BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **MUHAMMAD N. TUFAIL, M.D.** **Respondent.**	**Case No. 22-12872-1**

FILED
AUG 18 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
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COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, J.D., Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Muhammad N. Tufail, 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. 9265). Respondent was originally licensed by the Board on January 4, 2000.

2. Patient A[2] was a 72-year-old female at the time of the events at issue. She had a past medical history of dyslipidemia, diabetes mellitus, hypertension, glaucoma, knee surgery, breast lumpectomy, and foot surgery.

3. On June 17, 2016, Patient A was admitted to Valley Hospital Medical Center with an initial complaint of chronic back and lower extremity pain with a failed conservative radiculopathy management on an outpatient basis. Her MRI revealed spinal stenosis from L2-L5,

[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 Mr. M. Neil Duxbury, Aury Nagy, M.D., and Michael C. Edwards, M.D.

[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.

and she underwent a surgical intervention that included a L2-L5 bilateral laminectomy and foraminotomy and a posterior lateral fusion at L4-L5. The operating physician noted in Patient A's medical records that she suffered a dural tear during this procedure.

4. On June 18, 2016, Patient A presented to Respondent in a post-operative status. Respondent's initial notes indicated that Patient A was to be on "bedrest for 48 hours pursuant to the orthopedic recommendation," and that she was to commence physical therapy starting on June 20, 2016. Respondent's assessment of Patient A was a posterior lumbar fusion with a history of hypertension, a history of dyslipidemia, a history of diabetes mellitus, and anemia and that she was post- operative in a stable condition. Respondent's treatment plan was for postoperative care/supportive care/DVT (Deep Vein Thrombosis) prophylaxis/insulin coverage/home medication to resume.

5. In Respondent's initial consultation with Patient A, he did not include a review of systems. A review of systems by Respondent would have elicited from Patient A her initial subjective complaint of weakness. Respondent did not document Patient A's pre-operative hemoglobin level (a scanned report was available in the record showing it was 4 g/dL higher that the value on this date of consultation of 12.4g/dL compared to 8/4 g/dL). Respondent did not investigate or evaluate this hemoglobin 4 g/dL deficit, which then subsequently worsened to a 5.5 g/dL deficit by the time she was transferred to the Intensive Care Unit (ICU). Later that night of June 18, 2016, Patient A's vital signs began to deteriorate (e.g., the 4 g/dL hemoglobin deficit, opiate overdose, hypoxemia, and respiratory failure). Respondent noted that Patient A was upgraded to the ICU for a decreased level of consciousness, a shortness of breath, and a condition of hypoventilation. The general ICU was closed, so Respondent turned over Patient A's care to the ICU critical care team. Respondent did not order an MRI for Patient A's lumbar spine, despite knowing of the operating surgeon's notation that Patient A suffered a dural tear during the June 17, 2016, procedure.

6. On June 19, 2016, the nurses' notes indicated "weakness" in Patient A's neurological symptoms and that her gait could not be assessed (because patient was on ordered bedrest). Respondent failed to order an MRI for Patient A's lumbar, the documented dural tear.

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7. On June 20, 2016, a PT/OT (Physical Therapy/Occupational Therapy) visit indicated in her medical record that Patient A suffered from a significant weakness in her hips (0/5) and her knees (1/5) in her lower extremities.

8. On June 21, 2016, Respondent examined Patient A. He noted that she was alert and oriented times three (3). His treatment plan was to provide post-operative care, supportive care, DVT prophylaxis, insulin coverage, and manage at-home medications, but did not document any treatment plan to manage the recently identified neurological symptoms. Moreover, Respondent did not order an MRI despite the documented neurological deficits.

9. On June 22, 2016, Respondent saw Patient A and recommended that she start Coumadin (Warfarin Sodium) and that she should go to PT/OT in the morning of the following day, if Patient A was in a stable condition. Respondent, again, did not order an MRI for Patient A's lumbar spine, despite knowing of the operative physician's notation within Patient A's medical records that she suffered a dural tear on June 17, 2016. Patient A complained of lumbar pain of eight (8) out of ten (10) on the pain scale and was unable to perform left hip rotation and required total assistance in ambulation.

10. On June 23, 2016, Respondent discharged Patient A. He noted in Patient A's medical record that she had her procedure on June 17, 2016, and her post-operative course was complicated due to a respiratory failure, most likely secondary due to a narcotic overdose and then transferred back to the ICU, where she was decompensated and recovered well and transferred to back to the hospital main floor. He noted that Patient A did develop a lower extremity DVT on her right side based upon a Doppler examination. Respondent started an anticoagulation treatment without discussing the risks of a medical DVT prophylaxis following Patient A's surgery with her surgeon. There was no documentation within Patient A's medical record that indicates such a consultation occurred with the physician who performed Patient A's surgery. Respondent did not document the use of an alternative treatment with an IVC (Interior Vena Cava) filter after Patient A was found not to be suffering from a pulmonary embolism. Respondent did not consider the diagnosis and risk of a spinal hematoma. Respondent did not consider the risk of his anticoagulant and he did not investigate Patient A's post operation anemia. Yet, in Patient A's

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medical record, Respondent noted her overall condition was stable, and the plan was to transfer her to rehabilitation on June 23, 2016. Respondent did not order an MRI for Patient A's lumbar, despite knowing the operative physician's note within Patient A's medical record that she suffered a dural tear on June 17, 2016.

11. On June 25, 2016, Respondent noted that Patient A's blood pressure was controlled with the adjustment of antihypertensive medication. Patient A's INR (International normalized ratio) was trending up and she was in a stable condition. Respondent ordered a drain discharge prior to the PT/OT visit. Respondent did not order an MRI for Patient A's lumbar spine, despite knowing of the operative physician's notation within Patient A's medical that she suffered a dural tear on June 17, 2016. Patient A was transferred to Spanish Hills Wellness later that day.

12. On June 26, 2016, Patient was not able to move her lower extremities, yet she had sensation present in her lower extremities. She could wiggle her toes, but not able to move them against gravity.

13. Throughout Patient A's hospital stay, including the Respondent's discharge summary, repeatedly documented that the Patient's lower extremity neurological exam was unremarkable. Nursing documentation, and documentation provided by the PT/OT on June 20, 2016, demonstrated significant weakness and new neurologic deficits. Respondent's documentation or examination of the patient therefore contained gross inaccuracies which were highly relevant to Patient A's primary underlying diagnosis.

COUNT I

NRS 630.301(4) - Malpractice

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

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

16. 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."

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17. 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 when he failed to diagnose Patient A's neurological condition by not ordering an MRI following his knowledge of her dural tear during the procedure conducted by the operative physician on June 17, 2016; when he failed to properly diagnosis Patient A's hematoma prior to her discharge; when he failed to consider and investigate Patient A's post-operative anemia; when he failed to consult and discuss the risks of his treatment of anticoagulants post-operatively with the surgeon; when he failed to properly document his examination of Patient A; when he failed to properly document any consideration of Patient A's post-operative bleeding risks on his treatment of anticoagulants; when he failed to address Patient A's neurological defects during her PT/OT appointments; and, when he failed to document any discussion with the surgeon regarding Patient A's hematoma.

18. 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

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

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

21. 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."

22. Respondent failed to timely seek consultation with regard to Patient A's medical condition from June 17, 2016 to June 26, 2016 and Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of Patient A's medical condition (unable to use her lower extremities) and such a timely consultation would have

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confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided to the Patient with regard to her neurologic dysfunction and paralysis.

23. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in NRS 630.352.

COUNT III

NRS 630.3062(1)(a) - Failure to Maintain Proper Medical Records

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

24. 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" constitute grounds for initiating discipline against a licensee.

25. Respondent failed to maintain proper medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete, because Respondent failed to properly document his examination of Patient A; when he failed to properly document any consideration of Patient A's post-operative bleeding risks on his treatment of anticoagulants; when he failed to document any follow-up discussions regarding Patient A's neurological dysfunction demonstrated at her PT/OT appointments; and, when he failed to document any discussion with the surgeon regarding Patient A's hematoma.

26. 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);

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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 18th day of August, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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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 18th day of August, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

BRET W. FREY, M.D.
Chairman of the Investigative Committee

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