BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against:

MICHAEL LEE PERNULA, M.D.,

Respondent.

Case No. 22-38864-1

FILED

APR 14 2022

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, J.D., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Michael Lee Pernula, 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 always relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 15879). Respondent was originally licensed by the Board on June 5, 2015.

2. Patient A[2] was a 71-year-old female at the time of the events at issue.

3. On September 20, 2016, Patient A underwent cataract surgery with IOLL placement and iStent placement in her left eye with Dr. Liang, M.D.

4. After the surgery, Patient A left the United States to reside in the Philippines.

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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 Victor M. Muro, M.D., Weldon Havins, M.D., J.D., Maggie Arias-Petrel.

[2] Patient A's 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.

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5. On February 15, 2018, Patient A presented returned to the United States to the Center for Sight (Center) with a chief complaint that "something was blocking her vision in the right eye."

6. On March 15, 2018, Patient A presented to the Center for a pre-operative visit. The risks, benefits and alternatives for cataract surgery were discussed, including the risk of death. Patient indicated that she had no previous history of myocardial infarction, stroke, or prior cardiac surgical intervention.

7. On April 2, 2018, Patient A underwent cataract extraction with an extraocular lens implant and iStent implantation on her right eye as performed by the Respondent. The initial steps of the cataract surgery were performed: the right eye was prepped and draped, paracentesis creation accomplished, injection of lidocaine and preservative free epinephrine were injected into the anterior chamber, viscoat insertion into the anterior chamber was performed, primary incision creation with keratome, and capsulorrhexis creation were also performed. Shortly following these initial steps, the Respondent was instructed to cease performing the surgery on Patient A because she became apneic. Patient A's eye was taped shut by a member of the surgical team. Emergency medical personnel were called as Patient A's heart rate dropped from fifty-five (55) to twenty (20) beats per minute, epinephrine was administered by emergency services while CPR was initiated. Patient A was intubated by Dr. Steve Brown, M.D. Subsequently, Respondent decided to proceed with this surgery following Patient A being deemed in a stable condition as he (the surgeon) and the anesthesiologist discussed whether the operation could be completed safely due to the capsulorrhexis having been completed, and, from an ophthalmological standpoint, Respondent preferred to complete the surgery if the patient was deemed stable. Patient A, who was deemed in a stable condition on ventilator for her breathing, was redraped and prepped for completion of the cataract removal with an intraocular lens and an iStent implantation as her eye condition was noted to be unaffected by the previous maneuvers. Her incisions were tested and found to be watertight, and an eye shield was placed over the right eye. Following Respondent's surgery, Patient A left the operating room in a "guarded, but stable condition." She was extubated with no complications, as her respirations were spontaneous, and she followed commands. However,

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following Respondent signing out of this case, Patient A coded again. She was transferred to the PACU, and she was placed on a ventilator again. However, subsequent to being placed on the ventilator, Patient A went into ventricular fibrillation and a full ACLS was initiated. Patient A presented to the Mountainview Hospital (Mountainview) emergency room in a cardiopulmonary arrest condition. In less than an hour of arriving at Mountainview, Patient A had no pulse, and she was pronounced dead from intraoperative cardiac arrest during an elective, non-cardiac surgery, which was performed by the Respondent.

COUNT I

NRS 630.301(4) - Malpractice

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

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

10. 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."

11. 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: 1) when he failed to transfer her to a higher level of care for assessment after she became bradycardic and hypoxic, thus requiring CPR and intubation during her cataract surgery; 2) when he should have stopped immediately performing the cataract surgery and placed a shield over her right eye and transferred her to the closest hospital via EMS for a comprehensive medical evaluation; 3) when he completed Patient A's cataract surgery and iStent after she initially coded; 4) when he completed Patient A's cataract surgery after she became hypoxic, bradycardic, and CPR was initiated; and 5) when he did not recognize the seriousness of Patient A's initial cardiac arrest and did not immediately transfer his patient to the closest emergency room.

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12. 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

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

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

15. 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."

16. Respondent failed to timely seek consultation with regard to Patient A's medical condition on April 2, 2018 and Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of Patient A's medical condition and such a timely consultation would have confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided to Patient A with regard to her intraoperative cardiac arrest during her elective, non-cardiac surgery. Respondent should have consulted the nearest emergency room for further evaluation of her medical condition.

COUNT III

NRS 630.301(9) - Disreputable Conduct

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

18. NRS 630.301(9) provides that engaging in conduct that brings the medical profession into disrepute is grounds for initiating disciplinary action or denying licensure.

19. Respondent engaged in conduct that brings the medical profession into disrepute by breaching his Patient A's trust when he engaged in unethical treatment of her as both surgeons and anesthesiologists share responsibilities for the care of surgical patients. Respondent was responsible for the decision to complete the surgical procedure for Patient A despite her

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experiencing an acute cardiopulmonary arrest after the initial steps of the surgery. Patient A signed a consent for cataract surgery with an iStent implantation and placed her trust in the Respondent that her ailments (cataract and glaucoma for her right eye) would be addressed, yet in turn Respondent brought disrepute to the medical profession by his unethical conduct when he failed to safely guide Patient A through both the operation and subsequently through her recovery period, because he signed out of her case prior to her second code as she experienced an acute cardiopulmonary arrest.

20. 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/her] 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

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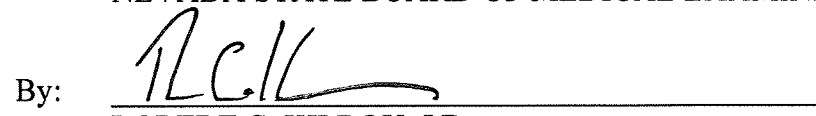
6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 14 day of April, 2022.

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 14th day of April, 2022.

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

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