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: **DAVID MICHAEL SNIPPER, M.D., Respondent.**	**Case No. 23-8772-1**

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Brandee Mooneyhan, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that David Michael Snipper, 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. 6112). Respondent was originally licensed by the Board on August 25, 1990, and specializes in anesthesiology.

2. At the time of the events at issue, Patient A[2] was twenty-seven (27) years old and thirty-eight (38) weeks pregnant.

3. On or about December 24, 2015, Patient A, went into labor and presented at Summerlin Hospital Medical Center in Las Vegas, Nevada, to deliver her child.

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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, 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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4. After arriving at the hospital, Patient A was attended to by an obstetrician and other medical professionals, including Respondent, who administered a series of epidural injections to address Patient A's pain.

5. Eventually, on or about December 25, 2015, the obstetrician overseeing Patient A's delivery determined that Patient A should deliver her child by Cesarean delivery (C-section), and the necessary arrangements were made.

6. At approximately 1:50 p.m. on December 25, 2015, Respondent re-dosed Patient A's epidural, and she was taken to the operating room.

7. Respondent and the obstetrician determined that Patient A's sensation level was appropriate for surgery, and at approximately 2:10 p.m., the obstetrician began the C-section by making an incision in Patient A's skin.

8. When Patient A experienced pain upon incision, Respondent administered additional medications intravenously to address that pain. When Patient A continued to experience pain, Respondent and the obstetrician determined that general anesthesia should be induced.

9. Respondent administered pre-oxygenation to Patient A and then propofol and succinylcholine to induce general anesthesia. In anticipation of intubating Patient A, Respondent proceeded to perform a laryngoscopy, during which he "could not see the glottic opening at all," and he "called for a glidescope" but there was not one immediately available.

10. Respondent attempted, and failed, to blindly insert the endotracheal tube. He then ventilated Patient A and placed upon her a laryngeal mask airway (LMA) and applied cricoid pressure and told the obstetrician to proceed with the C-section.

11. Respondent maintained Patient A's airway with the LMA during the C-section, and Patient A's baby was delivered.

12. Because Respondent was unable to visualize Patient A's glottic opening during the laryngoscopy and was unable to intubate her, he was aware that Patient A had a difficult airway.

13. After the C-section was complete, despite being aware that Patient A had a difficult airway, Respondent removed the LMA before Patient A emerged from anesthesia. At the time he

removed the LMA, Respondent was not prepared to properly manage Patient A's difficult airway, such as by arranging for the availability of specialized equipment for difficult airway management or ensuring that an additional person was immediately available to assist in managing a difficult airway.[3]

14. After Respondent removed the LMA, he had continued difficulty with assisted ventilation and oxygenation of Patient A, but did not call for appropriate assistance for approximately thirty (30) minutes.

15. Respondent's handwritten record of the anesthesia care he provided to Patient A on or about December 25, 2015, documented his care of Patient A only up until the time she was taken to the operating room; was largely illegible; and lacked times, vital signs, and a description of events.

16. Respondent did not document what occurred during and after Patient A's C-section until he completed an additional typewritten narrative three (3) days later.

COUNT I

NRS 630.301(4) – Malpractice

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

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

19. 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."

20. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by failing to make appropriate preparations to manage Patient A's difficult airway prior to removing the LMA and failing to promptly request assistance when he

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[3] *See, e.g.*, J.L. Apfelbaum et al., "Practice guidelines for management of the difficult airway: An updated report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway," Anesthesiology 118:251-70 (2013).

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had continued difficulty in ventilating and oxygenating Patient A after removal of the LMA on or about December 25, 2015.

21. 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 Timely, Legible, Accurate and Complete Medical Records

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

23. 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.

24. As set forth by the above-outlined facts, Respondent failed to maintain timely, legible, accurate and complete medical records relating to his diagnosis, treatment and care of Patient A on or about December 25, 2015.

25. 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 case as outlined in NRS 622.400;

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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 31st day of August, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandee Mooneyhan

BRANDEE MOONEYHAN
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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 31st day of August, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

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

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 31st day of August, 2023, I served a file-stamped copy of the foregoing **COMPLAINT** as well as file-stamped copy of the **PATIENT DESIGNATION** and required fingerprinting materials, via USPS Certified Mail, postage pre-paid, to the following parties:

DAVID MICHAEL SNIPPER, M.D.
7470 S. Dean Martin Drive, #101
Las Vegas, NV 89139

Tracking No.: 9171 9690 0935 0255 6836 59

DATED this 31st day of August, 2023.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners