BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **STEPHEN BRENT HORSLEY, M.D.** **Respondent.**	**Case No. 24-32518-1** FILED JAN 31 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 William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Stephen Brent Horsley, 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. 12245). Respondent was originally licensed by the Board on April 18, 2007.

2. Patient A[2] was a fifty-seven (57) year-old female at the time of the events at issue.

3. Patient A presented to Respondent on September 18, 2020, for evaluation of an enlarged right groin node that had previously been documented on an ultrasound. Respondent planned to perform an excision of Patient A's right groin lymph node.

4. On October 26, 2020, Respondent performed the excision, and then sent the specimen for a biopsy to a pathology services company.

[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., FACS.

[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 October 30, 2020, Respondent received a preliminary pathology report from the pathologist. The report stated, in pertinent part, "worrisome for B-cell lymphoma with follicular pattern however bcl-2 strain is not confirmatory. Additional ancillary studies are pending for further evaluation . . . an addendum final report will follow." The report also noted that the node would be sent for outside consultation for future findings.

6. On or about November 13, 2020, another pathologist sent an addendum to the pathology report to Respondent, stating that the tests were positive for B-cell rearrangement and that the results confirmed a diagnosis of lymphoma.

7. Patient A met with Respondent on November 17, 2020, for a post-operative visit. Respondent's notes from this visit stated, "path pending." Respondent's notes from the visit did not indicate that Respondent informed Patient A of the equivocal nature of the biopsy or the probability of lymphoma.

8. Respondent did not schedule a follow-up visit with Patient A after November 17, 2020, nor did Respondent instruct Patient A to consult with an oncologist.

9. On or about November 19, 2020, another pathologist sent to Respondent a further addendum to the pathology report. This addendum made the diagnosis of Follicular Lymphoma. Respondent did not directly convey the results of the November 19, 2020, addendum to Patient A.

COUNT I

NRS 630.301(4) - Malpractice

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

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

12. 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."

13. 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

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rendering medical services to Patient A, by failing to inform her on or after November 17, 2020, of the equivocal nature of the October 30, 2020, preliminary pathology report or the probability of lymphoma. Respondent further failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A, by failing to inform Patient A of further pathology report findings after Patient A's visit with Respondent on November 17, 2020.

14. 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 Appropriate Medical Records

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

16. 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.

17. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to accurately note any discussions with Patient A regarding the equivocal nature of the October 30, 2020, preliminary pathology report or the probability of lymphoma.

18. 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);

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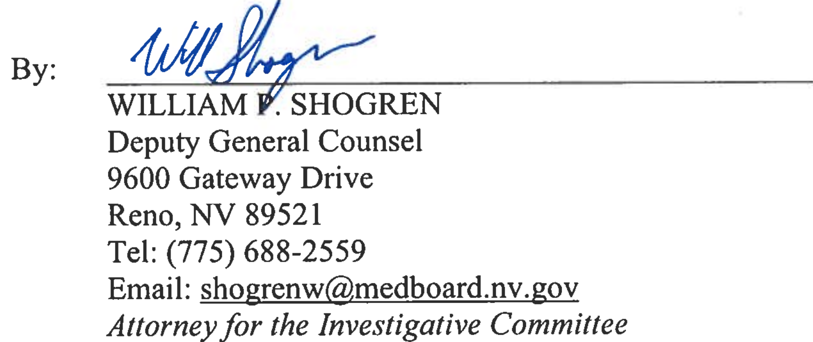
3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

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 31st day of January, 2024.



INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________

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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 31st day of January, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: ______________________________

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

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