BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against NABIL ELKHOURY, M.D., Respondent.	**Case No. 23-49864-1**

FILED

MAR 0 8 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

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The above-entitled matter came on regularly for decision before the Nevada State Board of Medical Examiners (Board), on March 1, 2024, at the Board's office located at 325 E. Warm Springs Road, Suite 225, Las Vegas, NV 89119, on the Complaint filed herein. Nabil Elkhoury, M.D., (Respondent), who was duly served with notice of the adjudication, was present by and through his counsel, Christian Balducci, Esq. The adjudicating members of the Board participating in these Findings of Fact, Conclusions of Law, and Order (FOFCOL) were: Nick M. Spirtos, M.D., F.A.C.O.G., Ms. Maggie Arias-Petrel, Aury Nagy, M.D., Ms. Pamela J. Beal, Irwin B. Simon, M.D., FACS, Joseph Olivarez, P.A.-C, Jason B. Farnsworth, RRT, MBA. Todd M. Weiss, Esq., Senior Deputy Attorney General, served as legal counsel to the Board.

The Board, having received and read the Complaint and exhibits admitted in the matter and filed into the record in this case, the "Findings and Recommendation," prepared by the Hearing Officer, Patricia Halstead, Esq., who presided over the hearing, and the transcript of the hearing, proceeded to make a decision pursuant to the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), NRS Chapter 622A, and NRS Chapter 233B, as applicable.

The Board, after due consideration of the record, evidence and law, and being fully advised in the premises, makes its FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER in this matter, as follows:

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FINDINGS OF FACT

I.

Respondent held a license to practice respiratory care in the State of Nevada issued by the Board at all relevant times.

II.

On June 27, 2023, the Investigative Committee filed its formal Complaint in Case No. 23-49864-1, alleging Respondent violated the Medical Practice Act. Respondent was personally served with the Complaint by FedEx on July 7, 2023. The Complaint alleges as follows: Count I, violation of NRS 630.301(4) Malpractice; Count II, violation of NRS 630.3062(1)(a) Failure to Maintain Proper Medical Records. Respondent did answer the allegations set forth in the Complaint on July 19, 2023. Pursuant to NAC 630.460(4), the allegations of the Complaint are deemed generally denied if an answer is not filed.

III.

An Order was filed on August 17, 2023, scheduling the Early Case Conference for the pending matter for August 22, 2023. This Order was personally served upon Respondent through his attorney. The Early Case Conference was held August 22, 2023, at which Respondent did appear through his counsel telephonically. As a result of the Early Case Conference, the Pre-Hearing Conference was scheduled for October 3, 2023, with the formal hearing calendared to commence on January 18, 2024, through January 19, 2024. Respondent's attorney accepted personal service of the Order Scheduling Pre-Hearing Conference and Exchange of Required Information and Documentation and Hearing on August 23, 2023. At the time fixed for the Pre-Hearing Conference, legal counsel for the Investigative Committee, Ian J. Cumings, Senior Deputy General Counsel appeared. Respondent, via counsel, appeared at the time fixed for the Pre-Hearing Conference. At the Pre-Hearing Conference, counsel for the Investigative Committee and Respondent's counsel provided the Hearing Officer with the mandated Pre-Hearing Conference Disclosures and had copies of both the Pre-Hearing Conference Statement and the mandated Pre-Hearing Disclosures available for the parties. Respondent was timely and properly served with the Pre-Hearing Conference Statement and the mandated Pre-Hearing Disclosures in

accord with NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and the requirements of due process.

IV.

On January 18, 2024, a contested case hearing was held before the Hearing Officer to receive evidence and to hear arguments. On or about January 25, 2024, the Hearing Officer received the complete Record of Proceedings, including the transcript of the testimony received and the exhibits admitted. Upon receipt of the Record of Proceedings, the hearing was closed. The Hearing Officer filed the Findings and Recommendations on February 13, 2024. The matter was scheduled for final adjudication on March 1, 2024, at a regularly scheduled Board meeting. The notice of the adjudication was mailed to Respondent on January 31, 2024, via first class certified mail with return receipt requested, and Respondent received and signed for said notice on February 5, 2024. The Findings and Recommendations were personally served upon Respondent on February 13, 2024.

V.

Pursuant to NRS 622A.300(5)(a), the Findings and Recommendations of the Hearing Officer are hereby approved by the Board in their entirety and are hereby specifically incorporated and made part of this Order by reference. *See* **Exhibit 1**.

VI.

In accord with the Findings and Recommendations, the Board hereby finds that each count set forth in the Complaint, and as recapitulated in Paragraph II above, has been established by a preponderance of the evidence.

VII.

If any of the foregoing Findings of Fact is more properly deemed a Conclusion of Law, it may be so construed.

CONCLUSIONS OF LAW

I.

The Board has jurisdiction over Respondent and the Complaint, and an adjudication of this matter by the Board members as set forth herein is proper.

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II.

Respondent was timely and properly served with the Complaint, and all notices and orders in advance of the hearing and adjudication thereon, in accord with NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and the requirements of due process.

III.

With respect to the allegations of the Complaint, the Board concludes that Respondent has violated NRS 630.301(4) Malpractice, as alleged in Count I; has violated NRS 630.3062(1)(a) Failure to Maintain Proper Medical Records, as alleged in Count II. Accordingly, Respondent is subject to discipline pursuant to NRS 630.352.

IV.

The Board finds that, pursuant to NRS 622.400, it may recover from Respondent reasonable attorneys' fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent as it hereby enters this FOFCOL finding that Respondent has violated the Medical Practice Act, which the Board has the authority to enforce.

V.

The Board has reviewed the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees, and the Board finds them to be the actual fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent, and finds them to be reasonable based on: (1) the abilities, training, education, experience, professional standing and skill demonstrated by Board staff and attorneys; (2) the character of the work done, its difficulty, intricacy, and its importance, the time and skill required, the responsibility imposed and the prominence and character of the parties where, as in this case, they affected the importance of the litigation; (3) the work actually performed by the Board's attorneys and staff, and the skill, time and attention given to that work; and (4) the product of the work and benefits to the Board and the people of Nevada that were derived therefrom.

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VI.

If any of the foregoing Conclusions of Law is more properly deemed a Finding of Fact, it may be so construed.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and good cause appearing therefore,

IT IS HEREBY ORDERED that:

1. Pursuant to NRS 630.352 and NRS 622.400, Respondent shall pay fines in the amount of ten thousand dollars ($10,000) for violation of NRS 630.301(4) Malpractice (Count I) and two thousand five hundred dollars ($2,500) for violation of NRS 630.3062(1)(a) Failure to Maintain Proper Medical Records (Count II), totaling twelve thousand five hundred dollars ($12,500.00) which must be paid no later than August 1, 2024.

2. Respondent shall complete five (5) hours of continuing medical education (CME) related to medical ethics and ten (10) hours of CME related to the management of high-risk pregnancies, totaling fifteen (15) hours of CME within six (6) months of service of the Board's order.

3. Respondent shall be issued a Public Letter of Reprimand; and

4. Respondent's discipline shall be reported to the appropriate entities, including the National Practitioner Databank (NPDB).

5. Respondent shall reimburse the Board the reasonable costs and expenses actually incurred in the investigation and prosecution of this case in the amount of fourteen thousand one hundred twenty-eight dollars and sixty-three cents ($14,128.63), which amount Respondent shall pay no later than September 2, 2024.

Dated this 8th day of March, 2024.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Nick M. Spirtos, M.D., F.A.C.O.G., President
Nevada State Board of Medical Examiners

CERTIFICATION

I certify that the foregoing is the full and true original FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER on file in the office of the Board of Medical Examiners in the matter of Nabil Elkhoury, M.D., Case No. 23-49864-1.

I further certify that Nick M. Spirtos, M.D., F.A.C.O.G., is the President of the Nevada State Board of Medical Examiners and that full force and credit is due to his official acts as such; and that the signature to the foregoing ORDER is the signature of said Nick M. Spirtos, M.D., F.A.C.O.G.

IN WITNESS THEREOF, I have hereunto set my hand in my official capacity as Secretary-Treasurer of the Nevada State Board of Medical Examiners.

Dated this 8th day of March, 2024.

Maggie Arias-Petrel

Maggie Arias-Petrel, Secretary-Treasurer
Nevada State Board of Medical Examiners

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EXHIBIT 1

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against

NABIL EKHOURY, M.D.,

Respondent.

Case No. 23-49864-1

FINDINGS AND RECOMMENDATION[1]

1. Introduction

This matter was heard on January 18, 2024, by fully remote means given Respondent is currently residing out of the country. Participating in the hearing were undersigned; Ian Cumings on behalf of the Investigative Committee of the Nevada State Board of Medical Examiners (the "IC"); Respondent Nabil Elkhoury, M.D. ("Respondent"); Respondent's counsel Christian Balducci, Esq.; IC witness Timothy McFarren, M.D., M.S. F.A.C.O.G. (also referred to as the "IC's expert"); and Respondent witness Robert Atlas, M.D. (also referred to as "Respondent's expert") All witnesses were sworn. The rule of exclusion was not invoked by either party.

2. Allegations

The Complaint alleges Count I, NRS 630.301(4), Malpractice, and Count II, NRS 630.3062(1)(a), Failure to Maintain Proper Medical Records. *See* Complaint, filed on June 27, 2023. The Complaint centers upon whether Respondent committed malpractice by failing to deliver dichorionic diamniotic twins within the delivery window recommended by Manijeh Kaymar, M.D., Maternal-Fetal Medicine Subspecialist (also referred to as the "MFM"), and for failing to document why he deviated from the MFM's recommendation. It is alleged that Respondent scheduled the delivery outside of the MFM's recommended delivery window by two

[1] Incorporated herein by reference are the full Hearing Transcript, dated January 18, 2024, which is referred to herein under the designation "TR," as well as the exhibits admitted at the hearing, which are IC Exhibits 1-8 and Respondent Exhibits 1-20.

days, within which Twin A suffered intrauterine fetal demise attributed to placenta abruption. Twin B survived and was successfully delivered.

3. Case Summary

In relation to the IC's case, undersigned heard from expert witness Timothy C. McFarren, M.D., M.S. F.A.C.O.G. who testified to his experience, explained the background necessary to understand the allegations, and opined that Respondent committed malpractice by failing to deliver the twins within the delivery window recommended by the MFM. Dr. McFarren further opined that Respondent failed to maintain proper medical records by failing to record his reasoning for deviating from the recommended delivery window. TR 11-86.

In relation to Respondent's case, undersigned heard from Respondent who testified that he spoke with the MFM about the delivery date Respondent scheduled, which was past the MFM's recommended delivery window, and that he and the MFM were in agreement as to the extended date based upon reassuring testing. TR 88-107; 157-160. Respondent's expert witness Robert Atlas, M.D. who is a Maternal-Fetal Medicine Specialist, testified that Respondent acted appropriately by scheduling the delivery date within the American College of Obstetricians and Gynecologists ("ACOG") guidelines for "Dichorionic-diamniotic twins with isolated grown restriction," which provides for delivery at "36 0/7 - and 37 6/7 weeks of gestation" – the MFM having recommended a delivery window of "37-0/7 to 37 3/7 weeks due to twin gestation with isolated growth restriction." TR 109 –155.

4. Witnesses and Testimony

The IC and its expert Dr. McFarren premised an allegation of malpractice on the undisputed facts that the patient had active problems that were noted to be Hepatitis, C Virus – Chronic; Maternal Mental Disorder Complicating Pregnancy Childbirth and Puerperium; Mutual Gestation; personal history of other mental and behavioral disorders; history of pregnancy complications; urinary tract infection; previous sexually-transmitted disease; history of drug abuse; and smoking, which rendered the pregnancy high risk beyond it just being a twin pregnancy, which alone is considered high risk. IC Exhibit 5, pp. 164-166; 109 – 127; TR 22-23.

As a result of the high risk pregnancy posed by the patient's conditions, the patient was referred to a Maternal-Fetal Medicine Specialist and, after having seen a specialist provider at a different office (IC Exhibit 5, p. 274), in May of 2020 consulted with Dr. Kaymar's office, which, commencing in July of 2020, recommended and undertook twice weekly antenatal testing that was to take place until delivery. IC Exhibit 5, p. 256. As a result of testing, it was communicated to Respondent, by correspondence dated July 20, 2020, and signed by Dr. Kamyar, that Twin A demonstrated fetal growth restriction. IC Exhibit 6, p. 355, TR 24-25. A finding of polyhydramnios was also brought to Respondent's attention. Id. As a result, the MFM recommended delivery "between 37 0/7 – 37 3/7 weeks, which remained the recommendation throughout the MFM's records up to August 11, 2020. IC Exhibit 5, pp. 213-216. The recommendation rendered a delivery window of August 12, 2020, through August 15, 2020.

On July 28, 2020, eight days after the MFM's initial designation of the delivery window, the patient saw Respondent who noted in his medical records the finding of polyhydramnios for both twins and wrote that he was going to induce labor at 38 weeks, which was past the MFM's recommended delivery window. IC Exhibit 5, pp. 117 of 116-118; TR 30-31. Thereafter, on August 5, 2020, two days after having again met with the MFM, the patient met with Respondent who then scheduled delivery for August 19, 2020, which would have been 37-5/7 weeks - two days past the window recommended by the MFM only days prior. IC Exhibit 5, pp. 113-115; IC Exhibit 6, p. 371; TR 33-35; 38-39.

In records dated August 12, 2020, Respondent notes that he discussed the ultrasound report with the patient at length but does not acknowledge the MFM recommended delivery window nor any reason for deviating from the MFM's recommendation. IC Exhibit 5, pp. 110-112.

On August 16, 2020, the day after the delivery window recommended by the MFM, the patient presented to an emergency room with bleeding. IC Exhibit 7. It was determined at that time that Twin A suffered intrauterine fetal demise. Id. Twin B survived and was delivered. Id.

Based upon the foregoing, the IC's expert Dr. McFadden opined that Respondent committed malpractice by not adhering to the recommended delivery window of the MFM, which

was consistent with the ACOG guidelines for "Dichorionic-diamniotic twins with concurrent condition," which provides for an "[i]ndividualized" determination for delivery, which was undertaken by the MFM and discounted by Respondent. TR 44-46; 82-83. The IC's expert further opined that the records were incomplete given that no reason for the deviation from the MFM's recommendation was provided. TR 32-33; 36-37; 78.

Respondent's retort was two-fold, that being: 1) that the ACOG guidelines for "Dichorionic-diamniotic twins with isolated grown restriction," which provides for delivery at "36 0/7 - and 37 6/7 weeks of gestation" was the applicable guideline and was adhered to; and 2) that the MFM agreed with the extended delivery date as evidenced by the notation on the MFM's August 13, 2020 records under "GENERAL COMMENT" that "[t]he patient is scheduled for delivery on 8/17/2020," and as testified to by Respondent.

5. Findings

The MFM recommended delivery window was consistently 37 0/7 to 37 3/7, which rendered an outside delivery date of August 15, 2020. To the extent Respondent claims the MFM modified this recommendation, the same is not supported by the record in that the record relied upon by Respondent, that being IC Exhibit 5, p. 208, only serves to note the scheduled delivery date by providing "[t]he patient is scheduled for delivery on 8/17/2020," and does not make a modified recommendation.

Notably, the MFM was consistently clear in all of his recommendations for a delivery window, providing language of "[r]ecommended delivery between 37-0/7 and 37-3/7 weeks due to twin gestational with isolated growth restriction." *See, e.g.*, IC Exhibit 5, p. 216. No such language followed the MFM's August 11, 2020, report that would have arguably modified the recommended delivery window.

While the notation by the MFM of "L & D As indicated" under "RECOMMENDATION" on IC Exhibit 5, p. 208, dated August 13, 2020, is arguably ambiguous in that it is not clear whether it is a reference to what the MFM had previously indicated as the recommended delivery window or whether it is a reference to the delivery date scheduled by Respondent noted below on the same document (assuming L & D means labor and delivery, which was never testified to nor

argued by Respondent), the ambiguity is clarified not only given the consistent recommendation language utilized by the MFM but more so by and through the allegation response letter to the IC dated November 1, 2021, whereby Respondent addressed the recommended delivery window and concedes that "[o]n August 13, 2020, [the patient] was seen by Dr. Kamyar. It was noted the gestational age was 37 weeks and still recommended delivery between 37-0/3 to 37-3/7 due to twin gestation with isolated growth restrictions. Dr. Kamyar noted [the patient] was scheduled for delivery on August 17, 2020." IC Exhibit 2, p. 8. Thus, by Respondent's own prior admission, he had understood the MFM's recommended delivery window as of August 13, 2020, to be 37 0/7 to 37 3/7, and he nonetheless scheduled delivery past that window, after which, Twin A passed in utero.

It is also telling that in the same response letter, when accused of ignoring the MFM's recommended delivery window, Respondent does not suggest that he spoke with the MFM and that the MFM modified his recommendation to support the date scheduled by Respondent. Rather, Respondent maintains that the delivery date he scheduled past the MFM's recommended window for delivery was consistent with the ACOG (and Society for Maternal Fetal Medicine) guidelines.[2] IC Exhibit 2, p. 9. Had Respondent spoken to the MFM and the MFM agreed to modify his recommendation, surely Respondent would have raised that in response to the allegation letter. There was also no testimony from the MFM himself to indicate that took place, nor any records evidencing such a conversation.

In response to the allegation letter Respondent also makes misstatements such as Twin A's passing on August 16, 2020, a day past the MFM's recommended delivery window and a day prior to the scheduled delivery, was within the MFM's recommended delivery window, which it was not given the outset of the MFM's recommended delivery window was August 15, 2020. In further response to the allegation letter, Respondent claims that he adhered to the MFM's delivery recommendation window, which by his own statement as to the delivery window having been from 37-0/7 to 37-3/7 and him scheduling delivery for 37-5/7, is not the case. IC Exhibit 2, pp. 8-9; IC Exhibit 5, p. 113 (whereby Respondent scheduled a C-Section delivery for August 17,

[2] The SMFM Guidelines were never submitted nor addressed.

2020).

Respondent never addressed the polyhydramnios and his expert downplayed it with no substantive response relating thereto. TR 120. Respondent's expert also downplayed Twin A's growth restriction (TR 123) and skirted addressing the meaning of "concurrent condition" as used in the ACOG guidelines, ultimately conceding it "would seem to be other factors that may be involved in this case." TR 136-137.

Here, the patient posed numerous risk factors that, even if discounted as relevant to a maternal condition and not a fetal condition, it remained that there was a noted concern of polyhydramnios relevant to both fetuses, which supports consideration of a concurrent condition to the growth restriction as relevant to the ACOG guidelines, and undersigned finds the IC's expert's presentation as to that issue substantially more credible (particularly as Respondent, and his expert to a lesser extent, emphasized individual care but then discounted the concept in application to this particular patient). TR 44-46; 82-83; 101-102; 147; 158. With that, the applicable ACOG guideline would have been "[d]ichorionic-diamniotic twins with concurrent condition" and the delivery guideline was properly "[i]ndividualized," which is what was undertaken by the MFM. Even if that was not the case, Respondent provided no basis in his records nor his testimony to deviate from the MFM's recommendation. Rather, Respondent purported to rely upon the biophysical profiles being normal (TR 124) but that testing was also known by the MFM who took them into consideration when making the delivery date window recommendation and, as testified to by the IC's expert, normal biophysical profiles do not eliminate the risk factors that were present. TR 75-77.

On a final note, Respondent's expert repeatedly stated that he did not know how the MFM deduced such a narrow delivery window (TR 117, 126, 146), and characterized the demise of Twin A having taken place past the MFM's recommended delivery window as a "coincidence" (TR 129), and stated that the MFM "got lucky" (TR 155). Yet, the whole point of consulting with an MFM is to take as much guess work out of choosing a safe delivery date as possible and, in this case, the MFM was spot on. Respondent's expert's inability to deduce the MFM's preciseness does not excuse Respondent's failure to abide by the MFM's recommendation for no

appropriate reason.

Based upon the foregoing, in addition to Respondent's failure to address his deviation from the MFM's delivery window recommendation in support of the delivery date he scheduled in his records otherwise and/or to note any conversations he deemed relevant with the MFM, I recommend that Respondent be found to have committed both malpractice and to have failed to maintain proper medical records.

While the situation was unfortunate and I have no doubt that Respondent regrets the outcome, I find Respondent's response to the allegations to lack credibility and deem it an attempt to shield himself from the consequences of his regrettable decision to discount the MFM's recommended delivery window. I defer to the Board with respect to any disciplinary action it may deem appropriate should the Board agree with and adopt these findings and recommendation.

DATED this 13th day of February 2024.

By: _____

Patricia Halstead, Esq.
Hearing Officer
(775) 322-2244

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing FINDINGS AND RECOMMENDATION addressed as follows:

Ian J. Cumings
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

Nabil Elkhoury, M.D.
c/o Christian T. Balducci, Esq. and
10001 Park Run Drive
Las Vegas, NV 89145

DATED this 13th day of February 2024.

Signature

Meg Byrd
Print

Legal Assistant
Title