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: **DEB KUMAR MUKHOPADHYAY, M.D.,** **Respondent.**	**Case No. 23-12850-1**

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Deb Kumar Mukhopadhyay, 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. 9249). Respondent was originally licensed by the Board on December 17, 1999.

2. Patient A[2] was a seventy-two (72) year-old female at the time of the events at issue.

3. On or about August 16, 2018, Patient A presented to Mountain View Hospital with complaints of feeling dehydrated and weak.

4. After arriving at Mountain View Hospital, Patient A was diagnosed with massive recurrence of oral tongue cancer extending to the area of the vocal cords, associated with the inability to swallow.

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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. While at Mountain View Hospital, Patient A's oncologist planned for chemotherapy and placement of a gastrostomy tube to bring medication and nutrition directly to Patient A's stomach, among other care measures.

6. On August 17, 2018, while at Mountain View Hospital, Respondent conducted a gastroenterologist consultation with Patient A. Respondent chose to perform a percutaneous endoscopic gastrostomy (PEG) tube placement by passing an adult gastroscope from Patient A's mouth to her stomach, instead of attempting a tracheostomy. The PEG tube placement was scheduled for August 18, 2018.

7. Respondent's notes and records do not show that Respondent conducted an oral examination of Patient A to assess the feasibility of using a gastroscope for the PEG tube placement.

8. Patient A's medical records, which were available to Respondent prior to the PEG tube placement, indicated that use of a gastroscope could be unsafe, due to Patient A's condition, including an x-ray report signed and dated on August 16, 2018, showed thickening in Patient A's throat area, suggesting either epiglottitis or angioedema.

9. Respondent's notes and records do not show that Respondent reviewed the August 16, 2018 x-ray report nor discussed the results with Patient A.

10. Respondent's notes and records further do not show that Respondent shared decision making regarding Patient A's care with Patient A, by explaining surgical alternatives open to Patient A, along with their risks and benefits, or that Respondent and Patient A agreed on a thoroughly discussed treatment plan.

11. Respondent's notes and records do not show that Respondent advised the anesthesiologist for the PEG tube placement of any obstructions in Patient A's mouth and throat that would have made Patient A's airway vulnerable.

12. On August 18, 2018, at Mountain View Hospital, Respondent attempted placement of the PEG tube with anesthesia.

13. During the PEG tube placement procedure, Respondent could not pass the adult gastroscopy over Patient A's tongue due to lack of room. Respondent decided to change the scope

from adult gastroscope to pediatric gastroscope. Patient A then developed low blood oxygen levels and stopped breathing. Patient A suffered cardiac arrest.

14. The attending anesthesiologist attempted intubation but was unsuccessful. A rapid response team was called, who then attempted full CPR, ventilation, and pharmacologic intervention. Patient A was then resuscitated.

15. Hospital surgeons then placed an emergent tracheostomy due to the inability to establish an oral airway with Patient A.

16. Patient A was then transferred to the ICU in an unstable condition, where she eventually was stabilized.

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 a licensee.

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. 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 (1) not being aware of Patient A's significant oral obstruction which would have made the PEG placement impossible; and (2) not advising the anesthesiologist for the August 18, 2018 procedure of the obstruction that would have made Patient A's airway vulnerable.

21. 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

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. 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 (1) not documenting an oral examination of Patient A on or about August 18, 2018, to assess the feasibility of gastroscopy; (2) not documenting review of the August 16, 2018 x-ray report; and (3) not documenting that Respondent shared decision making regarding treatment with Patient A on or about August 18, 2018, by explaining the alternatives open to Patient A and agreeing on a thoroughly discussed plan.

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 27th day of July, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

WILLIAM P. SHOGREN
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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 27th day of July, 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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