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:**<br>**RASHID JAHANGIR, M.D.,**<br>**Respondent.** | **Case No. 23-28648-1** |

FILED
JUL 27 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

## 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 Rashid Jahangir, 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. 11124). Respondent was originally licensed by the Board on September 2, 2004, and specializes in anesthesiology.

2. Patient A[2] was a forty-one (41) year-old female at the time of the events at issue.

3. On or about August 12, 2015, Patient A was transported to Sunrise Hospital in Las Vegas, Nevada, with a primary complaint of shortness of breath.

4. After arriving at the hospital, Patient A was diagnosed with community-acquired pneumonia and acute respiratory failure and was ultimately intubated.

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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 M. Neil Duxbury, Aury Nagy, M.D., and Michael C. Edwards, M.D.

[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. The doctor performing the intubation of Patient A noted that it was a "difficult intubation and glide scope was needed for visualization."

6. After several days in the hospital, the medical professionals caring for Patient A determined that she should receive a tracheostomy and a percutaneous endoscopic gastronomy (PEG) tube; those procedures were scheduled for August 23, 2015.

7. Respondent was the anesthesiologist for Patient A's August 23, 2015, tracheostomy and PEG tube placement.

8. Prior to initiating anesthesia of a patient, an anesthesiologist is responsible for assessing the patient's health, for example, by performing a physical examination and obtaining a medical history, in order to formulate a safe and effective anesthesia plan tailored to the particular patient.

9. Respondent failed to document that he conducted a physical examination of Patient A prior to initiating her anesthetic care.

10. Additionally, despite the documentation that Patient A's prior intubation was "difficult" and required a glide scope, Respondent also failed to document that he prepared to properly manage her difficult airway, such as by arranging for the availability of at a portable storage unit containing specialized equipment for difficult airway management, ascertaining that at least one additional person was immediately available to assist in managing the patient's difficult airway, administering preoxygenation, or pursuing opportunities to deliver supplemental oxygen throughout the procedure.[3]

11. During surgery, an anesthesiologist's responsibilities include monitoring and managing the patient's vital bodily functions, such as oxygenation, ventilation, and heart function.

12. During Patient A's procedure on August 23, 2015, the surgeon's first attempt at performing a tracheostomy on Patient A failed.

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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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13. During the surgeon's second attempt at performing a tracheostomy, Patient A experienced profound hypoxia, bradycardia, and cyanosis, and Patient A suffered anoxic brain injury.

14. In part, the operative notes completed by the surgeon stated that Patient A's oxygen "saturation status was decreasing quite a bit and patient actually became [bradycardic]," that Patient A "was almost about to crash due to respiratory distress," and that Patient A "became cyanotic as well."

15. Cyanosis is typically evident at oxygen saturation levels of 85% or less, and brain injury typically occurs when oxygen saturation levels are 80% or less for more than a few moments. Despite Patient A suffering both of these conditions, in his anesthesia record of the August 23, 2015, procedure, Respondent did not record an oxygen saturation rate below 87%.

16. In his anesthesia record of the August 23, 2015, procedure, Respondent failed to document Patient A's levels of hypoxia, bradycardia, or cyanosis.

17. In his anesthesia record of the August 23, 2015, procedure, Respondent failed to document his management of Patient A's airway during the tracheostomy attempts or any attempts he made to mitigate the critical problems Patient A was experiencing.

**COUNT I**

**NRS 630.301(4) – Malpractice**

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

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

20. 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."

21. Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by failing to properly assess Patient A's health or make appropriate

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preparations to manage her difficult airway prior to initiating her anesthetic care on or about August 23, 2015.

22. 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 Accurate and Complete Medical Records**

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

24. 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.

25. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A by failing to accurately record her oxygen levels; failing to document her levels of hypoxia, bradycardia, and cyanosis; and failing to document how he managed her airway during her procedure on or about August 23, 2015.

26. 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: 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 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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