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: **NATALIE SANDRA GOULD, M.D., Respondent.**	**Case No. 22-38040-1**

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 Natalie Sandra Gould, 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. 13673). Respondent was originally licensed by the Board on August 12, 2010.

2. Patient A[2] was a 71-year-old female at the time of the events at issue. Patient A was referred to Respondent for a complex right ovarian mass.

3. On September 21, 2018, Respondent performed a laparoscopic bilateral salpingo-ophorectomy on Patient A for an evaluation of a right adnexal (ovarian) mass of uncertain malignant potential. The mass was identified as a four (4) cm right cystadenoma and was benign. Respondent's surgery notes state "the colon is somewhat adherent to the posterior aspect of the

[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., and Ms. 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.

uterus...Patient has a laceration in the right epigastric artery and brisk bleeding from the right lower quadrant trocar site...Fibrillar was placed in the right pelvis...a Carter-Thompson device and 2-0 Vicryl suture was used to repair the injury to the epigastric vessel."

4. On September 24, 2018, Patient A was seen by Respondent for the removal of the urinary catheter, which was placed during the September 21, 2018, procedure post-operatively, for urinary retention purposes. At this visit, Patient A was hypotensive with a blood pressure (BP) reading of 73/36 mm/Hg. Respondent's notes indicated that Patient A was hypotensive and was experiencing mental status changes. According to Patient A's husband, Patient A was taking both Norco and Tizanidine on an empty stomach. Respondent counseled both Patient A and her husband to present to an emergency room (ER) if Patient A's mental status deteriorated. Patient A's vaginal culture indicated a light growth of pseudomonas in a pre-operative test. There was no documentation indicating that this was ever treated by Respondent. Additionally, there was no indication Respondent attempted to diagnose or treat Patient A's hypotension, based upon her blood pressure reading, or that Respondent attempted to diagnose Patient A's mental status changes.

5. On September 26, 2018, Patient A was admitted to Mountain View Hospital ER after she had vomited, with complaints about pain in her right lower abdomen and could not answer questions as her mental status continued to deteriorate. A CT scan with IV contrast of her abdomen and pelvis indicated the following: 1) large volume of pneumoperitoneum; 2) diffuse peritoneal hyperenhancement and thickening compatible with peritonitis; 3) developing abscess/phlegmon along the inferior margin of the right hepatic lobe, right paracolic gutter, and with the interior peritoneum; 4) mild colonic mucosal hypo enhancement; 5) moderate extrahepatic and minimal intrahepatic ductal dilatation status post cholecystectomy; and 6) air located within the endometrial canal.

6. On September 27, 2018, Patient A was taken to the operating room for an emergency surgery, which included an exploratory laparotomy, sigmoidectomy with an end colostomy, drainage of the pelvis abscess and right gutter abscess, and temporary abdominal closure with ABThera. Her diagnosis was as follows: 1) peritonitis; 2) pneumoperitoneum;

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3) severe sepsis; and 4) an acute kidney injury to her only kidney. She was admitted to the ICU (Intensive Care Unit) where she was intubated, placed on a ventilator, received a 2D echo, and a blood transfusion. She further received vasopressors, a broad spectrum of antibiotics, and her labs and cultures were monitored.

7. On September 30, 2018, Patient A underwent another surgery, her second surgery since Respondent's surgery (third surgery in total since September 21, 2018). This surgery included reopening the recent laparotomy, performing an abdominal washout, drainage of the intrabdominal abscess, duel abdominal pack placement, and abdominal closure. Her postoperative diagnosis was as follows: 1) septic shock; 2) perforated sigmoid status post sigmoidectomy, 3) peritonitis, and 4) closed abdomen.

COUNT I

NRS 630.301(4) - Malpractice

8. All 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 when Respondent inappropriately performed the operation of a laparoscopic bilateral salpingo-ophorectomy; when Respondent inappropriately placed the laparoscopic trocars perforating the viscus thus likely causing sepsis and an abscess formation; and when Respondent failed to treat or diagnose Patient A's hypotension or mental status changes at the follow-up encounter.

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

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COUNT II

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

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

14. 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.

15. Respondent failed to maintain complete medical records relating to the diagnosis, treatment, and care of Patient A, by failing to correctly document her actions when she treated Patient A and failed to specifically document the exact anatomical placements of the trocars when conducting the operation on Patient A.

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

COUNT III

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation –

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

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

19. 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."

20. Respondent failed to timely seek consultation with regard to Patient A's medical condition from September 21, 2018, to September 24, 2018. Respondent should have consulted with an appropriate care provider to address the doubtfulness of the diagnosis of Patient A's medical conditions of hypotension and/or mental status changes 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.

21. 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 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;

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 12 day of April, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

ROBERT G. KILROY, J.D.
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: rkilroy@medboard.nv.gov
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 11th 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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