BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **RONALD STEPHEN HOFFLANDER, M.D., Respondent.**	**Case No. 24-12765-1**

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 Alexander J Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Ronald Stephen Hofflander, 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. 9075). Respondent was originally licensed by the Board on July 9, 1999.

2. Patient A[2] was an eighty-two (82) year-old male at the time of the events at issue. Of relevance, Patient A's prior medical history includes surgery for a bilateral hernia in 1995, removal of his colon in 2003, and an abdominal hernia repair in 2005.

3. On July 17, 2017, Patient A presented to Respondent for an evaluation of a hiatal hernia and a left lower ventral hernia involving the descending colon.

/ / /

[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, and Carl N. Williams, Jr., M.D.

[2] Patient A's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

4. Respondent recommended laparoscopic repair of the hiatal hernia (fundoplication) and he would repair the incarcerated ventral hernia.

5. On September 12, 2017, Respondent performed the surgery on Patient A, using the direct trocar technique with an OPTIVIEW trocar, even though Patient A had undergone previous surgeries and had previous mesh placement, which put Patient A at a higher risk for adhesions.

6. Respondent's Operative Report indicated there were "no complications," experienced during the operation.

7. On September 14, 2017, Patient A's condition began deteriorating, as Patient A had atrial fibrillation with a rapid ventricular response.

8. On September 15, 2017, Patient A was having respiratory difficulty. Specifically, Patient A was diagnosed with acute respiratory failure, and had a partial pressure of oxygen (PO2) reading of fifty-nine (59), well in excess of normal ranges.

9. On September 16, 2017, Patient A's renal function had deteriorated. Records indicate that Patient A's Blood Urea Nitrogen (BUN) had elevated significantly, and his creatine levels had almost tripled.

10. On September 18, 2017, Patient A's condition deteriorated even further. Patient A was transferred to the Intensive Care Unit (ICU), where he was intubated, and a hemodialysis catheter was placed. A computerized tomography (CT) scan of the abdomen demonstrated a probable intestinal leak.

11. On September 19, 2017, seven (7) days after the first surgery, Respondent took Patient A back into surgery for an exploratory laparotomy. While performing the surgery, Respondent found a hole in the small bowel with multiple fluid collections and abdominal adhesions. Patient A was ultimately diagnosed with sepsis resulting from a perforated viscus.

12. Of note, there is no mention of ischemic changes or cautery burns found in Respondent's Operative Report; however, ischemic changes were found in the pathology report, thus, ischemia would have been noticed at the time of surgery and should have been reported.

13. On September 25, 2017, Patient A was consulted by a hospice nurse and a palliative care specialist. The hospice physician extubated the patient; however, Patient A did not

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

survive extubation, and was pronounced deceased shortly thereafter. The Certificate of Death listed the cause of the death as sepsis due to a perforated small intestine following hernia repair.

COUNT I

NRS 630.301(4) - Malpractice

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

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

16. 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."

17. 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, by using a riskier surgical technique than appropriate when performing Patient A's procedure, and by causing an unreasonable delay in diagnostic testing to discover the intestinal leak after the first surgery. Additionally, Patient A had multiple warning signs of a major problem and documented deterioration that went unrecognized and untreated by Respondent in a reasonable amount of time.

18. 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

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

20. 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.

///

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

21. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by noting that there were "no complications" after performing the first operation, and by failing to mention ischemic changes or cautery burns in the Operative Report of the second operation.

22. 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;

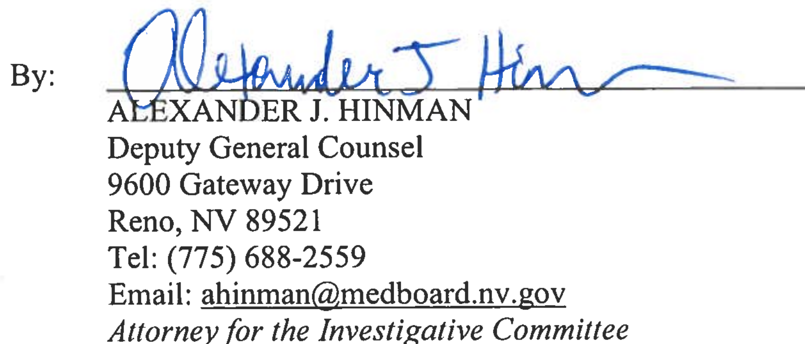
4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

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 6th day of March, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ALEXANDER J. HINMAN
Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: ahinman@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 6 day of March, 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