BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **ALI KIA, M.D.,** **Respondent.**	**Case No. 21-27978-1**

FILED
DEC 16 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

FIRST AMENDED COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through SARAH A. BRADLEY, J.D., Deputy Executive Director and attorney for the IC, having a reasonable basis to believe that ALI KIA, 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. 11940). Respondent was originally licensed by the Board on July 7, 2006.

2. Patient A[2] was a twenty-nine (29) year-old female at the time of the events at issue.[3]

3. On or about July 9, 2016, Patient A was admitted to Sunrise Hospital and Medical Center (Sunrise Hospital) for a cesarean delivery of her fourth child. On July 10, 2016, she was discharged from Sunrise Hospital.

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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., Aury Nagy, M.D., and Mr. M. Neil Duxbury.

[2] Patient A's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent August 14, 2021.

[3] Patient A turned thirty (30) years old on July 15, 2016 while she was hospitalized at Sunrise Hospital and Medical Center.

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4. Subsequently, on July 14, 2016, Patient A was admitted to Sunrise Hospital's Emergency Department for severe abdominal pain.

5. Patient A was under the care of Respondent during her hospitalization from July 14, 2016 to July 16, 2016 because he was the hospitalist.

6. When she was first examined on July 14, 2016, Patient A's medical records reflect the following regarding her abdomen: "epigastric tenderness, no ri[g]idity, no peritoneal signs small bowel obstruction, free fluid, possible intra-abdominal abscesses."

7. Patient A received a computed tomography (CT) scan of her abdomen and pelvis on July 14, 2016 which showed: (a) "Gas and fluid distension of stomach and proximal small bowel compatible with small bowel obstruction" and (b) "Moderate amount of free fluid in the abdomen and pelvis with several small gas bubbles anterior to the uterus. Intraperitoneal abscess suspected."

8. On July 14, 2016, Patient A's evaluation showed leukocytosis as a primary clinical impression with anemia, hypokalemia, partial bowel obstruction, sepsis, and status post cesarean section as secondary impressions.

9. Leukocytosis is not a normal symptom or a result of post-cesarean deliveries.

10. Patient A's white blood cell count (WBC) on July 14, 2016 was 19,700 WBCs per mcL, and it climbed to 20,600 WBCs per mcL, the next day, on July 15, 2016. This is much higher than the usual post-cesarean increase, the average increase of a patient's white blood count after a cesarean delivery is about 22%.

11. Records for Patient A dictated by Respondent on July 14, 2016 state "We will admit the patient under my service to medical surgical unit. . . . We will keep the patient nothing by mouth, IV fluid hydration, NG tube if need be, and repeat radiographic imaging of the abdomen."

12. Patient A's medical records show that only one CT scan was performed on July 14, 2016.

13. As of July 15, 2016, Patient A received 3,050 ccs of fluid via an intravenous line (IV) over the course of twenty-four (24) hours.

14. Patient A was not taking any fluid or food orally.

15. On July 15, 2016, Patient A continued to complain of abdominal pain, indicated that she was not feeling better, reported that she was not passing gas, and had not had a bowel movement.

16. Patient A was also experiencing nausea and vomiting, and was treated with ondanestron HCI via IV at 8:37 p.m. on July 15, 2016.

17. A physical examination of Patient A's abdomen on July 15, 2016 revealed "abnormal bowel sounds, distended (NO RIGIDITY), no rebound."

18. On July 15, 2016, Respondent notes in Patient A's medical records that she was not passing gas, had not had a bowel movement, yet he recommended Patient A try clear liquids that evening to the following night, with her discharge to occur on July 16, 2016.

19. Despite an abdominal X-ray on July 16, 2016, showing persistant small bowel obstruction without further imaging and continued nausea, vomiting, and abdominal pain, Respondent discharged Patient A with pain medications and Senokot for constipation, with instructions to follow up with her obstetrician for further care.

20. Respondent indicated in Patient A's medical records that he discussed Patient A's case with Patient A's obstetrician by telephone and general surgeon and that they both concurred with the discharge of Patient A.

21. Patient A's medical record does not show any documentation or notes from Patient A's obstetrician or the general surgeon.

22. On July 16, 2016, Patient A was discharged from Sunrise Hospital.

23. The CT scan findings for Patient A were not consistent with constipation.

24. No rectal examination was done to indicate presence of stool in the rectum.

25. Only one CT scan was done for Patient A, and further imaging is recommended to manage a small bowel obstruction.

26. Respondent stated that his discharge plan was discussed with Patient A who agreed with the plan.

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27. On July 17, 2016, the day after being discharged from Sunrise Hospital, Patient A was admitted to Centennial Hills Hospital Medical Center.

28. While at Centennial Hills, Patient A had an exploratory laparotomy performed on July 18, 2016.

29. She was then diagnosed with an infarcted omentum which required a partial omentectomy.

30. Patient A had a complication of respiratory failure requiring ventilator support for acute respiratory distress syndrome (ARDS).

31. After multiple additional complications, Patient A was transferred to a long-term acute care (LTAC) facility for further care on September 2, 2016.

32. Respondent's management of Patient A's small bowel obstruction during her hospitalization on July 14, 2016 to July 16, 2016 deviated from the standard of care.

33. The standard of care for management of small bowel obstruction is to monitor the patient for seventy-two (72) hours with repeated imaging needed to show resolution of the obstruction.

34. A nalogastric tube is recommended for decompression of the gut.

35. Before discharge, Patient A should have had documented flatus, bowel movements, and adequate oral intake.

36. Patient A's persistent abdominal pain, symptoms and imaging consistent with a bowel obstruction, leukocytosis, continued nausea and vomiting, and suggestion of an abscess warranted a formal surgical consultation.

37. The lack of a formal consultation by the general surgeon made Respondent the sole physician responsible for Patient A during her hospitalization.

38. Respondent's failure to properly manage Patient A's bowel obstruction led to a delay in her diagnosis and proper treatment.

39. As a result, Patient A experienced a more complicated hospitalization, which could have been avoided.

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COUNT I

NRS 630.301(4) - Malpractice

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

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

42. 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."

43. 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.

44. 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 Established by Regulation – Failure to Consult

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

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

47. 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."

48. Patient A's symptoms warranted a formal consultation with a surgeon during her hospitalization from July 14, 2016 to July 16, 2016, and Respondent failed to seek a formal consultation with a surgeon regarding to her medical condition in violation of the standard of care and which may have enhanced the quality of medical care provided to Patient A.

49. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners 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 case 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 16th day of December, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, 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 **16th** day of December, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman for the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 17th day of December, 2021, I served a file-stamped copy of the foregoing **FIRST AMENDED COMPLAINT**, via USPS Certified Mail, with a courtesty copy by electronic mail, to the following parties:

ALI KIA, M.D.
c/o Linda K. Rurangirwa, Esq.
Collinson, Daehnke, Inlow & Greco
2110 E. Flamingo Rd., Ste. 212
Las Vegas, NV 89119
Linda.Rurangirwa@cdiglaw.com
Tracking No.: 9171 9690 0935 0252 5627 28

Additionaly, I served by electronic mail, file-stamped copies of the same to:

PATRICIA HALSTEAD, ESQ.
phalstead@halsteadlawoffices.com
Hearing Officer

DATED this 17th day of December, 2021.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

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