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**BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA**

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In the Matter of Charges and Complaint

Case No. 23-46132-1

Against:

FARHAD WILLIAM SANI, M.D.,

Respondent.

FILED
MAY - 8 2023
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee¹ (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 Farhad William Sani, 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 a special purpose license to practice medicine in the State of Nevada (License No. SP401). Respondent was originally licensed by the Board on November 8, 2016. Respondent's specialty is listed as diagnostic radiology.

2. Patient A² was a sixty-five (65) year-old female at the time of the events at issue.

3. On September 28, 2018, Patient A underwent a contrast computed tomography (CT) scan of the abdomen and pelvis following a referral by another provider due to a history of ovarian 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., Chowdhury Ahsan, M.D., and Col. Eric D. Wade USAF (Ret.).

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.

1 4. Patient A's relevant medical history was listed on the intake sheet and patient
2 referral.

3 5. On September 30, 2018, Respondent examined Patient A's CT scan, but failed to
4 identify or note the existence of a conspicuous 4.4-centimeter right lateral wall soft tissue mass in
5 his report. Additionally, Respondent failed to identify or note an irregular right cardiophrenic
6 lymph node and three (3) small lung nodules which warranted further testing.

7 6. Patient A underwent additional diagnostic testing on July 25, 2019, which
8 demonstrated the presence of the soft-tissue mass.

9 7. Respondent's failure to properly interpret Patient A's CT imaging resulted in the
10 delay of diagnosis and treatment of recurrent metastatic cancer.

11 **COUNT I**

12 **NRS 630.301(4) - Malpractice**

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

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

17 10. NAC 630.040 defines malpractice as "the failure of a physician, in treating a
18 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar
19 circumstances."

20 11. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
21 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
22 rendering medical services to Patient A by failing to identify or note the existence of a 4.4-
23 centimeter mass, irregular lymph node, and nodules present on the lung.

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

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1 COUNT II

2 **NRS 630.3062(1)(a) – Failure to Maintain Proper Medical Records**

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

5 14. NRS 630.3062(1)(a) provides that the “failure to maintain timely, legible, accurate
6 and complete medical records relating to the diagnosis, treatment and care of a patient” constitute
7 grounds for initiating discipline against a licensee.

8 15. Respondent failed to maintain proper medical records relating to the diagnosis,
9 treatment and care of Patient A, by failing to correctly note the mass present on Patient A’s CT
10 scan.

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

13 COUNT III

14 **NRS 630.306(1)(b)(2) – Violation of Standards of Practice Established by Regulation**

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

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

19 19. NAC 630.210 requires a physician to “seek consultation with another provider of
20 health care in doubtful or difficult cases whenever it appears that consultation may enhance the
21 quality of medical services.”

22 20. Respondent failed to timely seek consultation with regard to Patient A’s medical
23 condition on September 30, 2018, and Respondent should have consulted with an appropriate care
24 provider to address the doubtfulness of the diagnosis of Patient A’s medical condition and such a
25 timely consultation would have confirmed or denied such a diagnosis and may have enhanced the
26 quality of medical care provided to the Patient with regard to the presence of conspicuous masses
27 on the September 28, 2018 CT scan.

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 8th day of May, 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:

FARHAD WILLIAM SANI, M.D.
11995 Singletree Lane, Ste. 500
Eden Prairie, MT 55344

Tracking No.: 9171 9690 0935 0254 7679 09

DATED this 9th day of May, 2023.



MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners