BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against:

JASON HOWARD LASRY, M.D.

Respondent.

Case No. 23-29251-1

FILED
DEC - 7 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The above-entitled matter came on regularly for decision before the Nevada State Board of Medical Examiners (Board), on December 1, 2023, at the Board's office located at 325 E Warm Springs Rd Suite 225, Las Vegas, NV 89119, on the Complaint filed herein. Jason Howard Lasry, M.D., (Respondent), who was duly served with notice of the adjudication, was present and represented by his counsel, Chelsea Hueth, Esq. The adjudicating members of the Board participating in these Findings of Fact, Conclusions of Law, and Order (FOFCOL) were: Nick M. Spirtos, M.D., F.A.C.O.G., Ms. Maggie Arias-Petrel, Aury Nagy, M.D., Ph.D., FACC, Ms. Pamela Beal, Irwin B. Simon, M.D., FACS, Jospeph Olivarez, P.A.-C., and Jason B. Farnsworth, RRT, MBA. Chricy E. Harris, Esq., Deputy Attorney General, served as legal counsel to the Board.

The Board, having received and read the Complaint and exhibits admitted in the matter and filed into the record in this case, the "Findings and Recommendations" prepared by the Hearing Officer, Patricia Halstead, Esq., who presided over the hearing, and the transcript of the hearing, proceeded to make a decision pursuant to the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), NRS Chapter 622A, and NRS Chapter 233B, as applicable.

/ / /

/ / /

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

The Board, after due consideration of the record, evidence and law, and being fully advised in the premises, makes its FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER in this matter, as follows:

FINDINGS OF FACT

I.

Respondent held a license to practice medicine in the State of Nevada issued by the Board at all relevant times.

II.

On March 8, 2023, the Investigative Committee filed its formal Complaint in Case No. 23-29251-1, alleging Respondent violated the Medical Practice Act. Respondent was personally served with the Complaint on or about March 20, 2023. The Complaint alleged three (3) violations of the Nevada Medical Practice Acts, including: one (1) violation of NRS 630.301(4), Malpractice (Count I), one (1) violation of NRS 630.306(1)(b)(2), Violation of Standards of Practice Established by Regulation – Failure to Consult (Count II), and one (1) violation of NRS 630.3062(1)(a), Failure to Maintain Appropriate Medical Records (Count III). Respondent filed an answer in response to the allegations set forth in the Complaint.

III.

An Order was filed on April 4, 2023, scheduling the Early Case Conference (ECC) for the pending matter for April 14, 2023. This Order was served upon Respondent's counsel by email and US Mail. The Early Case Conference was held at the scheduled time wherein all parties appeared telephonically. As a result of the ECC, the Prehearing Conference was scheduled for June 27, 2023, and a hearing date was set for September 21, 2023, through September 22, 2023, and a Scheduling Order was issued on April 14, 2023. Respondent's counsel was served a copy of the Scheduling Order by email and US Mail. At the time fixed for the Prehearing Conference, legal counsel for the Investigative Committee, William P. Shogren, Deputy General Counsel, appeared, as well as the Hearing Officer, Patricia Halstead, Esq. and counsel for Respondent, Chelsea Hueth, Esq. At the Prehearing Conference, counsel for the Investigative Committee and Respondent provided the Hearing Officer with the mandated Prehearing Conference Disclosures

and had copies of both the Prehearing Conference Statement and the mandated Prehearing Disclosures available for the parties. Respondent was timely and properly served with the Prehearing Conference Statement and the mandated Prehearing Disclosures in accord with NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and the requirements of due process.

IV.

On September 21, 2023, through September 22, 2023, a contested case hearing was held before the Hearing Officer to receive evidence and to hear arguments. The Hearing Officer received the complete Record of Proceedings, including the transcript of the testimony received and the exhibits admitted. Upon receipt of the Record of Proceedings, the hearing was closed. The Hearing Officer filed the Findings and Recommendations on November 8, 2023. The matter was scheduled for final adjudication on December 1, 2023, at a regularly scheduled Board meeting. The notice of the adjudication was mailed to Respondent on October 30, 2023, via US Certified Mail, with a copy by email as well. On November 8, 2023, Respondent was sent a copy of the Hearing Officer's Findings and Recommendations via US Certified Mail, with a copy by email. Additionally, on November 20, 2023, via Fed Ex 2-Day mail, Respondent was given a copy of the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees and a packet of the materials to be presented at the scheduled Board meeting.

V.

Pursuant to NRS 622A.300(5)(a), the Findings and Recommendations of the Hearing Officer are hereby approved by the Board in their entirety and are hereby specifically incorporated and made part of this Order by reference. *See* **Exhibit 1**.

VI.

In accord with the Findings and Recommendations, the Board hereby finds that all counts set forth in the Complaint, as recapitulated in Paragraph II above, have been established by a preponderance of the evidence.

VII.

If any of the foregoing Findings of Fact is more properly deemed a Conclusion of Law, it may be so construed.

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

CONCLUSIONS OF LAW

I.

The Board has jurisdiction over Respondent and the Complaint, and an adjudication of this matter by the Board members as set forth herein is proper.

II.

Respondent was timely and properly served with the Complaint, and all notices and orders in advance of the hearing and adjudication thereon, in accord with NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and the requirements of due process.

III.

With respect to the allegations of the Complaint, the Board concludes that Respondent has violated NRS 630.301(4), Malpractice as alleged in Count I, has violated NRS 630.306(1)(b)(2), Violation of Standards of Practice Established by Regulation – Failure to Consult as alleged in Count II, and has violated NRS 630.3062(1)(a), Failure to Maintain Appropriate Medical Records as alleged in Count III. Accordingly, Respondent is subject to discipline pursuant to NRS 630.352.

IV.

The Board finds that, pursuant to NRS 622.400, it may recover from Respondent reasonable attorneys' fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent as it hereby enters this Findings of Fact, Conclusions of Law, and Order finding that Respondent has violated the Medical Practice Act, which the Board has the authority to enforce.

V.

The Board has reviewed the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees, and the Board finds them to be the actual fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent, and finds them to be reasonable based on: (1) the abilities, training, education, experience, professional standing and skill demonstrated by Board staff and attorneys; (2) the character of the work done, its difficulty, its intricacy, its importance, the time and skill

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

required, the responsibility imposed and the prominence and character of the parties where, as in this case, they affected the importance of the litigation; (3) the work actually performed by the Board's attorneys and staff, and the skill, time and attention given to that work; and (4) the product of the work and benefits to the Board and the people of Nevada that were derived therefrom.

VI.

If any of the foregoing Conclusions of Law is more properly deemed a Finding of Fact, it may be so construed.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and good cause appearing therefore,

IT IS HEREBY ORDERED that:

1. Respondent shall reimburse the Board the reasonable costs and expenses actually incurred in the investigation and prosecution of this case in the amount of eighteen thousand two hundred sixty-eight dollar and four cents ($18,268.04) by April 1, 2024;

2. Respondent shall pay fines in the amount of five thousand dollars ($5,000) for Count I, one thousand two hundred and fifty dollars ($1,250) each for Counts II and III, for a total fine assessed of seven thousand five hundred dollars ($7,500), by April 1, 2024;

3. Respondent shall perform eight (8) hours of Continued Medical Education (CME), four (4) hours related best practices in emergency medicine critical care, including treating envenomization in patients, and four (4) hours on best practices in medical record keeping, within six (6) months of the date of this Order. These eight (8) hours of CME shall be in addition to the CME requirements regularly imposed upon Respondent as a condition of licensure in the State of Nevada pursuant to NAC 630.153(1).

4. Respondent shall be issued a Public Letter of Reprimand; and

/ / /

/ / /

/ / /

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

5. Respondent's discipline shall be reported to the appropriate entities, including the National Practitioner Databank (NPDB).

IT IS SO ORDERED.

DATED this 7th day of December, 2023.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

NICK M. SPIRTOS, M.D., F.A.C.O.G.
President of the Board

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

CERTIFICATION

I certify that the foregoing is the full and true original FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER on file in the office of the Board of Medical Examiners in the matter of Jason Howard Lasry, M.D., Case No. 23-29251-1.

I further certify that Nick M. Spirtos, M.D., F.A.C.O.G., is the President of the Nevada State Board of Medical Examiners and that full force and credit is due to his official acts as such; and that the signature to the foregoing ORDER is the signature of said Nick M. Spirtos, M.D., F.A.C.O.G.

IN WITNESS THEREOF, I have hereunto set my hand in my official capacity as Secretary-Treasurer of the Nevada State Board of Medical Examiners.

DATED this 7th day of December, 2023.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Maggie Arias-Petrel

MAGGIE ARIAS-PETREL
Secretary-Treasurer and Public Member of the Board

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

EXHIBIT 1

EXHIBIT 1

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

JASON HOWARD LASRY, M.D.,

Respondent.

Case No. 23-29251-1

FILED
NOV - 8 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: ____

FINDINGS AND RECOMMENDATION[1]

1. Introduction

This matter was heard on September 21-22, 2023. Present in the Reno office of the Nevada State Board of Medical Examiners (the "Board") were William P. Shogren on behalf of the Investigative Committee of the Nevada State Board of Medical Examiners (the "IC") and the undersigned hearing officer. Appearing and present on behalf of Respondent in the Las Vegas office of the Board were Chelsea R. Hueth, Esq. on behalf of Respondent and Respondent Jason Howard Lasry, M.D. IC witness Kristi Barbieri appeared in person at the Reno office of the Board. IC witness Eric Glissmeyer, M.D. appeared remotely, as did Respondent witness John Levin, M.D. All witnesses were sworn. The rule of exclusion was not invoked by either party. IC Exhibits 1-15 were admitted, as were Respondent Exhibits 1-8.

2. Allegations

The Complaint alleges Count I, NRS 630.301(4), Malpractice; Count II, NRS 630.306(1)(b)(2), Violation of Standards of Practice Established by Regulation – Failure to Consult; and Count III, NRS 630.3062(1)(a), Failure to Maintain Proper Medical Records. *See* Complaint, filed on March 8, 2023. The Complaint centers upon the treatment of a three year old

[1] Incorporated herein by reference are the full Hearing Transcripts, Volume I and II, dated September 21, 2023 and September 22, 2023, respectively, and which are referred to herein under the designation "TR" and "TR2," as well as the exhibits admitted at the hearing.

patient who suffered a rattlesnake bite, in relation to which antivenom was not administered by Respondent. Id. Count I, the Malpractice claim, is premised upon Respondent's alleged failure to "recognize hypotension and tachycardia" and Respondent's failure to treat the patient's "diminishing condition." Id. Count II, the Failure to Consult Claim, is premised upon Respondent's alleged failure to consult with a "medical toxicologist" to address Respondent's diagnosis, which would have "enhanced the quality of medical care" provided as to the need for antivenom and other therapies. Id. Count III, the Failure to Maintain Appropriate Medical Records, is premised upon the alleged failure to note the patient's tachycardia and hypotension. Id.

3. Witnesses and Testimony

In relation to the IC's case, the undersigned hearing officer heard from Kristi Barbieri, a Board Investigator (TR 18-39) and expert witness Eric Glissmeyer, M.D. (TR 40-147). In relation to Respondent's case, the undersigned hearing officer heard from Respondent Jason Howard Lasry, M.D. (TR 152-239) and expert witness John Levin, M.D. (TR2 5-43).

On behalf of the IC, Ms. Barbieri authenticated IC exhibits and cross-examination of her was utilized primarily to demonstrate her limited knowledge of the medical matters at issue in the case and the fact that the medical records were limited to twenty-one pages, although no other medical records were ever addressed and Ms. Barbieri testified on re-direct that she believed the medical records provided were complete (TR 38). The only other witness called by the IC was Dr. Glissmeyer, a pediatric emergency physician and the IC's expert, who testified to his background and opined that Respondent failed to meet the standard of care required for treatment of the patient. TR 40-48. Dr. Glissmeyer then established a timeline from the medical records as follows:

Rattlesnake bite occurred on May 9, 2020 at approximately 14:57 (2:57 p.m.) (TR 92)

EMS arrived on scene at 15:56 hours (3:56 p.m.) (TR 50)

EMS departed the scene at 16:07 hours (4:07 p.m.) (TR 50)

EMS arrived with the patient at Humboldt General Hospital in Winnemucca, Nevada, at 16:16 hours (4:16 p.m.) (TR 51)

Patient was seen by Respondent at 16:24 hours (4:24 p.m.), and Respondent assessed patient as having been bitten by a rattlesnake on her left knee with a 25% increase in swelling since EMS marked the initial swelling (the medical term for which is edema) (TR 51)

For approximately 35 minutes Respondent delivered care and assessment, which would bring the time to approximately 17:00 hours (5:00 p.m.) (TR 52)

Renown Hospital ("Renown") in Reno, Nevada, accepted the patient for transfer at 17:56 hours (5:56 p.m.) (TR 52)

Patient was discharged from Humboldt General Hospital at 18:32 hours (6:32 p.m.) (TR 53)

Patient departed Humbolt General Hospital by ground transport at 18:52 hours (6:52 p.m.) (TR 53)

Patient arrived at Renown at 21:29 hours (9:29 p.m.) (TR 53)

Patient was pronounced deceased on May 13, 2020 at 17:27 hours (5:27 p.m.). Cause of death was permanent cessation of cardiac function, secondary to MOS (Multiple Organ Dysfunction Syndrome), secondary to cardiac arrest, secondary to rattlesnake bite. (TR 54-55)

The Renown medical records provided as **IC Exhibit 8** establish that the patient started to decompensate (failed to maintain adequate circulation) in route to Renown and was being bagged upon arrival (being subject to manual resuscitation for forced ventilation, meaning the patient was in respiratory failure/arrest).[2] Efforts to treat the patient through defibrillation and otherwise were made but at 21:46 hours (9:48 p.m.) and the patient was deemed not to have a pulse. Id. The patient was intubated and kept on life support until the family made the decision to cease care. Id. At the time the decision was made, the patient's prognosis was "poor" from a "neurologic standpoint." Id. The Renown records further reiterate that the patient was not administered antivenom per Respondent but antivenom was started at Renown ("Antivenom had not been received at the outside hospital and was started here"). Id.

///

[2] The timeline of the patient's deteriorating condition during transport was not specifically testified to but the Renown records (**IC Exhibit 8**, NSBME 100) indicate that "bag-mask ventilation" took place for the "last 'few minutes' of transport" per the patient's mother who was in the ambulance.

To summarize Dr. Glissmeyer's opinions of the charges faced by Respondent, Dr. Glissmeyer opined that Respondent committed malpractice by failing to recognize the signs of envenomization and failing to timely administer the antivenom. *See, e.g.* TR 57.[3] As to failure to consult, Dr. Glissmeyer concluded that the conversation with the Renown physician, Dr. Gassen, was a hand-off versus an actual consultation (TR 85), and that Respondent failed to consult with a medical toxicologist through an emergency telephone number made available to health care providers since 2011. TR 65-66. As to failure to properly maintain medical records, Dr. Glissmeyer opined that the patient's blood pressure was not notated while the patient was under Respondent's direct care, which is relevant to the signs of envenomization - such signs being hypotension (low blood pressure); systematic bleeding; and neurotoxicity (as evidenced by vital sign abnormalities such as tachycardia). TR 64; 70-72; 75-76; 120; 136. Dr. Glissmeyer also takes issue with Respondent's failure to recognize and note the patient's increased heart rate (tachycardia), having instead noted that the patient's heart rate was normal as to rate on rhythm. TR 71; 100.

Respondent addressed Dr. Glissmeyer's opinions by and through documentation, cross-examination, and/or testimony, arguing that while Respondent did not personally note the tachycardia, the patient was tachycardic as was reflected in the medical records documenting the patient's vital signs, and that the high heart rate was deemed attributed to the stress of the situation. TR 100; 159-162; 209-210. The patient's relevant labs came back within acceptable ranges, which was not contested. TR109-112; 170-174. Although the edema had increased by 25% per Respondent, Respondent deemed it negligible going so far as to deem it "minuscule." TR 116; 167-169; 194; 210. The patient's hypotension as later noted in the ambulance stabilized for a period. TR 126-127. Respondent further argued that the patient's blood pressure was not recorded prior to transport but it was monitored and the failure to document it in the patient's record was the nurse's fault, which Respondent's expert witness John Levin, M.D. supported. TR

[3] In particular, Dr. Glissmeyer testified that Respondent should have obtained full vital signs including blood pressure, recognized the patient's elevated heart rate (tachycardia), recognized the progression of swelling, and for any of those conditions, administered tho antivenom before transferring the patient via the "fastest mode possible." TR 82.

162; 204-205; 208; TR2 41. Respondent also maintained that the patient was not hypotensive or would have been treated for such. TR 163; 195. Respondent further testified that he has been educated about, and has experience with, snakebites, having treated 15-20 snakebite patients prior. TR 226. Therefore, according to Respondent, consultation with a medical toxicologist was not necessary. TR 184.

John Levin, M.D. ("Dr. Levin"), an emergency medical specialist, testified on behalf of Respondent and indicated that upon arrival at Humboldt General Hospital, the patient had normal perfusion, meaning normal blood flow (TR2 11);[4] normal respiratory rate (TR2 12); acceptable temperature and oxygen saturation (Id.); and a heart rate of 149, which was high and, therefore, tachycardic, but which was attributable to the patient being young and enduring a traumatic event that was ongoing through the visit to the emergency room (TR2 12-13).

As to the patient's blood pressure, Dr. Levin testified that he did not see it recorded on the patient's records from Humboldt General Hospital but that was not unusual because blood pressure is not normally taken for toddlers. TR2 14-15.

Per Dr. Levin, the normal labs, the lack of an indication of muscle weakness, and the patient's ability to move her leg, all indicated that "there was no significant envenomization at that time." TR2 17-19.

Dr. Levin further testified that he did not believe that the decision to transfer the patient by ground was inappropriate, stating that ground transport is routine; the difference in timing was "maybe a half hour or an hour;" and that ground transport was the easiest and fastest option even though air transport was available.[5] TR2 19-22. In subsequent testimony, Dr. Levin admitted to not being familiar with the travel distance relative to this matter and opined that an hour difference in travel time would not have been impactful. TR2 42-43.

As to the patient's blood pressure, Dr. Levin testified that it was "a little hypotensive" when it was measured during transport but that it became normal within an hour. TR2 22-23.

///

[4] TR2 = Transcript Volume II

[5] This is inaccurate as addressed further herein.

Dr. Levin also testified that in his experience, which he later testified was the treatment of two snakebites in forty years (TR2 31), the vast majority of snakebites are non-lethal and that it is very rare to die from a snakebite but clarified that in a study he relied upon "some got antivenoms" and noted other resulting problems absent death. TR2 23-25; 37-38. As to this patient in particular, Dr. Levin noted the patient's death as "[u]nusual and unfortunate" and opined that it was a judgment call for Respondent not to administer the antivenom and Respondent's failure to do so was reasonable based upon the low mortality rate affiliated with snakebites. TR2 25; 28.

On cross-examination, Dr. Levin testified that a single symptom of envenomization, hypotension in particular, is insufficient to justify administering antivenom, particularly here when it was noted as temporary (TR2 33-34), and that it is reasonable not to take a toddler's blood pressure in snakebite situations (TR2 34-35). Dr. Levin also indicated that it was reasonable for Respondent not to have administered antivenom but that in the same or similar situation he himself "might have given it." TR2 35-36.

4. Further Dispositive Testimony/Evidence.

Dr. Glissmeyer by and through the IC submitted three articles on envenomization that, other than one potentially post-dating the incident,[6] were addressed by both parties and that were deemed to establish the standard of care for the treatment of snakebites and envenomization.

In particular, **IC Exhibit 11** is titled *How Should Native Crotalid Evnenomation Be Managed in the Emergency Department*, Clinical Practice Statement (September 14, 2020 and updated on April 26, 2021 and September 16, 2021) [authors omitted].

IC Exhibit 12 is titled *Wilderness Medical Society Practice Guidelines for the Treatment of Pitviper Envenomations in the United States and Canada*, Wilderness and Environmental Medicine, 26, 472-487 (2015) [authors omitted].

IC Exhibit 13 is titled *Bites by Crotalinae Snakes (Rattlesnakes, Water Moccasins [Cottonmouths], or Copperheads) in the United States: Management*, UpToDate (current through

[6] The 2022 year referenced for such was a review and update reference, so it is not clear when the article was first written and the standards stated therein were not challenged despite whether the article did or did not post-date the incident at issue.

October 2022) [author omitted].

Exhibit 11 plainly states that antivenom should be administered for *any* of the following:

- Significant or progressive local tissue damage, e.g. tenderness, swelling, hemorrhagic bleb, described as being more than minimal and having extended past a major joint of, if not having extended past a major joint, then if there is significant local tissue injury;

- Systemic toxicity, e.g. hypotension (low blood pressure), airway swelling, neurological toxicity (here tachycardia as relied upon by the IC); and

- Significant or progressive hematologic toxicity, particularly identified fibrinogen or platelet levels.

Exhibit 11 also indicates that if a limb was bitten, it should be elevated to keep tissue swelling from exacerbating. In this instance, no testimony was sought nor provided as to whether the patient's leg (the bite was on her knee) was elevated, and undersigned did not find such a reference in the Humbolt General Hospital Records submitted as **IC Exhibit 6.**

IC Exhibit 12 establishes that "more severe" envenomization systemic symptoms include hypotension, bleeding, angioedema, vomiting, and neurotoxicity (also noting that the vomiting can arise from an autonomic response to fear and anxiety). The article defines "minor envenomization" as swelling and local pain at the envenomization site. Antivenom is recommended for patients with moderate to severe envenomization; thus, any time symptoms of envenomization progress, which includes swelling progressing past tissue local to the bite site and *any* signs of systemic toxicity, common signs of which are hypotension, systemic bleeding, or neurotoxicity, antivenom should be administered. If a patient is suspected of having minor envenomization, which is what Respondent relied upon by way of his testimony, one of the factors influencing the standard of care as it relates to observation includes healthcare access.

IC Exhibit 13 likewise recommends the administration of antivenom as soon as possible when there is progressive swelling *or* signs of systemic toxicity, clarifying that antivenom is appropriate when there are any symptoms beyond minor localized swelling. **IC Exhibit 13** further states that antivenom administration "is the mainstay for treatment," and that some patients may be asymptomatic at presentation but go on to develop signs of severe envenomization over time.

All three articles recommend consultation with a medical toxicologist or other physician with expertise in managing snakebites. **IC Exhibit 11** did not address potential negative impacts of administering antivenom but **IC Exhibit 12** indicated that antivenom induced hypersensitivity reactions and serum sickness occur in approximately 8% to 13%, respectively, of patients, and that providers should be prepared to treat the same with epinephrine, steroids, antihistamines, or emergency airway management. **IC Exhibit 13** notes that serum sickness occurs in about 2-3% of patients (or up to 8% per **IC Exhibit 12**), and that the risk of an allergic reaction is less than 1% (or up to 13% per **IC Exhibit 12**). *See* TR 218.

5. <u>Findings</u>

Count 1, NRS 630.301(4) - Malpractice

Undersigned finds that Respondent committed malpractice, primarily for Respondent's failure to treat the patient's diminishing condition, but also based upon Respondent's failure to recognize tachycardia in a patient suffering from a snakebite. While the malpractice claim was also based upon Respondent's failure to recognize hypotension in conjunction with the snakebite as a sign of systemic toxicity, because there were no records of hypotension from Humboldt General Hospital (as addressed further below), the only testimony as to such was Respondent's testimony that it was monitored, not present, and would have been treated had it occurred. TR 162-163; 205-06. Given the inability to address recognition of hypotension in relation to the snakebite outside of Respondent's testimony because of the lack of documentation or other testimony, giving Respondent the benefit of the doubt, this factor is not deemed to support the malpractice count; however, remaining factors do.[7]

Starting with the tachycardia, tachycardia was noted in the Humboldt General Hospital medical records and was indicated as a potential consequence of the traumatic circumstances, which alone and without the impact of a snakebite could excuse concern, but in conjunction with the snakebite, and in consideration of Respondent's own observations that that patient was calm and did not appear to be in distress, the tachycardia was a legitimate concern and should have

[7] Respondent acknowledged that both the tachycardia and hypotension would have been cause for concern with regard to envenomization. TR 210

been considered in evaluation of systemic toxicity. TR 105-106; 165; 176.

Even more concerning was Respondent's failure to administer antivenom, which is attributable to the Complaint allegation of failure to treat the patient's diminishing condition. While Respondent and his expert Dr. Levin attempted to minimize the impact of the failure to administer the antivenom by relying on the labs and deeming the patient's condition stable, the articles that outline the standard of care, which were consistent with Dr. Glissmeyer's testimony, plainly indicate that any sign of swelling beyond the bite site or any sign of systemic toxicity, should be treated as soon as possible with antivenom.[8]

Here, even by Respondent's own testimony, the patient was tachycardic; the swelling at the bite site increased by 25% (TR 168; 211); and, even though he denied it, the cross-examination and the records show that there was mottling at the bite site (TR 193; 211-212; **Exhibit 6** NSBME 079). In attempting to minimize the importance of the increased swelling and tissue damage, Respondent testified that the swelling never extended past the patient's knee and much was made about whether the swelling was sufficient to pass through the ankle (*see, e.g.*, TR 124; 193), but that is not the standard for administration of antivenom. The standard is whether swelling increases past the bite site and that occurred. Moreover, contrary to Respondent's testimony, the swelling increased past the knee and extended through the patient's thigh and lower leg. TR 124 (Dr. Glissmeyer addressing the relevant patient record from Humboldt General Hospital) versus TR 169 (Respondent testifying to substantially less swelling than noted on the records). Notably, Humboldt General Hospital records read as follows:

> Patient had two puncture marks on the anterior left knee. A circle was drawn on the area indicating initial swelling and ecchymosis upon arrival to the ER. There was a small amount of ecchymosis around the wound as well as extending past the circle approximately one inch. *Current swelling was extended to the entire extremity. The patient's leg was approximately three times the size of the opposite leg. The knee had swollen to the same extent. Streaking was noted on the medial thigh. CMS was noted in all extremities, although the patient's left leg was weak and she was unable to move it without assistance.* Providers limited the movement of the extremity.

---

[8] Dr. Levin testified to having only ever treated two snakebites and, in doing so, had transferred the patients to nearby hospitals for the administration of antivenom. TR2 31; 42.

Exhibit 6 NSBME 084 (emphasis added).

The time of the assessment quoted above is referenced as 19:00 hours (7:00 p.m.), with the patient having been discharged from Humboldt General Hospital at 18:32 hours (6:32 p.m.), and departing at 18:52 hours (6:52 p.m.), only eight minutes prior to the notation of the patient's condition as quoted. Given the timing, such symptoms would have manifested under Respondent's care (TR 169-170; 193-194), particularly where the patient did not initially present with any such findings. TR 167; Exhibit 6 NSBME 034) (As noted by Respondent at 16:24 hours (4:24 p.m.): "On the anterior left knee there are 2 puncture wounds which are likely the site of envenomation and there is just a small amount of ecchymosis noted in that generalized area. No significant edema, no streaking, no skin necrosis, no peripheral edema, no petechiae, no vesicles ulcers or pustules"). To emphasize this, Respondent stated in his transfer call to Renown physician Dr. Gassen that the swelling was visually increasing – such call being placed at approximately 17:56 hours (5:56 p.m.) (TR 52), which was 36 minutes prior to discharge (18:32 hours or 6:32 p.m.) and 56 minutes prior to the patient's departure (18:52 hours or 6:52 p.m.). TR 53.

Furthermore, in failing to treat the patient's diminishing condition, Respondent failed to account for the travel time that the patient was required to endure prior to arriving at Renown. Even though Respondent acknowledged the chance that the patient's condition could deteriorate during transport (TR 192-193), Respondent had the patient transported by ground even though air transport was readily available. TR 184-186. Respondent initially indicated it was the patient's mother's preference that the patient be transported by ground given that the mother could not ride with the patient if the patient was transported by air, but Respondent made clear that it was his decision and he felt that the patient was stable enough to go by ground despite the time difference in transport by air. Id.

Undersigned takes notice that the mileage between Humboldt General Hospital and Renown is 166.9 miles. Per the patient's records, the ground travel took approximately 2 hours and 37 minutes. Comparatively, air transport, as was estimated by Respondent, would have taken one hour. TR 222. Although Respondent deemed ground transport appropriate, Respondent

acknowledged that if the mode of transport was determinative he would have insisted on air transport. TR 187; 221-222.

The administration of antivenom sooner rather than later for anything more than minor envenomization, which can present hours after an initial assessment, is the crux of the applicable standard of care for a snakebite. *See, e.g.* **Exhibits 11-13.** Respondent was aware of the importance of monitoring the patient, which was the basis for transfer when the admitting physician for Humboldt General Hospital, Dr. Thorpe, would not permit admission. TR 177-178; 181-182; 192; 224-225.

With respect to transfer versus mode of transport in particular, Dr. Glissmeyer, Respondent, and Dr. Levin all seemed to agree that the decision to transfer a minor patient was up to the parent but the mode of transport was up to the treating physician. TR 144 (Dr. Glissmeyer: "How the patient is transferred regardless of what parents want is what - - is in the decision-making ability of the physician."); TR 187 (Respondent: "if I thought that the decision between helicopter or ambulance was going to make a critical difference in the patient's outcome, I would have insisted that she go by helicopter with or without the mother"); TR2 19; 42-43 (Dr. Levin: "In general, you need parental consent for some procedure or transfer, et cetera, but you do what's in the best interests of the patient if you are unable to get parental consent," and also testifying that it would be appropriate to factor in travel time for treatment).

Here, given the tachycardia, increased swelling, and the prior documented vomiting (*see* **IC Exhibit 6** NSBME 034; **Exhibit 12**), transporting the patient by ground when air transport was available and time was of the essence to administer antivenom additionally fell below the reasonable standard of care.[9]

Respondent attempted to justify not administering the antivenom prior to transport by claiming that antivenom needed to be administered in a hospital setting for continued monitoring, which could not be provided at Humboldt General Hospital given that admission was denied by Dr. Thorpe. TR 178-182; 187-191. Respondent also attempted to justify not administering the

---

[9] Dr. Levin was particularly ineffective in refuting this finding in that Dr. Levin had no idea of the distance at issue nor the timing as between ground and air transport and surmised that ground transport in this situation would have been "the easiest and fastest." TR2 22; 42.

1 antivenom prior to transport by claiming concern for an adverse reaction and weighing that risk
2 against the administration. Id. Both purported bases are unsupported.
3 When Respondent was asked about whether antivenom was available to administer, his
4 answer was "I cannot say for sure." TR 216. Respondent also testified that the administration of
5 antivenom required preparation and takes approximately an hour or two to administer, and that
6 out of 15 to 20 prior snakebite patients Respondent had treated, he had administered antivenom to
7 approximately two-thirds; thus, Respondent was familiar with its administration. TR 155; 188.
8 Respondent was also clear that Humboldt General Hospital had the medications necessary to treat
9 any severe allergic reaction to antivenom had he chosen to administer it and an adverse reaction
10 took place. TR 216.
11 When asked about the availability of antivenom by undersigned, Respondent indicated that
12 he assumed it was available and that, if it was not available, antivenom could have been retrieved
13 from another health care facility. TR 231. Respondent also testified that despite a lead time of 15
14 to 30 minutes prior to the patient's arrival, he never checked to confirm whether any antivenom
15 was available. Id. When additionally inquired of by IC counsel if the first dose of antivenom
16 could have been administered and then the patient transported, Respondent's answer was
17 "[e]verything is possible. I mean, sure, that is within the realm of possibility, yes." TR 227.
18 Per the literature submitted as **IC Exhibits 11-13**, as well as indicated by Respondent's
19 own testimony, an initial dose of antivenom could have been administered while the patient was
20 in Respondent's care, and Respondent had available all the resources necessary to deal with an
21 adverse reaction, the chances of which were low, contrary to Respondent's testimony of them
22 being much higher than the submitted literature supported (a variation as to which Respondent
23 presented no authority to substantiate). *See* TR 190, whereat Respondent claims there is "a
24 significant risk of adverse reactions with antivenom" and claiming it could be as high as twenty
25 percent; *but see* TR 58; 60, whereby Dr. Glissmeyer testifies that there are no "absolute"
26 contraindications to antivenom and that the biggest consideration is whether a patient has received
27 antivenom prior and had an allergic reaction, a scenario not at issue in the present matter, and
28 testifying that the chances of an initial allergic reaction are small and that any medication poses

the risk of an allergic reaction. Per Dr. Glissmeyer, there were no contraindications that should have been concerning with respect to administering antivenom for this particular patient. TR 79. Dr. Glissmeyer also made it clear, and such testimony was uncontroverted, that antivenom could be administered at locations even outside of a hospital but certainly in emergency departments and emergency centers. TR 57.

Upon an initial dose of antivenom, maintenance dosing is to be undertaken every six hours if necessary. **IC Exhibits 11-13**. To that end, an initial dose of antivenom could have been administered and the patient could have been monitored for any adverse reaction and, assuming none, transport could have been completed before any maintenance dosing was to take place. Alternatively, had there been an adverse reaction, Respondent could have addressed it by his own account. TR 216.

Given the progressive swelling and tissue damage in addition to a known and recognized sign of systematic envenomization as indicated herein (specifically tachycardia), Respondent's failure to administer the antivenom was below the required standard of care and that conclusion cannot be overcome by a false claim of an inability to monitor the patient or a claim that the failure to administer the antivenom was properly weighed against the risk of an adverse reaction, particularly given the travel time and the known risk of the patient's condition deteriorating in transit. TR 193; 224-225; 227. The patient's symptoms made it clear that the bite was not a "dry bite" and that envenomization was occurring. There was even sufficient concern by another health care professional, specifically a nurse, to suggest to Respondent that the antivenom be administered. TR 232-233.

Given that the applicable standard of care for a snakebite contemplates the administration of antivenom for progressive swelling or tissue damage beyond the bite location or where a patient demonstrates any sign of systemic envenomization, and the sooner the antivenom is administered, the better, it was incumbent upon Respondent to have administered the antivenom. Respondent's failure to timely administer the antivenom was then compounded by his failure to transport the patient by the fastest means possible, which was by air.

///

Notably, in the conversation between Renown physician Dr. Gassen and Respondent with respect to the patient's transfer to Renown (*see* Respondent's **Exhibit 7**), which is addressed in more detail below, Respondent indicated that he "was on the fence" about administering antivenom and further indicated that the swelling was growing visually before his eyes. Given the ongoing increased swelling, not to mention the vomiting, complaint by the patient of the "owie" on her knee reasonably indicating pain (Id.), the tachycardia, and in consideration of the length of time it was going to take to transfer the patient by ground (or even by air given the distance to Renown), Respondent took an unwarranted gamble by not administering the antivenom, which would have not only treated the effects already happening but prevented the progression. TR 66. I submit that a reasonable physician under the same or similar circumstances would have erred on the side of caution and hedged their bet by administering the antivenom, particularly given the length of time the transport required. Even Dr. Levin, Respondent's expert, testified that in the same circumstances he "might have given it," which is about as much of a concession as one can expect from a retained defense expert. TR2 36.

Count II, NRS 630.306(1)(b)2) – Violation of Standards of Practice Established by Regulation – Failure to Consult

As cited in the Complaint, 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." This may be considered a violation of NRS 630.306(1)(b)(2), which constitutes discipline for the violation of a standard of practice established by regulation – the NAC (Nevada Administrative Code) establishing the consultation regulation.

Notably, witnesses were never questioned as to whether they deemed this matter to constitute a "doubtful or difficult case" so one can only attempt to glean such from the record. In relation to which, Respondent on the one hand indicated that he felt sufficiently qualified to address the snakebite without consulting a toxicologist (TR 184); yet, on the other, Respondent indicated that he was "on the fence" about administering antivenom. **Respondent's Exhibit 7**; TR 117.

1 The fact that Respondent was "on the fence" indicates that he could have benefited from
2 consulting a toxicologist, as to which all three articles on the standard of care admitted as **IC**
3 **Exhibits 11-13** advise. **IC Exhibit 11** ("Early medical toxicology consultation is encouraged");
4 **IC Exhibit 12** ("Consultation with a local toxicologist familiar with envenomations or poison
5 control center is recommended to assist in patient management."); **IC Exhibit 13** ("Consultation
6 with a medical toxicologist or other physician with expertise and prior experience treating
7 venomous snakebites is strongly encouraged **before** initiating antivenom therapy" and
8 recommending antivenom for patients with progressive swelling or signs of systemic toxicity).

9 To attempt to avoid the conclusion that Respondent failed to consult, Respondent offers
10 that he consulted with Dr. Gassen of Renown as reflected in **Respondent's Exhibit 7**. According
11 to Respondent, his discussion of the background of the patient's medical condition, and Dr.
12 Gassen's silence about possible concerns regarding Respondent's treatment to that point, was
13 implicit accord as to Respondent's care. TR 183-184. Dr. Glissmeyer, in interpreting the same
14 conversation, deemed it a "hand-off" and not a consultation. TR 85.

15 Relevant to this contention, there is nothing in the record to indicate Dr. Gassen's
16 experience, if any, with envenomization.[10] While the applicable NAC provision only provides to
17 "consultation with another provider of health care," it is axiomatic that consulting with another
18 health care provider who cannot lend any expertise to "enhance the quality of medical services"
19 defeats the point of the regulation. In that respect, each of the articles regarding the issue of
20 consultation recommend consulting a medical toxicologist or a resource of equivalent value.

21 Consultation also implicates asking for advice or an opinion. *See* Black's Law Dictionary
22 (11th ed. 2019), defining consultation as the act of asking the advice or opinion of someone or a
23 meeting in which parties consult or confer. Consultation as defined by the Oxford Languages
24 Dictionary defines consultation as a meeting with an expert or professional to seek advice. The
25 Cambridge Dictionary defines consultation as "the act of exchanging information and opinions
26 about something in order to reach a better understanding of it or to make a decision, or a meeting
27

28 [10] Dr. Gassen is apparently an ER pediatric physician per Respondent's Exhibit 6, which is the recording of a nurse's call to the Renown Transfer Center.

for this purpose."

As the recording of the conversation with Respondent and Dr. Gassen reflects (**Respondent's Exhibit 7**), the only query posed by Respondent other than asking Dr. Gassen to repeat his name was "I was wondering if I could send her to you to be watched?" Respondent also stated that he was "on the fence" about administering antivenom but that "I don't think there's any emergency to give her antivenom at this point." Respondent also definitively stated "she is coming by ground." None of which sought consultation about administering antivenom or the mode of transport.

Respondent also testified that he gave Dr. Gassen "a good and complete report of the patient's presentation" (TR 183) but, as to the patient's vitals, Respondent only indicated that "vital signs are good," thus failing to address the tachycardia and giving no indication of blood pressure, which was known to be low during transport and which was not documented while the patient was at Humboldt General Hospital. With that, Respondent testified that Dr. Gassen "agree[d] that antivenom wasn't indicated at this moment but we were considering it." TR 183. However, there was no such agreement and, when Respondent's testimony was clarified, Respondent testified that Dr. Gassen had the opportunity to ask Respondent to do something and Dr. Gassen did not do so. Id.

I find that Respondent called Dr. Gassen to facilitate a transfer of the patient and that is what took place. At no time did Respondent seek advice as to the administration of antivenom or transport and instead made conclusory statements about both. **Respondent's Exhibit 7**. Nor did Dr. Gassen "agree" with Respondent's decision not to administer antivenom. TR 183. Respondent took silence as agreement. TR 184. Silence, however, does not equal agreement – that was an assumption not supported by the actual conversation. Had Respondent truly intended to seek to enhance the quality of the medical services he sought to provide via consultation, it was incumbent upon him to actually seek consult and not just provide background he found relevant to the patient's transfer.[11]

---

[11] Dr. Thorpe was only consulted regarding admission and had no experience to consult on envenomization. TR 177-178; 181-182.

Count III, NRS 630.3062 – Failure to Maintain Appropriate Medical Records

I find that the patient's increased heart rate, the medical term for which is tachycardia, was properly reflected in the patient's medical records given that the patient's heart rate was recorded and where it was high was noted with an "h." The use of the exact term "tachycardia" does not preclude the fact it was recorded and that the patient being tachycardic is readily apparent to a medical professional able to interpret such records. TR 69-71.

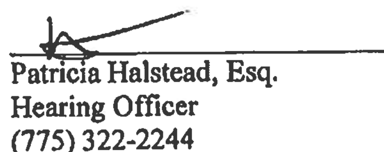
Turning to blood pressure, which was not noted in relation to the treatment records related to Respondent (*see* TR 204), Respondent places blame upon the nurses for failing to record it. TR 162; 204-205; 208. However, NRS 630.3062 requires *Respondent* to be responsible for maintaining complete medical records "relating to the diagnosis, treatment and care of a patient."

To the extent blood pressure is relevant to the care and treatment of a snakebite patient, which it is given concerns regarding hypotension (*see* TR 210, whereby Respondent acknowledges low blood pressure and a high heart rate would be a cause for concern), it was incumbent upon Respondent to have recorded the patient's blood pressure and, to the extent he relied upon blood pressure readings, which he indicates he did and that they were normal, it was necessary for him to maintain a record of such himself so that the veracity of his representation could be substantiated.

6. Recommendation

Based upon the foregoing, I respectfully submit that the IC has met its burden by a preponderance of the evidence and that Respondent, Jason Howard Lasry, M.D., be found by the Board to have committed malpractice; failed to have consulted; and failed to have maintained complete records for the reasons set forth herein. I defer to the Board as to the appropriate sanction.

DATED this 7th day of November 2023.

By: 

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

9171 9690 0935 0241 5578 34

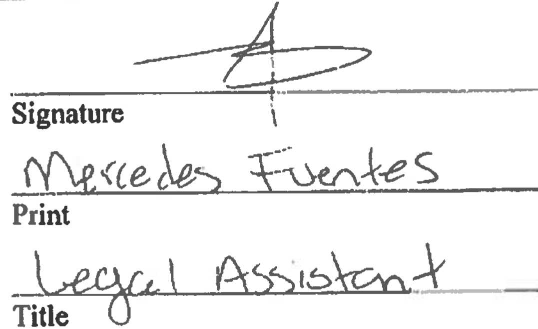
CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing FINDINGS AND RECOMMENDATION addressed as follows:

William P. Shogren
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Jason Howard Lasry, M.D.
c/o Robert C. McBride, Esq. and
Chelsea R. Hueth, Esq.
McBride Hall
8329 West Sunset Road, Ste 260
Las Vegas, NV 89113

DATED this 8th day of November 2023.



Signature

Mercedes Fuentes
Print

Legal Assistant
Title