BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against:

SHANNON MARIE SMITH, M.D.,

Respondent.

Case No. 23-38849-1

FILED

JUN 20 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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Shannon Marie Smith, 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. 15407). Respondent was originally licensed by the Board on July 1, 2014.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. On June 26, 2019, Patient A was referred from Canyon Medical Center to Sunrise Hospital complaining of dizziness, weakness, fever, a fast heart rate, and shortness of breath.

4. Patient A's past medical history included an aortic valve replacement, hypertension, hyperlipidemia, obesity, and smoking.

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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., Carl N. Williams, Jr., M.D., FACS 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. Patient A's clinical outlook at the emergency room was consistent with sepsis.

6. Blood cultures were drawn and Patient A was started on a medically appropriate sepsis treatment regimen with IV fluids and IV antibiotics and was admitted to the hospital.

7. The first blood culture had a positive gram stain for gram pistive cocci in clusters.

8. On June 27, 2019, an Advanced Practice Registered Nurse (APRN) was notified of the growth and the attending physician added IV vancomycin to the treatment of Patient A.

9. Care of the patient was transferred to Respondent on June 29, 2019 and she was the attending physician until Patient A's discharge on June 30, 2019.

10. An APRN wrote in a progress note on June 29, 2019 "blood cultures PCR+ Staph aureus. Repeat blood cultures without growth thus far." The APRN signed the note on June 29, 2019, but was not signed by Respondent until July 3, 2019.

11. Both of the original blood cultures drawn on June 26, 2019 were reported positive and were growing staph aureus by the time Respondent became the attending physician on June 29, 2019.

12. Additionally, on June 29, 2019, both of the additional blood cultures drawn on June 28, 2019 were also growing staph aureus, which was reported to an RN, who passed this information on to another APRN.

13. On June 30, 2019, Patient A now had four (4) positive blood cultures, tachycardia, elevated white blood cell count of sixteen thousand five hundred (16,500) (with immature neutrophils including band forms, metamyelocytes, myelocytes, and promyelocytes).

14. Despite these significant findings, an APRN, under the direction of Respondent, discharged Patient A with no antibiotics and attributed his severe medical condition to being "viral" and stating the patient was "medically stable for discharge."

15. After Patient A was discharged, his blood culture results returned positive for staph aureus. However, between June 29, 2019 and June 30, 2019, Respondent did not follow up with the blood culture results. In fact, Respondent stated that she expected to be called with results from the lab.

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16. Patient A was readmitted to Sunrise Hospital on July 5, 2019 with severe sepsis and succumbed on July 7, 2019.

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 she did not follow up with the laboratory nor Patient A about the blood cultures positive for staph aureus. She was then unable to provide Patient A the appropriate treatment because the patient had been prematurely discharged from the hospital which ultimately lead to Patient A's demise.

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

COUNT II

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation

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

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

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

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25. Respondent failed to timely seek consultation with regard to Patient A's medical condition from June 29-30, 2019. Respondent should have consulted with an appropriate care provider. Specifically, she should have consulted with the laboratory physicians regarding the growing blood cultures to address the doubtfulness of the diagnosis of Patient A's medical condition and such a timely consultation would have confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided to the Patient with regard to Patient A's staph aureus growing cultures and the resulting sepsis.

26. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against her and give her notice that she 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

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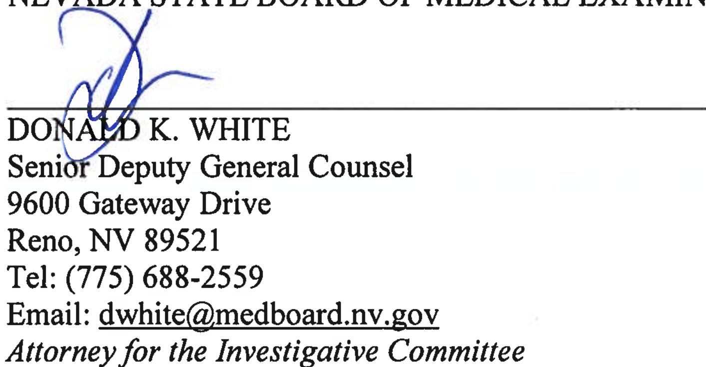
6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 20th day of June, 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 16th day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

BRET W. FREY, M.D.
Chairman of the Investigative Committee