BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **VISHAL SATISH SHAH, M.D.,** **Respondent.**	**Case No. 24-42815-1**

FILED
FEB 29 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 Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Vishal Satish Shah, 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. 15482). Respondent was originally licensed by the Board on August 11, 2014.

2. Patient A[2] was a forty-one (41) year-old female at the time of the events at issue.

3. Patient A was admitted to Centennial Hills Hospital on May 3, 2017, for a suicide attempt and overdose of multiple drugs including, Benadryl, Cymbalta, and Ambien.

4. Shortly thereafter, Patient A was placed on a ventilator to assist with her breathing and placed in the Intensive Care Unit (ICU) at Centennial Hills Hospital.

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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 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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5. On May 6, 2017, Patient A was weaned off the ventilator, extubated, and transferred to a medical floor. Patient A was documented as having "no shortness of breath."

6. Patient A was initially showing signs of improvement and was "on room air" without the need for supplemental oxygen; however, Patient A's condition began to deteriorate in the coming days.

7. On May 10, 2017, Patient A, still in the hospital, was seen by a physical therapist that noted in their medical report at 11:35 a.m., "[patient] exhibits very shallow and more labored breathing compared to initial eval" and "[patient] ambulated 10' to chair requiring very long seated break afterwards with VC's (verbal cues) for pursed lip breathing," and that the patient "demos significantly decreased activity tolerance."

8. A few hours later, at 3:13 p.m., a nurse documented, "[patient] has "complaints of shortness of breath." Respondent had still not re-examined Patient A after her deterioration.

9. At 4:11 p.m., a progress note from the same RN stated, "[patient] complaining of increased labor of breathing, [she] states she feels like she is drowning." A breathing treatment was ordered, and Patient A was given Ativan for anxiety; however, she showed no improvement. Patient A was then moved to get a chest X-ray (CXR). The RN also called Respondent and informed him that Patient A had shortness of breath and that she had felt like she was "drowning."

10. At 4:21 p.m., a "Valley Health System Rapid Response Protocol" was ordered, signifying that Patient A was in a high degree of distress from her shortness of breath. Patient A was not examined by a physician after this event.

11. After the CXR was completed and Patient A's arterial blood gas analysis (ABG) was resulted, there were no changes on the CXR and the ABG was consistent with a patient who had been hyperventilating. This should have alerted Respondent to Patient A's deteriorating state.

12. At 5:12 p.m., Patient A's pulmonologist wrote a progress note that stated, "patient had rapid called when down for CXR." The pulmonologist then recommended that a computed tomography angiography (CTA) of the chest be performed. Inexplicably, this recommendation was not followed at this time. He also notes, "increased dyspnea poss[ibly] from too rapid taper steroid."

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13. Around this same time, Patient A's infectious disease physician diagnosed Patient A with a Methicillin-resistant Staphylococcus aureus infection (MRSA) and aspiration pneumonia and began treating her for these issues. In his note, he describes Patient A as "extremely short of breath" and "[a]cute dyspnea over the past 18 hours. Rule out PE," referencing the possibility of a pulmonary embolism. This order to rule out pulmonary embolism was ordered "STAT," but was not performed until after 2:00 a.m., on May 11, 2017.

14. At the end of his shift, Respondent wrote the discharge summary for Patient A, in which he stated "[he] told the RN to contact the pulmonologist to see if that patient would require upgrade or any additional orders needed." He had no further documented contact with Patient A or medical staff after this.

15. By May 11, 2017, Patient A's health had declined rapidly, and Patient A was pronounced deceased at 6:57 a.m.

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 he failed to physically examine Patient A after the substantial warning signs elucidated in the medical record of Patient A's continued decline in recovery and respiratory symptoms, and when he simply told the RN to contact the pulmonologist.

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 Complete 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 complete medical records relating to the diagnosis, treatment, and care of Patient A, by among other things, failing to correctly document the severity of Patient A's status throughout his care of Patient A, and by failing to leave a complete and accurate medical record for the next attending physician.

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 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

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

DATED this 29th day of February, 2024

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

ALEXANDER J. HINMAN
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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 29th day of February, 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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