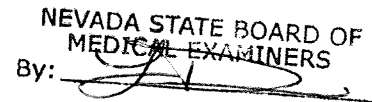
In the Matter of Charges and Complaint Against: DAVID GRANT STEWART, JR., M.D., Respondent.	Case No. 21-29988-1

FILED

SEP 2 0 2021

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that David Grant Stewart, 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. At all times relative to this Complaint, Respondent held an active license to practice medicine in the State of Nevada (License No. 11337), and originally licensed by the Board on February 17, 2005.

2. On January 14, 2016, Patient A[2] presented to St. Rose Dominican Hospital (San Martin Campus) after suffering a fall while at school. Several physicians from the hospital evaluated Patient A, and documented adequate perfusion and strong pulses. An x-ray was performed and revealed that Patient A had a supracondylar humerus fracture resulting from the fall. Medical personnel performed a closed reduction of Patient A's fracture, then contacted Respondent, as the on-call Pediatric Orthopedist, who recommended that Patient A be transferred

[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 Prabhu, M.D., Ms. Sandy Peltyn, and Victor M. Muro, M.D.

[2] Patient A's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

and admitted to the Siena Campus of St. Rose Dominican Hospital for a surgical reduction on his right arm to be performed the following morning. Respondent did not conduct an examination or order a manometer study of Patient A's right arm, wrist and hand for any compartment pressures that would have alerted him to Compartment Syndrome.[3]

3. Patient A was transferred to the Siena Campus where the nursing notes indicate the bandaging, after the initial reduction, was too tight, with a nurse noting she was unable to palpate the right radial pulse, or right brachial [pulse]. The monitoring physician from the Siena Campus contacted Respondent the evening of January 14, 2016 by phone after reports of decreased sensation and movement of the patient's fingers, right elbow tenderness, swelling and restricted range of motion as well as replacement of the splint. After the call, Respondent still did not report to the hospital that evening to perform a physical examination of Patient A.

4. On January 15, 2016, Respondent performed a physical examination of Patient A for the first time at approximately 8:32 a.m. Respondent's consultation record noted the attempted closed reduction surgery performed the previous evening. Upon physical examination, Respondent noted mild swelling, warmth, and tenderness in the region of the supracondylar. Respondent recommended closed versus open reduction, and a percutaneous pinning of a right supacondylar humerus fracture. Respondent performed the procedure upon Patient A without complication. However, Respondent did not perform and/or order a manometer study of Patient A's forearm compartment, nor did he explore Patient A' s forearm compartments during the initial examination encounter, during the subsequent aforementioned procedure, and prior to discharge from the Siena Campus.

5. On January 18, 2016, Patient A presented for follow up, and Respondent's physical examination revealed a 7/10 pain factor, continued paresthesia to his swollen fingers, and global nerve palsy along his forearm, hand, and wrist. Respondent did not perform a fasciotomy during this encounter or order a manometer study to confirm any possible forearm compartment pressure within Patient A's arm. Over the next week, Patient A's symptoms became worse.

[3] Compartment syndrome is an emergent diagnosis that requires immediate surgical intervention.

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1 6. On January 21, 2016, due to Patient A's worsening symptoms, Respondent had
2 Patient A return to the Siena Campus for surgical exploration of his forearm, and to undergo
3 fasciotomies in the right upper extremity including irrigation and debridement, nerve exploration
4 and neurolysis. Respondent encountered a whitish, greyish area of the flexor muscles from the
5 right side elbow to the wrist of Patient A. Respondent debrided the necrotic muscle tissues then
6 admitted Patient A into the hospital for further observation, irrigation and debridement procedure
7 to his right forearm.
8 7. On January 26, 2016, Patient A, who was unable to move his fingers, underwent
9 his second debridement and fourth total surgical procedure to his forearm, which revealed some
10 areas of the flexors, especially the superficial flexors, which had some whitish areas of nonviable
11 muscle including the flexor carpi radialis and the superficial digital flexors.
12 8. On February 3, 2016, Patient A underwent his third debridement and fifth surgical
13 procedure, wherein Respondent noted that there was a large amount of questionable tissue in the
14 muscles, which had mixed features, somewhat pink, but also with pale areas.
15 9. On February 26, 2016, Patient A was discharged. Respondent continued to post-
16 operatively treat Patient A, who was still unable move his wrist or fingers. Respondent referred
17 Patient A to two (2) different specialists for possible coverage options and physical therapy with
18 rehabilitation.

19 **COUNT I**

20 **NRS 630.301(4) (Malpractice)**

21 7. All of the allegations contained in the above paragraphs are hereby incorporated by
22 reference as though fully set forth herein.
23 8. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating
24 disciplinary action against a licensee.
25 9. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient,
26 to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.
27 10. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
28 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when

he provided medical services to Patient A, because on January 14, 2016, he failed to perform any physical examinations even when the patient's symptoms indicated serious deterioration in medical his condition; and, on January, 15, 2016, Respondent failed to timely diagnose Compartment Syndrome in Patient A's right upper extremity. Additionally, Respondent failed to order a manometer study of Patient A's forearm compartment and failed to explore Patient A's forearm compartments during the initial examination, during the surgical procedure, and prior to discharge from the Siena Campus.

11. 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)

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 disciplinary action against a licensee.

14. 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 treated Patient A, whose medical records were not timely, legible, accurate, and complete.

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

COUNT III

NRS 630.306(1)(b)(2) (Violation of Standards of Practice Established by Regulation)

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

17. Violation of a standard of practice adopted by the Board is grounds for initiating disciplinary action against a licensee pursuant to NRS 630.306(1)(b)(2).

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18. NAC 630.210 requires a physician to seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services for the patient.

19. Respondent failed to seek consultation, and such consultation could have enhanced the treatment of Patient A's medical condition and address Patient A's worsening symptoms, such as having no feeling and limited movement in his right hand and wrist.

20. 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(s) 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

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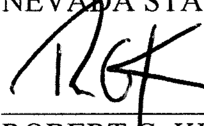
6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 20th day of September, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

ROBERT G. KILROY, J.D.
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Attorney for the Investigative Committee

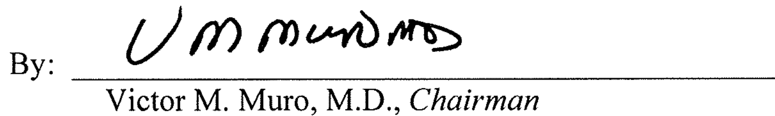
VERIFICATION

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 20th day of September, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ______________________________
Victor M. Muro, M.D., *Chairman*

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