BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **CHRISTINA LYNNE KUSHNIR, M.D.,** **Respondent.**	**Case No. 23-32717-1**

FILED
FEB 24 2023
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

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 Christina Lynne Kushnir, 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. 14396). Respondent was originally licensed by the Board on June 7, 2012.

2. Patient A[2] was a twenty-nine (29) year-old female at the time of the events at issue.

3. On February 24, 2015, Patient A was referred to the Respondent's clinic after an abnormal pap smear, colposcopy, and vaginal bleeding, whereupon she was diagnosed with cervical cancer.

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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 Bret W. Frey, M.D., Col. Eric D. Wade, USAF (Ret.), and Carl N. Williams, Jr., 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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4. On March 3, 2015, Patient A presented to the Respondent, who discussed treatment protocols with Patient A, and recommended the placement of a MediPort, a surgically implanted catheter installed beneath the skin into a vein that delivers chemotherapy medications.

5. On March 13, 2015, the patient presented to Respondent for an examination under anesthesia which included a cervical biopsy, laparoscopic periaortic lymph node dissection, and placement of the MediPort.

6. During the implantation of the MediPort, Respondent utilized a left subclavian approach and implanted the catheter directly into Patient A's aortic arch. Despite an attempt to verify the placement of the catheter in Patient A's vena cava with the use of fluoroscopy, the catheter was incorrectly placed into the arterial system.

7. Respondent's operative note fails to document the character of the blood returning during placement of the catheter, and the details of the targeted vein are incorrect or omitted.

8. On April 18, 2015, Patient A was admitted to the hospital after suffering an acute embolic stroke.

9. On April 20, 2015, a computed tomography angiogram (CTA) of Patient A's neck demonstrated that the catheter tip of the MediPort was incorrectly placed into Patient A's aortic arch at the origin of the left common carotid artery.

COUNT I

NRS 630.301(4) - Malpractice

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

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

12. 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."

13. 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 incorrectly placing a MediPort catheter tip into Patient A's arterial system.

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

COUNT II

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

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

16. 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.

17. 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, whose medical records were not timely, legible, accurate, and complete.

18. 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 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

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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 24th day of February, 2023.

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 24th day of February, 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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