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

* * * * *

In the Matter of Charges and Complaint Against: **IRA ALAN KLEIN, M.D., Respondent.**	**Case No. 23-43977-2**

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 fifty-six (56) year-old male at the time of the events at issue.

3. On January 24, 2018, Patient A was admitted to St. Rose Dominican Hospital with a left foot infection.

4. On January 27, 2018, at or around 8:15 a.m., Patient A was taken to the operating room for surgery on his left foot. Respondent was the anesthesiologist during the surgery.

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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 H. Ahsan, M.D., Ph.D., FACC, and Col. Eric D. Wade, USAF (Ret.).

[2] Patient A's true identity is not disclosed herein to protect his privacy but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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5. Respondent's pre-operative evaluation indicated that Respondent suffered from obstructive sleep apnea, obesity, and probable difficulty with intubation.

6. Prior to the surgery, Respondent provided pre-oxygenation to Patient A. However, Respondent's medical record from the January 27, 2018, surgery did not mention any other methods of airway preparation undertaken by Respondent.

7. Respondent then induced general anesthesia and placed a laryngeal mask airway (LMA) in Patient A.

8. After placement of the LMA, Respondent was unable to effectively secure Patient A's airway with the LMA, or otherwise effectively ventilate Patient A. As a result, Patient A's heart rate and blood pressure dropped, and Patient A suffered cardiac arrest.

9. A code blue was called at or around 8:38 a.m. Chest compressions and epinephrine were then administered. Respondent attempted both a direct laryngoscopy and Glidescope.

10. Respondent's medical record from the January 27, 2018, surgery does not indicate that other airway management maneuvers were undertaken, or that alternative modes of ventilation, including oral and nasal airways, were used.

11. After Respondent's second attempt to place an LMA, Patient A's heart rate and blood pressure then improved and Patient A was stabilized at or around 9:00 a.m. Patient A's surgery was then initiated.

12. Patient A was unable to wake up from general anesthesia after the surgery. Patient A was taken to the ICU, where Patient A was diagnosed with a severe anoxic brain injury. Patient A did not recover any type of meaningful neurological function. Patient A passed away on February 1, 2018.

COUNT I

NRS 630.301(4) - Malpractice

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

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

15. 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."

16. 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 on January 27, 2018, by (1) failing to adequately prepare for dealing with Patient A's difficult airway prior to surgery; (2) failing to adequately and timely attempt means to secure Patient A's airway once Respondent knew that the LMA failed to secure Patient A's airway; and (3) failing to attempt alternative modes of ventilation when Patient A's airway was not secure.

17. 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 Appropriate Medical Records

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

19. 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.

20. Respondent failed to maintain complete and 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 medical records on January 27, 2018, did not adequately list Respondent's methods of airway preparation prior to the surgery, and were generally illegible and failed to sufficiently document the failure to secure Patient A's airway.

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

WHEREFORE, the Investigative Committee prays:

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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

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: _____

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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