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: FRANK JOSEPH DE LEE, M.D., Respondent.	Case No. 24-6109-1

FILED
AUG 15 2024
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 Sarah A. Bradley, Deputy Executive Director and attorney for the IC, having a reasonable basis to believe that Frank Joseph De Lee, 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. 4126). Respondent was originally licensed by the Board on October 4, 1980.

Treatment of Patient A

2. Patient A[2] was a forty-two (42) year-old female at the time of the events at issue.

3. On or about October 2016, Patient A began seeing Respondent for gynecological care, specifically her "heavy periods."

/ / /

[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., Aury Nagy, M.D., and Col. Eric D. Wade, USAF (Ret.)

[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.

4. On March 23, 2018, Patient A was seen at the Henderson Hospital Emergency Department and treated for pelvic inflammatory disease.

5. On March 23, 2018, Patient A's white blood count was 15.17×10^3.

6. Upon information and belief, this white blood count is consistent with moderate pelvic inflammatory disease heading toward severe pelvic inflammatory disease.

7. Patient A had a vaginal culture while at the hospital which revealed Gardnerella.

8. Patient A did not receive culture or testing for gonorrhea or chlamydia.

9. Patient A was discharged from the hospital and given doxycycline 100 mg to take daily by mouth.

10. Patient A was told to follow up with Respondent who is her regular gynecologist.

11. On March 26, 2018, Patient A was seen at Respondent's office for an evaluation of her pelvic pain and heavy menses.

12. At this visit Respondent did not document that he completed a thorough history and physical in Patient A's medical records in that visit.

13. Respondent only noted that Patient A was experiencing pelvic pain and heavy periods and that he recommended a total abdominal hysterectomy without developing a differential diagnosis.

14. Respondent did not document any possibility that Patient A had pelvic inflammatory diseases, a pelvic infection, or a pelvic abscess.

15. Respondent further did not document the quality of Patient A's pelvic pain, such as whether it was acute, chronic, stabbing, or radiating.

16. Respondent did not note in Patient A's medical records the timing of her pelvic pain or the provocative/palliative and precipitating/relieving causes of her pelvic pain.

17. Respondent also did not address the etiology of Patient A's pelvic pain in her medical records.

18. Respondent only noted in Patient A's medical records that her pelvic pain was severe and did not document a pain scale.

/ / /

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

19. Respondent reviewed a pelvic ultrasound for Patient A which revealed bilateral simple ovarian cysts, with no uterine masses or fibroids.

20. Based on Patient A's pelvic pain and heavy menses, Respondent recommended that she undergo a total abdominal hysterectomy bilateral salpingo-oophorectomy.

21. Part of the standard of care when providing care to a patient is to discuss the risks, benefits, alternatives, and possible outcomes of a recommended treatment and/or procedure. This discussion should be documented in the patient's medical records.

22. There is no documentation in Patient A's medical records that Respondent had a discussion with Patient A of the risks and benefits of keeping her ovaries versus having them removed prior to her surgery on May 7, 2018.

23. Accordingly, Respondent's documentation of Patient A's medical condition, possible diagnoses, and possible treatment in her medical records is lacking and inadequate.

24. Upon information and belief, Respondent should have treated Patient A for a progressive pelvic infectious process and pelvic inflammatory disease at this time.

25. Upon information and belief, Respondent should have considered providing Patient A with IV parenteral antibiotic therapy at this time.

26. On May 7, 2018, Respondent operated on Patient A and performed a total abdominal hysterectomy, bilateral salpingo-oophorectomy, supracervical I hysterectomy.

27. Patient A's pre-operative white blood count was 19.11×10^3, which is a high level of white blood cells.

28. Respondent did not address Patient A's high white blood count prior to her elective surgery procedure in Patient A's medical records.

29. Accordingly, there is no evidence that Respondent discussed Patient A's high white blood count with her prior to her surgery or that Patient A was even aware of her high white blood count prior to her surgery.

30. Given Patient A's history of treatment for pelvic inflammatory disease in March 2018 and Patient A's high white blood count, Respondent should have suspected that Patient A still had a pelvic infection on May 7, 2018, and treated that infection prior to her surgery.

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

31. Upon information and belief, Respondent should have cancelled Patient A's surgery on May 7, 2018, after seeing her high white blood count (19.11 x 10^3) and admitted Patient A into the hospital and initiated IV parenteral antibiotics.

32. In addition to Patient A's high white blood count, her platelets were elevated on May 7, 2018 (729 x 10^3).

33. There are many reasons that a patient may have elevated platelets, but the most common reason is infection.

34. Upon information and belief, Patient A's elevated platelets were an additional sign that she was suffering from an infection and Respondent should have postponed her elective surgery until after her infection was adequately treated with parenteral IV antibiotics.

35. Upon information and belief, Patient A had a pelvic infection on May 7, 2018, that was present prior to and after her surgery.

36. Upon information and belief, this infection developed into severe sepsis and abscess formation.

37. Accordingly, given Patient A's white blood count and elevated platelets, Respondent failed to use the reasonable care, skill, or knowledge ordinarily used by physicians under similar circumstances when he proceeded with Patient A's elective surgery on May 7, 2018.

38. Patient A received prophylaxis clindamycin by IV as documented in the anesthesiologist's note in her medical records.

39. Respondent checked a box in Patient A's medical records indicating that he had reviewed her history and physical and had examined her. Respondent further indicated that there was no change to her history and physical.

40. A post-operative note for Patient A showed that her urine output was clear and 25–30 cc, which is a low urine output.

41. On May 8, 2018, Patient A's white blood count was 23.7 x 10^3, hemoglobin 7.7 gm/dl. This is a high white blood count, and it had increased from the previous day, May 7, 2018.

///

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

42. Patient A's hemoglobin of 7.7 on May 8, 2018, indicated that she had severe anemia.

43. On May 10, 2018, Patient A was discharged from the hospital and received Percocet and Premarin.

44. Patient A did not receive antibiotics with her discharge.

45. Given Patient A's high white blood count, Patient A should have received post-operative antibiotics with her discharge.

46. Given Patient A's anemia, Patient A should have also received treatment for her anemia post-operatively.

47. On May 14, 2018, Patient A saw Respondent for a post-operative follow-up visit, with complaints of incisional pressure.

48. Respondent noted in Patient A's medical record for this visit "doing good, incision is healing. RTO in 2 weeks."

49. On May 29, 2018, Patient A saw Respondent for a follow-up visit, with complaints of abdominal pain, constipation, and pelvic pain. Respondent recommended for her to return for a follow up in one week.

50. On June 5, 2018, Patient A, as recommended, saw Respondent for a follow-up visit, with complaints of painful numbness in her leg and a left-sided abdominal lump. At this visit Respondent ordered a pelvic ultrasound for Patient A.

51. On June 6, 2018, Patient A had a pelvic ultrasound. The pelvic ultrasound revealed a 6.1 x 4.8 cm hypoechoic collection in the left lower quadrant anterior wall, which may represent a hematoma or seroma.

52. On June 7, 2018, Patient A was taken to the Henderson Hospital Emergency Department.

53. On June 7, 2018, Patient A's white blood count was 24.95 x 10^3 and she was suspected to be suffering from sepsis and possible strangulation of a ventral hernia.

54. A CT scan of Patient A's abdomen further revealed an abdominal wall abscess and an intraabdominal abscess and Patient A was taken to the operating room (OR) for surgery.

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

55. The OR physicians, Dr. D and Dr. C, described finding an abscess in Patient A's abdominal wall, which was an intra-abdominal process through a defect in the fascia; copious clear fluid mixing with purulent material was found in the abscess.

56. Dr. D and Dr. C also found a 4 cm laceration on the dome of Patient A's bladder.

57. Patient A's bladder was sewn to her rectus muscle and the rectosigmoid posteriorly.

58. Upon information and belief, Respondent injured Patient A's bladder during her surgery on May 7, 2018.

59. Generally, when performing a hysterectomy, a physician will create a bladder flap or develop an incision above the bladder to advance the bladder. This involves dissecting the vesicouterine peritoneum with scissors and advancing, in order to develop a bladder flap and protect the bladder from injury. The bladder is then advanced either by sharp dissection or by gently pushing the bladder inferiorly by applying pressure with a sponge stick pressing on the cervix. This operative step, and the manner it is completed by the physician, should be documented in the operative notes for the patient.

60. In Patient A's medical records for her surgery on May 7, 2018, Respondent did not describe this operative step.

61. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used by physicians under similar circumstances when he sutured Patient A's bladder to her rectus muscle and sutured Patient A's bladder to her rectum and sigmoid colon as found by Dr. D and C on June 7, 2018.

62. Upon information and belief, suturing Patient A's bladder to her rectus muscle and suturing Patient A's bladder to her rectum and sigmoid colon is evidence that Respondent provided substandard care to Patient A.

63. Throughout his care of Patient A, it is not clear what Respondent's possible diagnoses and/or differential diagnoses are for Patient A based on her symptoms and blood work, as Respondent failed to document any notes, diagnosis, or assessments related to Patient A's symptoms, ongoing complaints and test results.

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

64. On June 7, 2018, Patient A, while at the hospital, received three antibiotics by IV in order to combat her infection.

65. On June 21, 2018, Patient A was discharged after spending fourteen (14) days at Henderson Hospital.

Treatment of Patient B

66. Patient B[3] was an eighteen (18) year-old female at the time of the events at issue.

67. On November 18, 2019, Patient B was transported to North Vista Hospital by ambulance and was admitted to the Emergency Department and triaged.

68. Patient B was thirty-three (33) weeks pregnant at this time, with an estimated due date of January 6, 2020.

69. Patient B complained of abdominal pain both in the ambulance and to North Vista Emergency Department staff.

70. Patient B's temperature was normal, but her pulse was elevated.

71. North Vista Hospital Emergency Department staff recorded Patient B's temperature as normal and her pulse being at 117 beats per minute (BPM), and then elevating to 138 BPM. Patient B also began to have abdominal cramping.

72. North Vista Hospital Emergency Department staff were concerned that Patient B was in pre-term labor and discussed transporting Patient B to University Medical Center, where her obstetrician, Dr. M., works, so that Patient B and her fetus may receive a higher level of care.

73. On November 18, 2019, at approximately 9:08 p.m., Patient B experienced a spontaneous rupture of membranes with bloody fluid.

74. A North Vista Hospital Emergency Department nurse placed her hand in Patient B's vagina to prevent vaginal delivery and to attempt to prevent prolapse of the cord.

75. At this time, Patient B's pulse was 138 BPM and she was experiencing contractions every three (3) minutes.

76. At approximately 10:22 p.m. on November 18, 2019, Respondent was called by the North Vista Hospital Emergency Department to come to the hospital to provide care for Patient B.

[3] Patient B'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.

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

77. Patient B was now experiencing pre-term labor with premature rupture of membranes with bloody fluid, tachycardia, with a footling breech.

78. At approximately 11:00 p.m. on November 18, 2019, Patient B is transported by gurney into the operating room at North Vista Hospital for an emergency C-section.

79. At approximately 11:21 p.m. on November 18, 2019, Patient B is evaluated by Dr. C, an anesthesiologist.

80. At approximately 11:24 p.m. on November 18, 2019, Respondent arrived and evaluated Patient B.

81. This is one hour and two minutes after he was called to provide care for Patient B.

82. The following was noted in Patient B's medical records: "@2320 Patient into OR for emergency c-section, respiratory team in room. Baby out at 2330. Surgery done. Foley inserted at 2344. Abdominal x-ray s/p surgery per Dr. DeLee. Transport for baby and mother called for by ER charge nurse. Patient appears pale, tachycardic, hypotensive. Uterus firm-bleeding noted-2 pads saturated with blood. Anesthesia—Surgeon continue to massage uterus. PACU nurses in room to recover patient. Pt. clean and put in diaper. Pt. stable and awaiting transport."

83. Patient B was then transported to Sunrise Hospital and would eventually be evaluated by Dr. G.

84. Patient B's hemoglobin at this time was 5.1 gm/dl, and was in need of a blood transfusion.

85. While waiting for a blood transfusion, Patient B became unresponsive and code blue was activated. While Patient B did not lose her pulse, the code was activated because of her critical care need.

86. At this time, Patient B had marked lethargy but was arousable.

87. Respondent was notified and aware of Patient B's transfer.

88. Respondent determined that Patient B did not need to return to the operating room at this time.

///

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

89. Upon evaluation, Dr. G. indicated that Patient B had hemorrhagic shock, acute bleeding, possible disseminated intravascular coagulopathy or HELLP syndrome (hemolysis, elevated liver proteins, and low platelets).

90. Dr. G. initiated massive transfusion protocol with aggressive resuscitation and described her prognosis as "overall very guarded."

91. Dr. G. indicated a need to consult with hematology, obstetrics, nephrology, and neurology for Patient B's care.

92. On November 19, 2019, at approximately 10:00 a.m., Patient B received a computed tomography angiogram (CTA) of her abdomen and pelvis with contrast.

93. This CTA revealed a large hemoperitoneum with acute contrast extravasation which originates in the right parametrial region.

94. On November 19, 2019, at approximately 10:20 a.m., Patient B received a computed tomography angiogram (CTA) of her chest with contrast.

95. This CTA showed no evidence of pulmonary emboli. It showed bilateral extensive consolidations, more prominent in the dependent aspect. These findings may be due to severe pulmonary edema, aspirations, or acute respiratory distress syndrome (ARDS).

96. On November 19, 2019, at approximately 10:33 a.m., Patient B received a computed tomography (CT) of her brain without contrast.

97. The CT showed that she had a left cerebral acute or chronic subdural hematoma.

98. On November 19, 2019, at approximately 11:49 a.m., Dr. S. signed a note indicating that Patient B had thrombocytopenia likely due to disseminated intravascular coagulation (DIC) and severe sepsis and consumption. Dr. S. also noted "macrocytic anemia, DIC, leukocytosis, septic/hemorrhagic shock vasopressors per cc."

99. At Sunrise Hospital on November 19, 2019, Respondent authored a note documenting the transfer of Patient B from North Vista Hospital. Respondent stated, "Blood loss less than normal for cesarean section and the patient seemed to tolerate it well. I received a phone call from Anesthesia (North Vista Hospital) that the patient was slightly tachycardic and after discussing the case with him, it was his decision that the patient was stable for transport. She was

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

transported to Sunrise Post Anesthesia Care Unit on Labor and Deliver at which time she was talking with the nurse and appeared stable. She was pale and slightly tachycardic with a blood pressure at 80/40's. Blood was ordered and her H and H was 5.5 and 16. I received a phone call from Dr. D. telling me of the plan. I received a second phone call that the patient was stable and somewhat lethargic, and they were waiting for the blood to be transfused. Approximately 2 hours later, I received another phone call that the patient had a cardiac arrest and was being transported to the ICU. At this time the intensivist were taking care of the patient. I received another phone call from the intensivist that that patient was having some vaginal bleeding. After talking with the doctor, it was not deemed an emergency since she has a cesarian section and birth of a baby. I arrived at the hospital and this time her belly was soft. The bleeding was not significant for a postpartum patient and at this time she had another cardiac arrest. There were multiple doctors taking care of the patient at this time and I observed for a while, talked to the family and left. 3 hours later I was told that a CT scan showed a massive amount of blood in the belly as well as a subdural hematoma. I made a call to Dr. F. and to see if he would consult on this patient and meet me in the operating room to try to take care of this problem. Unfortunately, while in the operating room, the patient coded multiple times, and finally time of death was stated as approximately 12:50, I believe."

100. Dr. F. dictated an Operative Report at 1:05 p.m. on November 19, 2019, stating "When we opened the abdomen, we emptied out 5,000 ml of blood and clots, we lifted up the uterus and could see bleeding coming from the area of the right uterine artery. At this point the patient was completely unstable and we decided to . . . see if we could control the bleeding on the right side, which appeared to be the bleeding."

101. Dr. F. and Respondent performed a subtotal hysterectomy on Patient B.

102. During the procedure, Patient B was pronounced dead.

103. Patient B's autopsy showed the following: "The history of laboratory work demonstrates progressive decrease in platelets, starting from normal, and coagulation studies demonstrate an initially somewhat elevated D-Dimer and normal other studies, with subsequent coagulation studies showing increasing abnormalities. Peripheral blood smears at different times

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

demonstrate decrease in platelets with time, but do not show microangiopathic changes in these laboratory results and peripheral smear results can be explained by significant hemorrhage, and a high number of transfused blood products which do not completely replace the blood loss."

104. Patient B's autopsy, internal examination, showed the following: "The cervix, paracervical/endocervical tissues demonstrate a significant degree of hemorrhage within the tissue itself. It is not possible to reconstruct vessels in this area as both the hysterectomy specimen and the pelvis as visualized contain surgical instrumentation, and no spare medium to large vascular structures."

105. Upon information and belief, most hospital bylaws require that an obstetrician be present within thirty (30) minutes to labor and delivery when called regarding an emergency situation.

106. Respondent's presentation to labor and delivery after one hour and two minutes does not meet this requirement.

107. Upon information and belief, Respondent injured Patient B's right uterine vessels at the time of her cesarean section.

108. This is evidenced by Dr. F. noting that 5,000 ml of blood and clots were found in Patient B's abdomen and his observation that there was bleeding coming from Patient B's right uterine artery.

109. Patient B's medical records do not document that another obstetrician/gynecologist assisted during Patient B's cesarean section.

110. Patient B's medical records do note that Patient B was in the operating room at 2320 for cesarean section and that the baby was out at 2330. This is just ten (10) minutes for the baby to be delivered.

111. The North Vista Hospital records do not contain an operative report dictated by Respondent regarding Patient B's delivery by cesarean section.

112. Upon information and belief, Respondent did not prepare an operative report regarding Patient B's delivery by cesarean section.

///

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

113. Respondent's note on November 19, 2019, at Sunrise Hospital summarizing Patient B's care from the time of her transfer from North Vista to Sunrise states "Mother was stable from cesarian section and seemed to tolerate it well."

114. However, a North Vista Hospital nurse indicated in Patient B's medical records post cesarean that Patient B "appears pale, tachycardic and hypotensive. Uterus firm. Bleeding saturated with blood. Anesthesiologist and Surgeon aware. Continued to massage the uterus."

115. The nurse's description post Patient B's cesarean does not match Respondent's.

116. Respondent does not note in Patient B's medical records that he considered drawing labs post-operatively at North Vista Hospital or performing an ultrasound post-operatively on Patient B at her bedside at North Vista Hospital in order to determine if she is experiencing intra-abdominal bleeding.

117. Respondent does not document that he considered administering misoprostol 600 mcg sublingually or 15-methylprostaglandin F-2 alpha intramuscularly) due to a post-partum hemorrhage.

118. Upon information and belief, the lack of documentation described in ¶ 116–117 is evidence at best that Respondent failed to maintain adequate and complete medical records for Patient B and at worst that Respondent provided substandard care to Patient B.

119. Respondent did not obtain post-operative laboratory testing for Patient B such as PT, PTT, INR, disseminated coagulation panel, or a urine toxicity panel.

120. Respondent did not attempt to perform uterine packing or balloon tamponade with a balloon device or a transvaginal pelvic packing device.

121. When Patient B was transferred to Sunrise Hospital, Respondent did not intervene with surgery or provide for a ready operative team to treat Patient B.

122. Respondent failed to recognize that surgical options may have helped Patient B, including evaluation of Patient B's uterus for abnormal bleeding, B-Lynch procedure, uterine artery ligation, or hysterectomy.

///

///

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

123. Post-cesarean at North Vista Hospital, according to her medical records noted by Dr. C, Patient B's systolic blood pressure was 80, her diastolic blood pressure was 40, and her heart rate was 138.

124. A systolic blood pressure less than 80 is abnormal, diastolic blood pressure less than 50 is abnormal, and heart rate greater than 120 is abnormal.

125. Two of those three were abnormal for Patient B, meaning that she was not stable to transport.

126. Upon information and belief, Respondent should not have transferred Patient B to Sunrise Hospital, and, instead, should have evaluated her at North Vista Hospital, ultimately taking her back into the operating room to evaluate hemorrhage.

127. Respondent should have ordered all of the laboratory testing and imaging studies ordered by Dr. G. at Sunrise Hospital prior to her transfer.

128. Respondent should have performed an exploratory laparotomy to evaluate Patient B's blood loss and Respondent should have created a differential diagnosis for Patient B.

129. Assuming, arguendo, the transfer to Sunrise Hospital was appropriate in order to provide Patient B with a higher level of care, Respondent should have followed the ambulance to Sunrise Hospital, been present, and discussed the case with Dr. G. and taken Patient B to the operating room at Sunrise Hospital rather than allowing Patient B to be transferred to the ICU and giving up authority to Emergency Department and ICU personnel at Sunrise Hospital.

130. The Emergency Department and ICU personnel could not take Patient B to the operating room for an exploratory laparotomy.

131. Respondent did not do anything with regard to Patient B's care until November 19, 2019, at 10:20 a.m. after receiving the results of her CTA of her abdomen and pelvis.

132. Then, Respondent considers exploring the source of the hemorrhage and calls Dr. F. to assist him.

133. By this time, too much time had already passed and Patient B had already lost too much blood.

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

134. Upon information and belief, Respondent failed to timely diagnose Patient B's life-threatening hemorrhage.

135. Upon information and belief, Patient B's tachycardia and hypotension post-cesarean were symptoms of her hemorrhage.

136. Upon information and belief, Respondent should have suspected Patient B was experiencing a hemorrhage post-cesarean and quickly provided her treatment for this condition.

Treatment of Patient C

137. Patient C[4] was a twenty-three (23) year-old female at the time of the events at issue.

138. On October 14, 2016, Respondent delivered Patient C's baby by cesarean section.

139. Prior to the cesarean section, Patient C had undergone a long induction with Cervidil, followed by Pitocin.

140. Prior to the cesarean section, Patient C had elevated tachycardia, and her baby was tachycardic.

141. Patient C's diagnosis was failure to progress, fetal intolerance to labor with cephalopelvic disproportion.

142. Patient C had a prolonged rupture of membranes, meconium staining, an internal fetal scalp electrode, intrauterine pressure catheter, untreated Gardnerella Vaginalis infection, chorioamnionitis, and cesarean section.

143. At her discharge from the hospital, post-cesarean, Patient C's pulse was 108 BPM.

144. Patient C's post-cesarean placental pathology revealed acute early chorioamnionitis.

145. Patient C saw Respondent for two (2) post-operative visits.

146. Respondent noted at Patient C's first post-operative visit, on October 20, 2016, she had complaints of cesarean section wound discomfort, pus from the incision, sweats, and fatigue.

147. Respondent did not treat Patient C with antibiotics nor did he take an incisional or vaginal culture.

[4] Patient C'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.

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

148. Respondent's handwriting in Patient C's medical records for this visit are difficult to decipher. Respondent noted in Patient C's medical records for this visit "without infection, swelling" and that her blood pressure was 128/80.

149. Respondent did not take and/or document Patient C's temperature in her medical records, despite Patient C's complaints of sweating.

150. Respondent did not take and/or document Patient C's pulse.

151. Respondent did not adequately document an abdominal examination of Patient C at this visit.

152. Respondent did not perform and/or did not document a speculum examination for cervical or uterine tenderness or foul-smelling lochia.

153. Respondent did not perform and/or did not document a wet prep or examination of Patient C for infection.

154. On October 24, 2016, Patient C was seen by Respondent, in which he noted in her medical records that her abdomen was tense/painful and she complained of feeling weak and stated she may have "overdone it" over the weekend.

155. At that visit, Respondent ordered a pelvic ultrasound for Patient C and a complete blood count test, and referred her to the Spring Valley Hospital Emergency Department.

156. Patient C's medical records for her visit on October 24, 2016 show inadequate documentation for her vital signs and physical examination. They further show no assessment or plan for treatment other than that Respondent was sending her to the Spring Valley Hospital Emergency Department.

157. After presenting at the Spring Valley Hospital Emergency Department, Patient C was transferred to the ICU where she was treated by Dr. S., who requested numerous consultations with colleagues from surgery, infectious disease, and nephrology.

158. Patient C was diagnosed with septic shock, necrotizing fasciitis of her cesarian section incisional wound, extended spectrum beta-lactamase E. Coli, acute renal failure, and altered mental status.

///

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

159. On that day, October 24, 2016, Patient C was taken to the Operating Room at Spring Valley Hospital where she underwent an exploratory laparotomy by Dr. M. with extensive debridement of her abdominal wall. During the laparotomy Dr. M found purulent drainage.

160. Patient C's family was informed of her likely need for further treatment, including further debridement and hysterectomy.

161. The next day, October 25, 2016, Patient C underwent a second exploratory laparotomy for indications of necrotizing fasciitis and purulent pelvic peritonitis. Patient C then received a subtotal hysterectomy performed by Dr. F. and Dr. D.

162. Patient C was anemic and received two units of packed red blood cells (PRBC).

163. Patient C's pathology revealed that she had acute and chronic endometritis and acute and chronic serositis.

164. Patient C had a PIIC line placed as well as a CVP line, and she received multiple regimens of antibiotics.

165. Patient C was placed on a ventilator and received pressor support and blood transfusions.

166. Patient C experienced acute multi-organ failure.

167. In a Cochrane Review, the mean incidence of endometritis following low transverse cesarean section for non-elective or emergency cesarean section was 30%.

168. Risk factors for endometritis following cesarean section include long inductions, amniotomy with longer duration of rupture of membranes, multiple pelvic exams prior to incision, meconium staining, bacterial vaginosis (Gardnerella vaginitis), urgency of operation, younger patients, non-white patients, unmarried patients, Medicaid or no health insurance patients, chorioamnionitis, induced labor, amnioinfusion, and artificial rupture of membranes.

169. Patient C experienced the majority of these risk factors. Therefore, according to the Cochrane Review, Patient C would have then had a 30% chance of endometritis.

170. On November 7, 2016, after her critical care admission, treatment for septic shock, two surgeries including debridement of necrotizing fasciitis, subtotal hysterectomy, vent dependent respiratory failure, acute multi-organ failure gradually improving, acute renal

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

insufficiency improving, lactic acidosis improving, mild transaminitis, severe protein caloric malnutrition, hypoalbuminemia, and acute anemia resolution, treatment with heparin subcutaneous for DVT prophylaxis, Patient C was transferred from Spring Valley Hospital to Mountain View Hospital Rehabilitation.

On November 14, 2016, Patient C had a CT of her abdomen and pelvis with and without contrast, with findings of multiple fluid collections that were identified within her right lower quadrant abdomen and pelvis, which may have indicated possible abscesses.

171. On November 17, 2016, Patient C was transferred to Desert Springs Hospital.

172. Then, on November 18, 2016, Patient C was re-admitted to Spring Valley Hospital when she developed a low-grade fever and the CT on November 14, 2016, revealed possible abscesses.

173. On November 20, 2016, Patient C was discharged after receiving antibiotics and drain placements, with tissue plasminogen activators placed in both catheters.

174. Patient C's diagnosis was infected hematomas and pneumonia, showing retrocardiac airspace disease consistent with atelectasis.

175. Patient C again received a PIIC line, UTI-treatment, DVT prophylaxis, and consultations with infectious disease, interventional radiology, and wound care.

176. Upon information and belief, Patient C's injuries and infections that resulted in her hospitalization on October 24, 2016, were caused by the cesarean section performed by Respondent on October 14, 2016.

177. Respondent failed to recognize Patient C's injuries and infections at her first post-operative appointment on October 20, 2016, when she complained of wound discomfort with pus, sweats, and fatigue.

178. Accordingly, Respondent failed to initiate antibiotic treatment in a timely manner, which allowed Patient C's infections to worsen and exacerbate her medical condition, requiring more extensive treatment and hospitalization.

///

///

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

COUNTS I–III

NRS 630.301(4) - Malpractice

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

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

181. 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."

182. 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 Patients A, B, and C.

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

COUNTS IV-VI

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

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

185. 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.

186. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to maintain complete and adequate medical records relating to the diagnosis, treatment, examination, and care of Patients A, B, and C, by failing to correctly document his actions when he treated Patients A, B, and C, whose medical records were not timely, legible, accurate, and complete.

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

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

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;

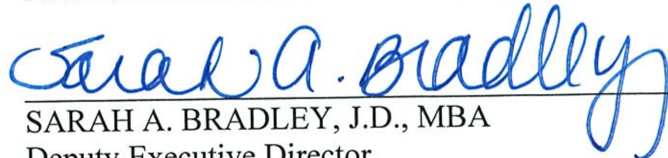
4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

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

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

DATED this 8th day of August, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

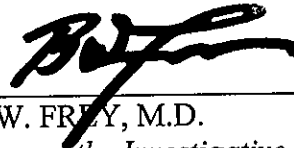
VERIFICATION

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 8th day of August, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



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

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