THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against	**Case No. 19-32717-1**
CHRISTINA LYNNE KUSHNIR, M.D.,	
Respondent.	

FILED
MAR 11 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 (IC) of the Nevada State Board of Medical Examiners (Board) hereby issues this First Amended Complaint (Complaint) against Christina Lynne Kushnir, 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 the 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 June 7, 2012, and is currently licensed in active status (License No. 14396).

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 June 1, 2015, Patient A was seen at the Women's Cancer Center of Nevada (WCCN) for uterine fibroids and pelvic pain. Previously, Patient A had two prior open myomectemies, diabetes, high blood pressure, and obesity and a known history of severe adhesive disease (well-documented within Respondent's notes and Valley Health Systems). Patient A consented for Respondent to perform an exploratory laparotomy, total abdominal hysterectomy, and bilateral salpingo-oophorectomy. Patient A's preoperative level of creatinine was 0.89.

[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.

Following the aforementioned procedure, Patient A's incision was closed with a monocryl suture when Respondent was present. Postoperatively, Patient A developed pneumonia and was placed on antibiotics. Additionally, Patient A's creatinine levels rose and all nephrotoxic agents were discontinued.

4. On June 5, 2015, Respondent ordered a renal ultrasound due to Patient A's elevated serum creatinine levels, conducted Patient A's abdominal examination, and at 7:13 p.m. later that evening, Respondent documented such within the hospital entry progress notes. Patient's creatinine reached a high of 1.72.

5. On June 6, 2015, Patient A was discharged following Respondent's renal ultrasound that morning. Results of the aforementioned ultrasound indicated a mild hydronephrosis, and the attending radiologist recommended a CT scan for further evaluation. The medical records do not indicate whether Respondent knew of these results prior to Patient A's discharge.

6. On June 17, 2015, Respondent dictated her surgical report (of June 1, 2015 operation on Patient A) and commented the following: "I perform complicated cancer procedures three days a week. In addition to that, I specialize in complicated benign GYN procedures (May 24, 2015)." Details of this report differ from those recorded by the nursing staff, the treating anesthesiologist and physicians involved in Patient A's postoperative care. Specifically, the Respondent's report does not comment on the repair of a small bowel injury, nor does it indicate completing a bilateral hypogastric artery ligation – all of which are well-documented in the hospital records. Additionally, Respondent stated that she used monocryl sutures to close Patient A's incision, but her operative dictation done on June 1, 2015 states that staples were used to close the incision on Patient A, contradictory to her prior statement.

COUNT I

NRS 630.3062 - Failure to Maintain Complete Medical Records

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

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8. 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.

9. 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 from June 1, 2015 through Patient A's discharge on June 6, 2015.

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

COUNT II

NAC 630.210 - Violation of Standards of Practice Established by Regulation

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

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

13. 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.

14. Respondent failed to timely seek consultation with regard to Patient A's medical condition of a "mild hydronephrosis" and disregarded the attending radiologist's recommendation of a "CT scan for further evaluation." Respondent should have consulted with an appropriate care provider to address the doubtfulness of the aforementioned condition and recommendation of the radiologist for a CT scan. This consultation would have confirmed or denied such a diagnosis.

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;

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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 determines what sanctions to impose should it find and conclude 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 11 day of March, 2021.

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)

Mr. M. Neil Duxbury 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 11th day of March, 2021.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

M. Neil Duxbury

Mr. M. Neil Duxbury, Chairman