BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **SUSHIL RAMAN PATEL, M.D.,** **Respondent.**	**Case No. 24-34052-1** FILED FEB 16 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 William P. Shogren, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Sushil Raman Patel, 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. 12914). Respondent was originally licensed by the Board on October 4, 2008.

2. Patient A[2] was a thirty-seven (37) year-old male at the time of the events at issue.

3. On November 3, 2019, Patient A was admitted to the hospital and evaluated with several debilitating underlying medical conditions, including acute myocardial infarction, occipital stroke, atrial fibrillation, and jugular vein deep vein thrombosis. Patient A also developed pneumonia with hypoxia and tachycardia during his hospital stay. Additionally,

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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 Aury Nagy, M.D. , Nicola M. Spirtos, M.D., F.A.C.O.G. and Ms. Maggie Arias-Petrel.

[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.

Patient A's past medical history included a diagnosis of steroid-dependent Crohn's Disease, developmental delay, chronic debility, and weakness.

4. On November 8, 2019, Patient A was transferred to Dignity Health Rehabilitation Facility (hereinafter, "Dignity Health") for inpatient care of Patient A's ongoing medical conditions.

5. Prior to transfer on November 8, 2019, Patient A's hemoglobin level was recorded as 11.4 g/dl.

6. Patient A's prescriptions at the time of admission to Dignity Health included an anticoagulant medication (Equilis) and an antiplatelet medication (Aspirin), along with prednisone. Patient A was continued on these medications while at Dignity Health.

7. Equilis may cause active internal bleeding, and typically takes twenty-four (24) to forty-eight hours (48) to leave the system once stopped.

8. On November 10, 2019, Patient A's hemoglobin level was noted to drop to 9.8 g/dl, indicating the possibility of gastrointestinal (GI) bleeding.

9. Respondent first consulted with Patient A on November 11, 2019. Respondent noted that Patient A's hemoglobin was low, and that Patient A could not confirm if he had noticed blood in his stools. Respondent planned to have Patient A's hemoglobin levels monitored while on Equilis, and have Patient A monitored for GI bleeding.

10. On November 11, 2019, Dignity Health staff noted that Patient A began having black stools. Patient A continued to have black, water stools at approximately midnight on November 12, 2019.

11. On November 12, 2019, Patient A's hemoglobin levels dropped critically low to 7.0 g/dl, and then several hours later dropped down to 6.8 g/dl. Respondent ordered that Patient A's Eliquis and Aspirin be discontinued, but Patient A was not transferred to the hospital.

12. That same day, Respondent noted that he was still concerned about GI bleeding and again noted that he asked Patient A about the color of his stools. There is no documentation from Respondent referring to nursing notes that clearly documented multiple black stools. Respondent also documented that Patient A had tachycardia.

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13. On November 13, 2019, Patient A's hemoglobin level was noted to be 4.5 g/dl.

14. That same morning Patient A was noted to have been found on the floor of the bathroom with a large amount of black, tarry stool.

15. Patient A was transported to the emergency room that same morning, where he ultimately passed away.

COUNT I

NRS 630.301(4) - Malpractice

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

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

18. 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."

19. 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 Respondent failed to recognize and treat Patient A's critically low hemoglobin levels, and an obvious gastrointestinal bleed, while Patient A was taking Equilis and Aspirin. Respondent's failure to recognize and treat Patient A's condition includes, but is not limited to, failure to (1) stop Patient A's Eliquis immediately on November 11, 2018, while awaiting further test results; (2) perform a rectal exam and order a fecal occult blood test or coagulation studies to confirm Patient A's suspected GI bleeding; (3) review nursing documentation of Patient A's stool color and consistency on November 12, 2018; (4) recognize on November 12, 2018, that Patient A required urgent evaluation in an emergency and transfusion, given Patient A's recent myocardial infarction and low hemoglobin levels; (5) recognize on November 12, 2018 that Patient A needed an urgent endoscopy to control his GI bleeding source; and (6) document that Patient A's platelet count was low and dropping, further increasing the risk of gastrointestinal hemorrhage.

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20. 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

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

22. 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.

23. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document (1) Patient A's stool color and consistency on November 12, 2018; (2) a rectal examination of Patient A; (3) the ordering of a fecal occult blood test or coagulation studies to confirm Patient A's suspected GI bleeding; (4) the ordering of a an urgent endoscopy on November 12, 2018; and (5) that Patient A's platelet count was low and dropping, further increasing the risk of gastrointestinal hemorrhage.

24. 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;

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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 16th day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

WILLIAM P. SHOGREN
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Aury Nagy, 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 16 day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

AURY NAGY, M.D.
Chairman of the Investigative Committee

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 26th day of February, 2024, I served a file-stamped copy of the foregoing **COMPLAINT** and **PATIENT DESIGNATION,** via USPS Certified Mail, postage pre-paid, to the following parties:

SUSHIL R. PATEL, M.D.
c/o Robert C. McBride, Esq.
Sean Kelly, Esq.
McBride Hall
8329 West Sunset Road, Suite 260
Las Vegas, NV 89113

Tracking No.: 9171 9690 0935 0241 6240 00

With courtesy copy by email to:

Robert C. McBride, Esq.: rcmcbride@mcbridehall.com
Sean Kelly, Esq.: smkelly@mcbridehall.com

DATED this 26th day of February, 2024.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners