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: **BARRY JAMES RIVES, M.D, Respondent.**	**Case No. 23-28365-2**

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Barry James Rives, 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. 10642). Respondent was originally licensed by the Board on September 16, 2003. Respondent's specialty is listed as general surgery and abdominal surgery on the Board's website.

2. Patient A[2] was a fifty-three (53) year-old female at the time of the events at issue.

3. Patient A previously had a hernia that had been repaired in 2014 with mesh.

4. On July 3, 2015, Patient A presented to Respondent for a laparoscopic reduction and repair of a recurrent incarcerated incisional hernia.

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

[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.

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5. Respondent's operative note documented significant adhesion of the transverse colon to the mesh utilized in the previous hernia repair. Respondent elected to continue operating laparoscopically and utilized a LigaSure device to extract the transverse colon from the mesh, causing at least two (2) colotomies (incisions in the intestine).

6. Despite two (2) confirmed colotomies, Respondent did not convert the laparoscopic surgery to an open surgery and attempted to repair the damage with a gastrointestinal anastomosis (GIA) stapler.

7. On or about July 4, 2015, Patient A's condition worsened, and she was transferred to the Intensive Care Unit (ICU) with a high white blood cell count.

8. On or about July 5, 2015, Patient A continued to deteriorate, and required intubation. A computed tomography (CT) scan of Patient A's abdomen did not show any blockage of the lungs. Respondent failed to document a reason for the patient's worsening condition and elected not to take Patient A back into surgery for re-exploration to determine if there was any additional bowel perforations, despite two (2) confirmed colotomies during the July 3, 2015, laparoscopic hernia repair.

9. From on or about July 6, 2015, until on or about July 8, 2015, Respondent continued to document examinations of the patient but failed to mention any post-surgical complications or sepsis.

10. On July 9, 2015, Respondent documented that the Patient did not have signs or symptoms of sepsis. Patient A's family sought a second opinion from another surgeon who advised there was a possible leak from one or both of the colotomies and recommended a diagnostic laparoscopic exploration.

11. On July 10, 2015, Respondent maintained his opinion that there was no sign of leak or sepsis and failed to address the second opinion in the medical record.

12. On July 14, 2015, Respondent documented that Patient A had an elevated fever, elevated white blood cell count, and ordered a repeat CT. Respondent did not elect to surgically intervene despite Patient A's worsening condition. The CT scan demonstrated free air and fluid outside of the bowel, confirming a bowel leak.

13. On July 16, 2015, Patient A underwent a laparotomy performed by another surgeon who discovered a hole in Patient A's colon with extensive fecal peritonitis and adhesions.

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."

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 by causing a perforation of Patient A's bowels during the July 3, 2015, laparoscopic surgery by use of a LigaSure device and failing to convert the surgery to an open surgery despite the confirmation of two (2) colotomies.

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

COUNT II

NRS 630.301(4) - Malpractice

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

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

21. 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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22. 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 by failing to adequately manage Patient A's post-surgical complications by not recognizing clear signs of sepsis, bowel perforation, and failing to intervene surgically after Patient A deteriorated.

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

COUNT III

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

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

25. 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.

26. Respondent failed to maintain complete 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 by failing to address Patient A's sepsis and worsening clinical presentation in the medical record.

27. 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);

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;

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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 15th day of November, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

IAN J. CUMINGS
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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 15th day of November, 2023.

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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