BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **DAN GARY SNOW, M.D.,** **Respondent.**	**Case No. 23-30078-1**

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 Dan Gary Snow, 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. 14778). Respondent was originally licensed by the Board on April 29, 2013.

2. Patient A[2] was a 50-year-old female at the time of the events at issue.

3. Patient A had a medical history of breast cancer and underwent a mastectomy in 2016.

4. On September 18, 2017, Patient A presented to Respondent's practice to undergo hormone replacement therapy, which involves the implantation of a testosterone pellet. Respondent administered the testosterone pellet to Patient A, but initially documented in 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 Rachakonda D. Prabhu, M.D., Ms. April Mastroluca, and Victor M. Muro, 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.

electronic medical record that Patient A had been injected with a 50mg of estrogen pellet. Patient A was scheduled for a repeat procedure with the Respondent's Physician Assistant (PA) three (3) months later.

5. On December 19, 2017, Patient A presented to Respondent's PA for a repeat procedure. The PA, in relying on the prior electronic medical record of Patient A, administered a dosage of "estrogen" (50mg) pellets and discharged Patient A. Immediately following the procedure, the PA discovered the charting error while documenting a patient note for the encounter and informed the Respondent.

6. Upon discovery of the error, Respondent instructed this PA to call Patient A back and inform her that she was given the "wrong amount" of the pellet (presumed to be testosterone); but rather, in fact, PA had improperly inserted the wrong medication. The PA should have inserted testosterone - not estrogen. Without a signed informed patient consent form, and due to inaccurate electronic medical records, Patient A was exposed to a dosage of estrogen, which could have potentially increased Patient A's risk for a recurrence of her past breast cancer.

7. Respondent's PA requested Patient A return to the practice as instructed, who was under the assumption she had received the incorrect dosage of testosterone. During this second encounter, which is not documented in the medical records, Patient A was subjected to an unsuccessful attempt to remove the estrogen pellets. Consequently, Respondent decided to inject an estrogen blocker instead. Patient A's electronic medical records are ambiguous as to whether the Patient A received testosterone or not.

8. Respondent did not inform Patient A of the error, nor did he receive informed consent prior to attempting to remove the estrogen pellet or injecting the patient with an estrogen blocker. Following the second patient encounter, Respondent retroactively addended the medical record to indicate Patient A had been administered with a 50mg testosterone pellet.

///

///

///

///

COUNT I

NRS 630.301(4) - Malpractice

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

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

11. 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.

12. 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 he provided medical services to Patient A, by failing to correctly document the correct procedure which led to Patient A receiving the wrong medication, which may have increased her risk of having a recurrence of breast cancer. Additionally, Respondent failed to inform Patient of the errors in the administration of the wrong pellet or obtain informed consent prior to his attempt to remove the estrogen pellet and providing an estrogen blocker.

13. 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

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

15. 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 is grounds for initiating disciplinary action against a licensee.

16. Respondent failed to maintain proper medical records relating to the diagnosis, treatment, and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete. Respondent's electronic medical records were inaccurate by listing the wrong medication having been administered on

September 19, 2017. The electronic medical records are incomplete as to the second encounter with Patient A following Respondent's PA's improper procedure, inaccurate billing for the dosage given, and failure to obtain informed consent.

17. 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

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

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

20. 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.

21. Respondent failed to timely seek consultation or referral about Patient A's unknown medical condition following his failure to supervise his PA, who inserted an estrogen pellet instead of the required testosterone pellet. Respondent should have consulted with an appropriate care provider to address the potential for exposing Patient A to estrogen, which could potentially cause her to suffer a recurrence of breast cancer.

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

COUNT IV

NRS 630.306(1)(r) - Failure to Adequately Supervise

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

24. NRS 630.306(1)(r) provides that a failure to adequately supervise a physician assistant pursuant to the regulations of the Board is an act that constitutes grounds for initiating disciplinary action.

25. By the conduct described herein, Respondent failed to adequately supervise, or supervise in any way, his PA and any other medical assistant(s) in their performance of their medical procedures and billing duties to Patient A.

26. On information and belief, Respondent's PA, a supervisee, inserted the wrong medication into Patient A. Therefore, Respondent failed to properly supervise the PA when she inserted estrogen into Patient A instead of testosterone, who previously had survived breast cancer, and did not act accordingly to correct the error.

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

COUNT V

NRS 630.306(1)(b)(1) - Engaging in Conduct Which Is Intended to Deceive

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

29. NRS 630.306(1)(b)(1) provides that engaging in conduct which is intended to deceive is grounds for initiating disciplinary action against a licensee.

30. Following the Respondent's PA administering the incorrect medication to Patient A, Respondent deceived Patient A by asking her to return under false information and pretenses and did not inform her of the incorrect medication that was administered and its accompanying risks.

31. 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.

4. That the Board award fees and costs for the investigation and prosecution of this matter 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 20th day of January 2023.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

IAN J. CUMINGS, J.D.
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: icumings@medboard.nv.gov

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 20th day of January 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: V M MURO MD
VICTOR M. MURO, M.D., *Chairman*