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. 21-35135-1**
DOUGLAS JACKSON FIFE, M.D.,	FILED
Respondent.	JUL 20 2021
	NEVADA STATE BOARD OF MEDICAL EXAMINERS By: [signature]

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 Douglas Jackson Fife, 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. 13164). Respondent was originally licensed by the Board on July 1, 2009.

2. On April, 7, 2015, Patient A[2] presented to Respondent with a history of multiple skin cancers. Due to Patient A's rapidly growing scalp lesion on his forehead, Respondent recommended a Mohs procedure be performed to remove it. On April 14, 2015, Patient A underwent the Mohs procedure were performed by Respondent and his Physician Assistant in three (3) stages. Respondent supervised his Physician Assistant (PA) for the surgical removal of the scalp lesion tumor (squamous cell carcinoma). Respondent planned the flap, lifted the flap,

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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 Rachakonda D. 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 cauterized the wound at the subcutaneous skin level. The medical records do not indicate whether Respondent or his PA cleaned the wound and placed the subcutaneous sutures for closure of the surgical site. Medical records do not note whether any type of surgical gauze was used, who used it and whether Respondent or his PA placed the gauze within Patient A's wound on this date.

3. On April, 21, 2015, Patient A returned to Respondent for suture removal. Respondent noted Patient A's surgical area was swelling and the elevation of the skin overlying the sutured wound had some fluctuance. On April 29, 2015, Respondent drained Patient A's wound, which had less swelling compared from the April 21, 2015 encounter, and recommended antibiotics for, what he presumed to be, a post-op infection. Despite the treatment, Patient A's wound continued to swell. From May 6 through May 19, 2015, Respondent maintained a follow-up of Patient A's surgical closure site.

4. On May 27, 2015, Patient A's wound got worse and discharged purulent liquid. Based upon the purulent discharge, Respondent opened Patient A's unhealed surgical site to investigate the cause of the discharge. He found and removed the three (3) pieces of surgical gauze left behind within the surgical site and had been inside Patient A's forehead since the initial surgery of April 14, 2015.

5. The medical records for Patient A are unclear as to who placed the surgical gauze in the lesion wound, and/or, who failed to remove the surgical gauze following the Mohs micrographic surgery making identification of the person who caused the error ambiguous. However, it is clear that Respondent was responsible for the patient and responsible for the actions of his PA before, during and after the surgery.

COUNT I

NRS 630.301(4) (Malpractice)

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

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

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8. 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.

9. 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 provided medical services to Patient A, because i) he failed to supervise his PA during the Moh's surgery; ii) he failed to remove or instruct his PA to remove the surgical gauze prior to closing Patient A's wound; and, iii) he failed to diagnose Patient A's swelling as the entrapment or retention of the surgical gauze that he failed to remove such foreign bodies during the April 14, 2015 procedure.

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

COUNT II

NRS 630.306(1)(b)(2) (Violation of Standards of Practice)

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

13. A physician is subject to discipline for violating of NRS 630.301 through 630.3065 inclusive, pursuant to NAC 630.380(1)(m).

14. 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).

15. Pursuant to NAC 630.230(1)(i), prohibited professional conduct, states that a person who is licensed as a physician shall not fail to provide adequate supervision of a physician assistant who is supervised by the physician.

16. Respondent failed to provide adequate supervision when he did not properly manage his physician assistant's activities during Patient A's surgery. Specifically, Respondent failed to supervise his PA before, during and after the surgery because there was surgical gauze left behind in Patient A's forehead wound unintentionally for several weeks.

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

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COUNT III

NRS 630.3062(1)(a) (Failure to Maintain Proper 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 disciplinary action against a licensee.

20. Respondent Fife failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions in during the closing of Patient A's wound as there was no documentation was to whether Respondent or his PA used the surgical gauze or who closed the wound with three (3) remaining pieces of surgical gauze in Patient A's forehead for weeks.

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

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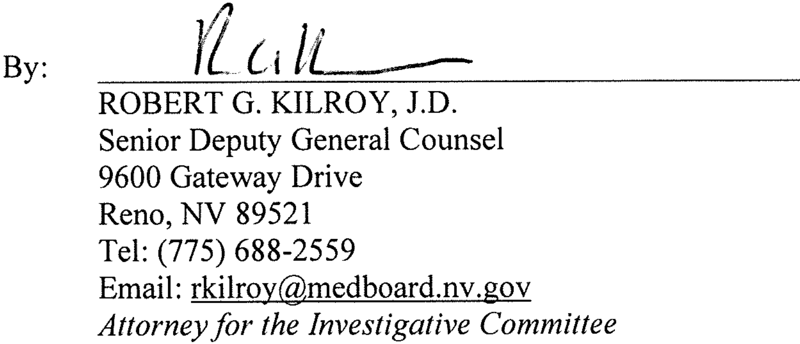
6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 20 day of July, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ______________________
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Attorney for the Investigative Committee

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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 20th day of July, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________
VICTOR M. MURO, M.D.
Chairman of the Investigative Committee

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