BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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Against:

RALPH MARCUS VENNART, M.D.,

In the Matter of Charges and Complaint

Respondent.

Case No. 24-8686-1

FILED

JUN 03 2024

NEVADA STATE BOARD OF MEDICAL EXAMINERS

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Ralph Marcus Vennart, 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. 6084). Respondent was originally licensed by the Board on July 1, 1990, with a specialty in obstetrics and gynecology.
 - 2. Patient A² was a forty-five (45) year-old female at the time of the events at issue.
- 3. On August 17, 2020, Respondent performed a consultation with Patient A, regarding sterilization and removal of a retained IUD with non-viable string. Respondent determined that Patient A's past medical history was too significant for two Loop Electrical Excision Procedures (a treatment to remove precancerous cells from the cervix) and that Patient A's cervix was flush with the vaginal apex.

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., Col. Eric D. Wade, USAF (Ret.), and Carl N. Williams, Jr., 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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- On November 9, 2020, Patient A had a pre-operative planning visit with 4. Respondent, where he discussed an operative laparoscopy with bilateral salpingectomy for elective sterilization, hysteroscopic removal of an intrauterine device (IUD), and a NovaSure ablation procedure (a procedure that removes the lining of the uterus).
- 5. On November 19, 2020, Patient A presented to Respondent for the procedures previously discussed.
- 6. During the procedure, Respondent attempted to perform the NovaSure ablation three (3) times without success. During those repeated attempts he created vaginal tears, and eventually Respondent abandoned the NovaSure ablation, and the vaginal lacerations created by the single tooth tenaculum were sutured.
- 7. Respondent did not indicate anywhere in Patient A's record that he performed an examination under anesthesia, nor was there any indication that he performed an ultrasound of the cervix or uterus to establish the appropriate length or measurements of the cervix and uterus prior to the procedure.
- On December 1, 2020, Patient A saw Respondent for her first, and what would be 8. her only post-operative visit. Respondent reportedly told Patient A he had attempted to do the NovaSure ablation three (3) times but was unsuccessful. This was the first time Patient A became aware that she had experienced multiple vaginal lacerations during the procedure.
- 9. Respondent scheduled a follow-up appointment; however, it was not for three (3) months later, on March 1, 2021.
- 10. On December 2, 2020, a day after the post-operative visit, Patient A experienced symptoms consistent with a urinary tract infection (UTI) and called Respondent's office multiple times requesting a prescription to treat a UTI. The prescription was delayed three (3) days, despite staff being aware that the patient was a post-operative patient of Respondent's.
- 11. On December 5, 2020, Patient A felt an initial "gush" of urine. She contacted Respondent's office and provided a urine sample thereafter.

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12.	. On	Decen	nber 8,	2020,	, Pati	ent A	felt	nause	eated	and	was	vor	niting	so	she	ag	air
contacted	Respon	dent's	office	staff	who	told	Patie	nt A	that	she	wou	ıld	have	to	go	to	the
Emergency Room because no appointments were available.																	

- Patient A presented to Aliante Emergency Room and the attending physician 13. determined that Patient A was suffering from a UTI.
- Over the next several weeks, Patient A would continue to suffer from multiple UTI's and experience worsening urinary incontinence. Additionally, Patient A received multiple prescriptions from other providers such as Augmentin and Bactrim for a MRSA infection.
- On January 6, 2021, Patient A experienced increasing incontinence and was no longer able to work, resulting in her filing for disability with her employer.
- On January 25, 2021, Patient A was seen by a urologist who suspected a 16. vesicovaginal fistula³, which is a known complication after vaginal or bladder surgery.
- 17. On February 3, 2021, a CT confirmed the diagnosis of vesicovaginal fistula, and a surgical correction was recommended.
- On March 6, 2021, a vesicovaginal fistula repair was performed by a urologist, and 18. the operative notes detail that the procedure was successful without complication.
- 19. Patient A had two follow-up appointments thereafter with other providers and is diagnosed with PTSD stemming from the surgical complications.

COUNT I

NRS 630.301(4) - Malpractice

- 20. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- NRS 630.301(4) provides that malpractice of a physician is grounds for initiating 21. disciplinary action against a licensee.
- NAC 630.040 defines malpractice as "the failure of a physician, in treating a 22. patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

³ A vesicovaginal fistula is an abnormal opening that forms between the bladder and the wall of the vagina.

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- 23. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A, when he failed to ensure that Patient A had appropriate care and was seen in a timely manner, despite Patient A calling his office and telling his staff that she was experiencing adverse symptoms after her procedure that had complications; and when he failed to diagnose a vesicovaginal fistula, despite knowledge of Patient A's adverse symptoms.
- 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 Complete Medical Records

- 25. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.
- 26. 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.
- Respondent failed to maintain complete medical records relating to the diagnosis, 27. treatment and care of Patient A, by failing to indicate in the record that he performed an examination under anesthesia, or that he performed an ultrasound of the cervix or uterus to establish the appropriate length of the cervix and uterus prior to the procedure. As a result, Patient A's medical records were not timely, legible, accurate, and complete.
- 28. 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
- 6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 3rd day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

ALEXANDER J. HINMA Deputy General Counsel 9600 Gateway Drive

Reno, NV 89521 Tel: (775) 688-2559

Email: <u>ahinman@medboard.nv.gov</u>
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners 9600 Gateway Drive Reno, Nevada 89521 (775) 688-2559

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 3rd day of June, 2024.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

Chairman of the Investigative Committee