BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **IRA ALAN KLEIN, M.D.,** **Respondent.**	**Case No. 23-43977-1** FILED JUL 27 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 William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Ira Alan Klein, 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. 16161). Respondent was originally licensed by the Board on October 13, 2015.

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.

---

[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.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

5. While at Mountain View Hospital, the medical professionals caring for Patient A determined that Patient A should undergo a diagnostic endoscopic procedure and placement of a percutaneous endoscopic gastrostomy (PEG) tube, to allow access for medication and nutrition. These procedures were scheduled for August 18, 2018.

6. Respondent was the anesthesiologist for Patient A's August 18, 2018, diagnostic endoscopic procedure and PEG tube placement.

7. Patient A's medical notes and records, which were available to Respondent prior to the diagnostic endoscopic procedure and PEG tube placement procedure, indicated possible airway management difficulties and difficulty with intubation, 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.

8. Respondent's pre-operative assessment of Patient A did not adequately address the anticipated airway difficulties consistent with possible epiglottitis or angioedema.

9. The PEG placement procedure on August 18, 2018, took place in the endoscopy suite at Mountain View Hospital, instead of the operating room. Respondent did not follow an epiglottitis or angioedema protocol by not having the procedure performed in an operating room with a surgeon and staff available for a surgical airway.

10. During the August 18, 2018, procedure Respondent provided monitored anesthesia care to Patient A. Respondent sedated Patient A with 2 mg of Midazolam and 70 mg of Propofol intravenously.

11. During the August 18, 2018, procedure Patient A developed low blood oxygen levels and stopped breathing upon the admission of anesthesia. Respondent was able to oxygenate but could not ventilate Patient A. Patient A suffered cardiac arrest.

12. A rapid response team was called, who then attempted full CPR, ventilation, and pharmacologic intervention. Patient A was then resuscitated.

13. Respondent unsuccessfully attempted a direct laryngoscopy in order to intubate Patient A's trachea, but was unable to do so due to Patient A's tumor distorting the airway and making it impossible to visualize the larynx.

14. Surgeons were called into the procedure room, where they performed an emergency tracheostomy on Patient A. Patient A was then transferred to the ICU in an unstable condition, where she eventually was stabilized.

15. Respondent's post-anesthesia assessment record indicated that there were no complications involved with the August 18, 2018 PEG tube placement procedure.

16. Respondent further did not record any post-procedure notes regarding Patient A.

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, when (1) Respondent's pre-operative assessment of Patient A did not adequately address Patient A's preoperative status, including anticipated airway difficulties consistent with possible epiglottitis or angioedema; (2) Respondent did not perform the intubation in an operating room with a surgeon and staff available for a surgical airway; and (3) Respondent failed to anticipate that a direct laryngoscopy and successful intubation for Patient A would not have been possible during the procedure on or about August 18, 2018.

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

///

///

///

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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 adequately document a pre-operative assessment of Patient A's difficult airway, including assessment of possible epiglottitis or angioedema, prior to initiating Patient A's anesthetic care on or about August 18, 2018. Respondent also failed to document that Patient A suffered complications during her procedure on or about August 18, 2018. Respondent further failed to record any post-procedure notes, including any follow-up visits with Patient A.

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;

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

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: shogrenw@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559