BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **ANDREW JACKSON WELCH, M.D.,** **Respondent.**	**Case No. 24-5474-2**

FILED
JUL 15 2024
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 Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Andrew Jackson Welch, 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. 3713). Respondent was originally licensed by the Board on December 2, 1978.

2. Patient A[2] was a sixty-two (62) year-old female at the time of the events at issue.

3. Patient A had a history of circulatory problems since 2014, including two (2) femoral popliteal bypasses and six (6) stents to her left lower extremity.

4. On or about May 19, 2018, Patient A was transferred from Kingman Regional Medical Center in Kingman, Arizona to Desert Springs Hospital ("DSH") in Las Vegas, Nevada and was evaluated by an APRN at DSH for abnormal left leg pain and a swollen left foot.

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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 Victor M. Muro, M.D., Ms. April Mastroluca, and Weldon Havins, M.D.

[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.

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5. On or about May 23, 2018, Respondent was consulted as a surgeon on Patient A's condition. Patient A was diagnosed with an arterial occlusion of the left lower extremity and underwent a left below-knee amputation on May 29, 2018, by Respondent. Patient A was then discharged by DSH on June 4, 2018, under the care of a home health practitioner.

6. Upon information and belief, Respondent did not document his review of any testing and failed to document whether or not he had a conversation with Patient A about the risks and benefits of the proposed amputation of her left lower extremity.

7. In Respondent's allegation response he indicated there was contact made by Respondent, or his office, with Patient A on June 11, 2018, June 18, 2018, June 20, 2018, and July 2, 2018. On July 9, 2018, the home health practitioner advised Respondent that they sent Patient A to the emergency room due to concerns of septic shock from her wounds from the amputation.

8. Patient A arrived at Kingman Regional Medical Center on July 9, 2018, by ambulance with purulent drainage from her wound and pain secondary to ischemic necrosis at the amputation site. She was then transferred back to DSH under the care of Respondent.

9. On July 12, 2018, at 1:48 p.m. Respondent performed a debridement of Patient A's necrotic tissue using Bupivacaine, a local anesthetic while Patient A was complaining of pain. The entire surgery consisted of local anesthetic delivery and sharp dissection of the eschar at the amputation site.

10. According to medical records, the surgery began at 1:48 p.m. and was completed by 2:01 p.m., thirteen (13) minutes after Respondent began the surgery, not allowing enough time for the local anesthetic to become effective before performing the debridement of the wound. Additionally, there was no documentation as to Respondent's reasoning to elect local anesthetic versus the use of an anesthesiologist and general anesthesia, regional anesthesia, or deep sedation.

11. Portions of DSH operative records indicate that a local anesthetic was used, but in the narrative about the technique in the Operative Report presumably written by Respondent, the record states "general" anesthesia was used. Meanwhile in Respondent's records, the same

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Operative Report from DSH where the word "general" that was typed into the technique portion of the report has, by handwriting, been crossed out and the word "local" written above it.

COUNT I

NRS 630.301(4) - Malpractice

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

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

14. 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."

15. 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 he failed to allow enough time for the local anesthetic to become effective before performing debridement on Patient A's wound at her amputation site. Additionally, the volume of the local anesthetic, Bupivacaine, that was actually injected into Patient A was not documented.

16. 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 Proper Medical Records

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

18. 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.

19. Respondent failed to maintain complete and accurate medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document his review of any testing prior to Patient A's amputation and failed to document whether or not he had a

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conversation with Patient A about the risks and benefits of a proposed amputation of her left lower extremity. Additionally, there was no documentation as to Respondent's medical reasoning for determining if an anesthesiologist could not be present to provide either general anesthesia, regional anesthesia, or deep sedation. Further, there was omission of the site of the eschar and necrotic tissue and size of the overall wound. Moreover, there was an alteration to Respondent's version of the medical records from DSH that was not corrected with the hospital.

20. 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

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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 15th day of July, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 15th day of July, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
CHOWDHURY H. AHSAN, M.D., Ph.D., FACC
Chairman of the Investigative Committee

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