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

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
DEC 26 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This case was presented for adjudication and decision before the Nevada State Board of Medical Examiners (Board), during a regularly scheduled Board meeting on December 13, 2024, at 8:15 a.m. (Pacific Standard Time), located at 325 E. Warm Springs Road, Suite 225, Las Vegas, NV 89119, video conferenced to 9600 Gateway Drive, Reno, NV 89521. Stephen Brent Horsley, M.D., (Respondent) was properly served with a notice of the adjudication, including the date, time, and location. Respondent was present with his attorney, Randal Tindall, Esq. The adjudicating members of the Board participating in these Findings of Fact, Conclusions of Law and Order were: Nick M. Spirtos, M.D., F.A.C.O.G., Ms. Maggie Arias-Petrel, Chowdhury H. Ahsan, M.D., Ph.D., FACC, Ms. Pamela J. Beal, Irwin B. Simon, M.D., FACS, Joseph Olivarez, P.A.-C, and Jason B. Farnsworth, RRT, MBA. Matthew P. Feeley, Esq., Deputy Attorney General, served as legal counsel to the Board.

The Board, having received and read the formal Complaint (Complaint) and exhibits admitted at the hearing of this matter, the Hearing Officer's Findings and Recommendations,[1] and the transcript of the hearing, made its decision pursuant to its authority and provisions of the 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.

[1] The Hearing Officer's Findings and Recommendations were prepared by Paul Lipparelli, Esq., who was appointed as Hearing Officer under NRS 630.106 in this matter and presided over the hearing.

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:

FINDINGS OF FACT

I.

Respondent held a license to practice medicine in the State of Nevada issued by the Board on April 18, 2007.

II.

On January 31, 2024, the Investigative Committee filed a formal Complaint in Case No. 24-32518-1, alleging two (2) violations of the Medical Practice Act that constitutes grounds for initiating disciplinary action against a licensee, as follows: one (1) count of NRS 630.301(4), Malpractice and one (1) count of NRS 630.3062(1)(a), Failure to Maintain Appropriate Medical Records. The Complaint was served upon Respondent's counsel on February 1, 2024. Respondent filed an Answer to the allegations set forth in the Complaint on February 20, 2024.

III.

An Order was filed on March 12, 2024, scheduling an Early Case Conference for the pending matter for March 18, 2024, at 10:00 a.m., and was served upon Respondent's counsel by email.

On March 18, at 10:00 a.m., the Hearing Officer., conducted a telephonic Early Case Conference by Zoom in this matter. William P. Shogren, Deputy General Counsel, (Mr. Shogren) was present on behalf of the Investigative Committee (IC) and Dylan E. Houston, Esq. appeared on behalf of Respondent. At the scheduled Early Case Conference, the Hearing Officer set the date for the Prehearing Conference, the deadline for the parties to exchange lists of witnesses and documents, and the date for the Hearing.

On March 27, 2024, in compliance with NAC 630.465, a Scheduling Order setting the Prehearing Conference and Hearing was filed. Pursuant to that Order, the Prehearing Conference was set for June 17, 2024, at 10:00 a.m. and the formal Hearing was set for July 22, 2024, at

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9:00 a.m. The Scheduling Order was sent to Respondent's counsel by email and certified mail on March 28, 2024.

The IC's Prehearing Conference Statement, along with exhibits intended to be presented at the Hearing, was sent to Respondent's counsel via Fed Ex 2-Day Mail and was served on June 14, 2024.

The Prehearing Conference was held by Zoom as noticed and ordered, at which time, legal counsel for the IC, Mr. Shogren, appeared and Mr. Tindall appeared on behalf of Respondent.

A request for a continuance by Respondent's counsel was granted and an Order Rescheduling Date of Formal Hearing was filed July 19, 2024, moving the Hearing to September 11, 2024, at 9:00 a.m. The Order was sent to Respondent's counsel via email and certified mail on July 19, 2024.

IV.

On September 11, 2024, as duly noticed and ordered, a contested case hearing was held before the Hearing Officer to receive evidence and to hear arguments of both parties. Legal counsel for the IC, Mr. Shogren, appeared and Mr. Tindall and Respondent also appeared.

The Hearing Officer received the complete record of proceedings, including the transcript of the testimony received and the exhibits admitted at the formal hearing. The Hearing Officer issued his Findings and Recommendations, which were filed November 12, 2024. This matter was scheduled for final adjudication on December 13, 2024, at a regularly scheduled Board meeting. A copy of the Hearing Officers Findings and Recommendations was served upon Respondent's counsel via email and certified mail.

On November 12, 2024, a notice of the adjudication was sent to Respondent's counsel via email and certified mail.

A copy of the adjudication materials was sent via Fed Ex 2-Day mail to Respondent's counsel on December 5, 2024, and a copy of the Investigative Committee's Memorandum of Costs and Disbursements and Attorney's Fees was sent to Respondent's counsel by email on December 11, 2024.

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V.

Pursuant to NRS 622A.300(5)(a), the Findings and Recommendations of the Hearing Officer are hereby approved by the Board and are hereby specifically incorporated and made part of this Order by reference. A copy of the Findings and Recommendations filed November 12, 2024, in this matter are attached hereto as **Exhibit 1.**

VI.

The Board hereby finds that Counts I and II, as set forth in the Complaint, and as recapitulated in Paragraph II above, have 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's medical license and the Complaint, and an adjudication of this matter by the Board members as set forth herein is proper.

II.

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

III.

With respect to the allegations of the Complaint, the Board concludes that Respondent has violated the Medical Practice Act, as alleged in the Complaint, as follows: one (1) count of NRS 630.301(4), Malpractice and one (1) count of NRS 630.3062(1)(a), Failure to Maintain Appropriate Medical Records. Accordingly, Respondent is subject to discipline pursuant to NRS 630.352.

IV.

The Board finds that, pursuant to NRS 622.400, recovery from Respondent of reasonable attorneys' fees and costs incurred by the Board as part of its investigation and disciplinary

proceedings against Respondent is appropriate. 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 and necessary 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, its intricacy, 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.

V.

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. Respondent is hereby ordered to reimburse the Board the reasonable and necessary costs and expenses actually incurred in the investigation and prosecution of this case in the amount of fourteen thousand one hundred thirty-two dollars and ninety-eight cents ($14,132.98), which amount Respondent shall pay within sixty (60) days of service of this Order;

2. Respondent shall perform two (2) hours of Continuing Medical Education (CME), related to the subject of best practices in record keeping, within six (6) months of service of this Order. These two (2) hours of CME shall be in addition to the CME requirement regularly imposed upon Respondent as a condition of licensure in the State of Nevada pursuant to NAC 630.125(1);

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3. Pursuant to NRS 630.352(4)(e), a written public reprimand shall be issued to Respondent; and

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

IT IS SO ORDERED.

DATED this 26th day of December, 2024.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

NICK M. SPIRTOS, M.D., F.A.C.O.G.
President of the Board

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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 **STEPHEN BRENT HORSLEY, M.D.**, Case No. 24-32518-1.

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 the 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 26th day of December, 2024.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Maggie Arias-Petrel

MAGGIE ARIAS-PETREL
Secretary-Treasurer and Public Member of the Board

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EXHIBIT 1

EXHIBIT 1

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against: **STEPHEN BRENT HORSLEY, M.D., Respondent.**	**Case No. 24-32518-1**

FINDINGS AND RECOMMENDATIONS/SYNOPSIS OF RECORD

I. INTRODUCTION

A hearing was held in front of the under-signed hearing officer on September 11, 2024, beginning at 9:00 a.m. at the Reno office of the Nevada State Board of Medical Examiners (the "Board"). William P. Shogren, Deputy General Counsel, appeared on behalf of the Investigative Committee of the Nevada State Board of Medical Examiners (the "IC"). Mr. Shogren and the hearing officer were present in the hearing room. Randall Tindall, Esq. appeared by Zoom from Las Vegas on behalf of Respondent Stephen Brent Horsley, M.D. Court Reporter Gabrielle Johnson was present by Zoom and transcribed the proceedings. Legal Assistant Mercedes Fuentes was also present in the hearing room and operated the Zoom equipment.

The following witnesses appeared by Zoom and were sworn in by the court reporter before testifying: Alexis Kent, Dr. Michael Murray and Dr. Stephen Horsley. The hearing officer confirmed that all witnesses and participants could hear each other.

References to the hearing transcript are made below and designated by "TR" followed by the page number of the transcript. References are also made to the Bates-stamped exhibits submitted by the parties. NSBME signifies exhibits offered by the Board. RESP signifies exhibits offered by the Respondent. The parties to these cases cannot be sure what documents each is planning to present until the exchange of medical records prior to the prehearing conference. Understandably, the parties submit some of the same documents as exhibits.

The following exhibits were admitted into evidence:

- Exhibit 1—Formal Complaint, NSBME 001-005 (TR19)
- Exhibit 2—Proof of Service, NSBME 006 (TR20)
- Exhibit 3—Allegation Letter, NSBME 007-008 (TR20)
- Exhibit 4—Order to Product Records, NSBME 009-012 (TR20)
- Exhibit 5—Respondent's Response to Allegation Letter, NSBME 013-017 (TR20)
- Exhibit 6—Medical Records from Western Surgical, NSBME 018-067 (TR20)
- Exhibit 7—Medical Records from Dr. Horsley, NSBME 068-114 (TR20)
- Exhibit 8—Curriculum Vitae of Michael Murray, M.D., NSBME 115-117 (TR29)
- Exhibit 9—Quick Safety: Advancing Safety with Closed-Loop Communication of Test Results (December 2019), NSBME 118-119 (TR32)
- Exhibit 10—American Medical Association Code of Medical Ethics, 2.1..5 Reporting Clinical Test Results (1847, revised 2016), NSBME 120 (TR32)
- Excerpts of Ensign Family Medicine Records, RESP 000186-000189, (TR88)

The rule of exclusion for witnesses was invoked by both parties. The hearing concluded at 12:37 p.m.

II. ALLEGATIONS

A formal complaint was filed against Respondent on January 31, 2024. Count 1 of the Complaint alleges malpractice of a physician under NRS 630.301(4) for the failure of a physician in treating a patient to use reasonable care skill or knowledge ordinarily used under similar circumstances. Count 2 alleges the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient under NRS 630.3062(1)(a). The Answer was filed February 20, 2024 and denies many of the allegations.

Pursuant to the Complaint, the Respondent examined Patient A on September 18, 2020, for the evaluation of an enlarged right groin node (and other conditions unrelated to this matter). A few weeks later, on October 26, 2020, Respondent performed the excision of the node for a biopsy and the excised tissue was sent to a pathology services firm on the orders of Respondent. On or about October 30, 2020, Respondent received a preliminary pathology report which stated in part

"worrisome for B-cell lymphoma with follicular pattern however, bcl-2 strain is not confirmatory." The report also noted that the tissue would be sent for outside consultation. These allegations are admitted by the Respondent in the answer.

The dispute in this case centers on the actions the Respondent took, or did not take, following the successful surgical procedure.

III. WITNESSES AND TESTIMONY

A. Alexis Kent.

State Board of Medical Examiners investigator Alexis Kent was called by the IC. Ms. Kent was assigned as the investigator for the Respondent's case. Ms. Kent testified that prior to her involvement with the Respondent's case another investigator performed work on the case and that she took over the investigator duties on November 28, 2022. TR17. Ms. Kent explained she had experience in approximately 200 other investigations and that her work on the Respondent's case is like other cases she has investigated. TR16-17. Ms. Kent explained she was familiar with Exhibits 1 and 2 of the IC's exhibits and that they are true and correct copies. Exhibits 1 and 2 were admitted into evidence without objection. TR19. To save time during the hearing, Respondent's counsel courteously noted there were also no objections to the admission into evidence of exhibits 3 through 7. TR20. They were admitted.

On cross examination Ms. Kent testified that Ryan Swank was the prior investigator (TR21) and that she did not have input into the decision to file the formal complaint in this case. TR24. When Ms. Kent's testimony concluded she was removed from the Zoom call.

B. Michael Murray, M.D.

1. Direct Examination.

Dr. Michael Murray, a licensed Nevada physician, testified next for the IC. He has been licensed in Nevada for 27 years and explained his medical education. TR26. Dr. Murray is certified by the American Board of Surgery. TR 27. Exhibit 8 is a true and correct copy of his CV and Exhibit 8 was admitted over the objection of Respondent's counsel on the basis of relevance. TR26-29. Dr. Murray has served as a peer reviewer for the Board for 20 to 30 cases over the last 10 years. TR29. Dr. Murray explained his experience as a practicing physician in general surgery. TR32.

Dr. Murray testified that he was familiar with the IC's Exhibits 9 and 10 and that they were true and correct copies of what he provided to the ICC as part of his engagement with the Board. TR29-30. He testified that exhibit 9 is an article from the AMA about managing closed loop communications of test results and that Exhibit 10 is the AMA code of ethics on clinical test results and together elucidate the standard of management of information and communication. Dr. Murray testified that exhibits 9 and 10 are documents supporting the standard of care and management of information by physicians. TR29-30. Exhibits 9 and 10 were admitted into evidence over the objection of Respondent's council based on authenticity and foundation. TR31-32.

Dr. Murray testified that his on-going surgical practice includes surgeries like lymph node biopsies, breast biopsies and the collection of specimens for diagnosis. TR 33. Dr. Murray's experience includes close to 1000 diagnostic lymph node biopsies and the review of thousands of pathology reports. TR 33-34. Dr. Murray testified that he has reviewed the Complaint in the instant case along with the Respondent's response and the medical records provided to him for his review. TR34.

Dr. Murray testified in his professional opinion Respondent departed from the proper standards of care. TR35. Dr. Murray's opinion is the surgical procedure was performed for the purpose of diagnostics and to obtain the needed pathology report. TR35. Dr. Murray concludes there was not an adequate discussion of the patient's case and the patient was discharged from the practice without that discussion taking place. TR35.

The witness was examined at length about exhibits contained in the IC's submitted exhibits. Exhibit 7 (NSBME 71) reflects patient's initial consult by Respondent who recommended a biopsy of Patient A's enlarged right groin lymph node. TR36. The Respondent's operative note following the surgery and says that there were no difficulties or issues with the surgery which took place on October 26, 2020. TR37 (NSBME 74). The Aurora Diagnostics pathology report that followed the surgery was signed by pathologist, Dr. June Sigman, on October 30, 2020, was addressed to Dr. Stephen Horsley, Respondent. NSMBE 75--76. Dr. Murray notes the pathology report contains only a preliminary diagnosis including atypical lymphoid proliferation. TR38. Dr. Murray noted that there is something worrisome on the pathology and that more studies on more slides would be needed for

the final pathology. TR38. Additional ancillary studies are pending and will be reported on an addendum to the final report. TR38. In Dr. Murray's experience it is increasingly common for pathology reports to be amended based on the availability of additional testing. TR39.

The additional pathology noted in the first pathology report was performed. Addendum 1 of the pathology report dated November 13, 2020, addressed to Dr. Stephen Horsley of Durango Outpatient Surgery Center, notes positive results for B-cell gene rearrangement and confirms a diagnosis of lymphoma. TR39. NSBME 77. The addendum states the need for even more additional testing for further characterization. TR40. Dr. Murray explained that it is becoming increasingly common to delineate exactly what type of tumor is present TR 40.

Dr. Murray was examined about NSBME 81, the second addendum of the initial pathology report from Aurora Diagnostics. This third document was signed by David R. Coon M.D. and was also addressed to Dr. Horsley. That report provides a final diagnosis of the right groin lymph node as follicular lymphoma Grade 1 or 2. TR42. Dr. Murray testified that from his review of the Respondent's Response to Investigative Letter, Patient A was informed of the diagnosis of low-grade lymphoma in June of 2021. TR43. NSBME 016.

From Dr. Murray's review of the records provided to him in Respondent's case, he cannot find records indicating Dr. Horsley informed Patient A of the first addendum to the pathology report TR44. Dr. Murray believes Dr. Horsley should have told the patient there were some concerns for lymphoma and that Dr. Horsley should have brought the patient back after the final diagnosis and discussed the findings with the patient. TR44. There is no benefit to the biopsy procedure other than to get the diagnosis TR44. The main reason to accept the risks of a biopsy is that the patient wants to know the reason for an enlarged lymph node, and it is important to communicate this information to the patient. TR46. Dr. Murray would have communicated the concerns about the path pathology to the patient during another office visit to close the communication loop. TR46.

Dr. Murray's review of the patient records does not indicate there was a follow-up for the patient and no transfer of the patient to an oncologist who would deal with the pathology findings. TR47. Dr. Murray believes that the standard of care would have been to have a discussion with

Patient A about the pathology findings. TR47. The patient was not informed of the seriousness of her diagnosis after a diagnostic procedure. TR48.

Dr. Murray testified that from the early days of a physician's internship the long-standing traditions are that the physician who ordered a test is responsible for the actions taken afterward TR49. Physicians are responsible for the continued monitoring of records that are received about a patient and addressing the results TR49. Dr. Murray's practice is to review pathology and radiology and other things and to sign them off prior to them being placed in the patient's medical record. TR50-51.

2. Cross Examination.

Dr. Murray is aware that Dr. White was Patient A's family physician, but he does not recall reviewing Dr. White's records. TR52. Dr. Murray testified that about 85% of the biopsies he has performed came from a referral by another doctor. TR53.

Dr. Murray explained the process by which he is engaged as a peer reviewer for Board cases. TR 54. He is contacted by an investigator from the Board after the Board's investigation has begun. TR56. He gets materials from the investigator, reviews the materials and sends them back to the board along with a report. TR58-60.

Counsel for Dr. Horsley asked that Dr. Murray's report to the Board be displayed so that questions could be asked about the report. TR61. The hearing officer sustained an objection to that request because the investigative file is confidential except for those items which are used in the formal hearing. TR62. After another request for Dr. Murray's report by Respondent, the hearing officer ruled that Dr. Murray's live testimony which may have included matters addressed in his report did not turn the report into an admitted exhibit and destroy the confidentiality of the investigative file. TR62-63.

Dr. Murray explained the process he uses to research the standard of care when presented with a case from the Board. TR65. He may have spent an hour or two doing Internet research on the case. TR65. Dr. Murray admitted he did not have written authority for the long-standing traditions he testified to earlier applied to the facts of Dr. Horsley's case. TR66. Dr. Murray explained that he

probably could have found other information from organizations such as the AMA, JCAHO the Institute of Medicine, CMS and Medicare. TR64-67.

Dr. Murray admitted he could not say whether any doctor had discussed the preliminary lab results with Patient A and that there is no documentation for that. TR69. He also admitted he has no knowledge about the processes Dr. Horsley uses in his office and no knowledge about whether there has ever been a similar incident to that of Patient A. TR71. Dr. Horsley is not aware of any CME training or board of medical examiners mandates about a standard of care for communication. TR77.

Dr. Murray admitted that "quick safety" document produced by the Joint Commission and which he consulted (NSBME 118-119) contained a statement that the material is meant as information piece only and is not a standard. TR68. NSBME 018-019. Dr. Murray admitted that if Patient A's primary care doctor discussed the pathology reports with Patient A, that would have been good for the patient. TR69.

3. Re-direct Examination.

On re-direct examination, Dr. Murray testified he relied on his own experience as a surgeon in reaching his opinion that Dr. Horsley had committed malpractice. TR72. Dr. Murray explained that the role of a primary care physician does not change his opinion that Dr. Horsley had an obligation to explain all the pathology to the patient. TR72.

C Stephen Horsley, M.D.

1. Direct Examination.

Dr. Horsley briefly explained his education including his medical education internship and residency. TR76. Dr. Horsley has had one employer and one partner for the past 17 years and is a Board Certified general surgeon. TR76. The process of obtaining board certification includes taking qualifying exams (oral and written) and carries a rigorous process of continuing medical education to maintain the certification. TR76-77. In all of his schooling, training, board certifications and continuing medical education, Dr. Horsley does not recall being instructed on a standard of care for communicating test results to patients. TR77. Dr. Horsley has performed approximately 100 biopsies per year for 17 years and has also had experience with removing other tissue during surgery. TR78.

Dr. Horsley explained the challenges his medical practice experienced during the COVID pandemic in 2020. He lost 50% of his office staff, surgeries were being cancelled so operating rooms could be used for sick patients and the governor was asking people to stay home. Dr. White, a friend of Dr. Horsley, was having similar experiences with his office. The entire medical society was not functioning normally. TR79. Specifically, during the pandemic some medical procedures were being postponed and because Patient A was scheduled for a colonoscopy *and* the biopsy of the swollen lymph node, it was difficult to gain approval for Patient A's combination procedure. TR79.

Dr. Horsley testified about a telephone note created by the office of Dr. Sanford White which says that Dr. White discussed with the patient the pathology results for the inguinal lymph node and the need for further evaluation and a referral to oncology. TR81. He was referring to RESP 204. It was offered as evidence, but not admitted because Dr. Horsley did not author the record and could not be sure whether Dr. White or his assistant had spoken to the patient. TR85. The document did however match Dr. Horsley's knowledge of what happened in Patient A's case. TR86.

Dr. Horsley's testimony establishes that respondents exhibits 186, 187 and 188 (RESP 186-188) were the preliminary pathology findings of Dr. June Sigman (Auroa Diagnostics) and were reported on October 30th, 2020. They were sent from Mountain West Surgical (Dr. Horsley) to Dr. White's office November 16, 2020. TR87-88. These exhibits were admitted into evidence without objection.

Dr. Horsley conducted a post-op exam on Patient A which confirmed the right groin incision did not appear to be infected. He also notified Patient A that the colonoscopy showed nothing of concern. TR88-89. During that visit Dr. Horsley informed Patient A that there were "cells of concern" based on the pathology, but more expert analysis would be necessary. He informed Patient A that follow-up with him (Dr. Horsley) would be as-needed because Dr. White was also going to have a copy of the report. TR89.

Dr. Horsley felt it would be irresponsible to tell Patient A, who he knew was being treated for anxiety and depression, the words "possibly cancer" which could be devastating to her. TR89. He did, however, tell her that there are unusual cells that are not normal, and that Dr. Sigman (the

pathologist) needs more studies to tell exactly what we are dealing with. He also told the patient that it was not clear how long that would take. TR89.

Dr. Horsley has a good opinion of the pathologist and that if she could not determine what the test results show, the need for further analysis was appropriate. TR90. The lack of clarity in the test results could mean that Patient A's case was "borderline" or a "very low grade lymphoma" that may represent something concerning. TR90.

Aside from Patient A's case, Dr. Horsley said that he is unaware of any problems in communication of pathology findings to a patient by he or his partner in 17 years of general surgery practice. TR91. Dr. Horsley testified his office procedures for electronic medical records include reviewing the records, verifying records have been reviewed, and directing copies be sent to primary care providers. TR92.

Despite what he believed were adequate procedures within his office for handling pathology reports, Dr. Horsley was distressed to discover that several months had passed between the time Dr. White got the pathology report and the time Patient A was referred to other doctors for follow up care. TR92. After Patient A's case Dr. Horsley began the practice of printing pathology reports and handing them to patients and asking patients if they would like help making an appointment with an oncologist when oncology may be necessary instead of relying on primary care doctors to make those referrals TR92-93. Dr. Horsley also takes the additional step of sending pathology reports by registered mail with a return confirmation for patients that do not follow-up. TR93.

The Patient A case was the first instance Dr. Horsley knew there was any kind of problem involving pathology records. TR93. As soon as Dr. Horsley realized there was a communication problem between the surgical group, the primary care doctor, and the patient, he and his partner double and triple checks to make sure nothing similar would happen again. TR94.

Dr. Horsley admits that as to Count 2 involving medical records his record keeping could have better reflected the efforts he did make regarding communication and documenting communication. TR94-95.

2. Cross Examination.

Dr. Horsley did not recall personally sending the first pathology report to Dr. White, but he did advise his staff to be sure it was sent to Dr. White. TR96. During post-op exam which took place on November 17, 2020, Dr. Horsley did not convey to Patient A the contents of addendum #1 to the pathology report signed by Dr. Coon and dated November 13, 2020. TR96. That report may have been in his office but had not been processed and put into the patient's chart because it sometimes takes several days to be processed in the office. TR97.

The November 20, 2020 amended pathology report (second addendum) is dated November 20, 2020 and Dr. Horsley testified he likewise did not personally send the report to Dr. White but directed his staff to do so. TR98. Dr. Horsely also testified about electronic medical records systems within his office which confirm that he directed his staff to deliver the first addendum and the second addendum of the pathology reports to Dr. White. The "screen grab" of this record is NSBME 105. TR99.

The electronic medical records system also shows an entry for pathology "ADDENDUM" and contains the date 11/24/2020, but Dr. Horsley does not know what is meant by the term "scan date". The electronic record contains this language "please be sure Dr. White has this report." The "screen grab" is NSBME 106. TR99.

Dr. Horsley testified that the contents of the pathology reports concerning Patient A were concerning and that it is important for the patient to know the report results so the patient can potentially get care. TR100. Dr. Horsley testified that ideally, Patient A would have followed up with Dr. White as the referring doctor who would be able to communicate with patient in a compassionate way having known and treated her for a multitude of medical problems. TR100.

Dr. Horsley believes that Dr. White's office had the preliminary pathology report and did not communicate with the patient, nor did the patient choose to follow up with Dr. White or Dr. Horsley. TR101. There was no communication between Patient A and Dr. Horsley or Dr. White until June [of 2021]. TR101. Dr. Horsley admits that he did not reach out to Patient A after his November 17, 2020 post op exam. TR101.

D. Directed Verdict.

At the conclusion of the presentation by the IC the Respondent moved for a directed verdict on the basis that there is no testimony on the record, stated to a degree of medical probability, to support a finding of malpractice under Count 1 by a preponderance of the evidence. TR74. The hearing officer denied the motion but noted that the weight of Dr. Murray's testimony would reflect the bases for his opinion. TR74-75.

IV. FINDINGS

All the witnesses appeared genuine and gave credible testimony. The hearing officer finds the education, training and work experience of Ms. Kent, Dr. Murray and Dr. Horsley enabled them to provide helpful testimony about the facts and exhibits. Dr. Murray and Dr. Horsley, as highly educated and experienced professionals, are also considered able to offer opinions on facts and data that was available to them.

The record and the evidence establish there is no dispute about the dates of these events and occurrences:

- 10/26/2020—surgical procedure on Patient A for removal of enlarged lymph node from right groin by Dr. Horsley,
- 10/30/2020—date of signing of first Aurora Diagnostics pathology report with preliminary results "worrisome for B-cell lymphoma" but noting ancillary studies are pending and an addendum will follow,
- 11/13/2020—date of Addendum #1 of Aurora Diagnostics pathology report with findings that the results are "confirm the diagnosis of lymphoma" and that outside consultation is necessary to further characterization and findings,
- 11/16/2020—date preliminary pathology report (signed 10/30/2020) sent to Dr. White's office by Dr. Horsley's office (fax cover sheet),
- 11/17/2020—post-op exam of Patient A by Dr. Horsley,
- 11/20/2020—date of Addendum #2 of Aurora Diagnostics pathology report with final diagnosis of follicular lymphoma grade 1-2,
- 6/2021—Patient A is informed of diagnosis of low-grade lymphoma as part of a referral to oncology.

A. Malpractice.

Malpractice is the failure to use the reasonable care, skill, or knowledge ordinarily used under the circumstances in the treatment of patient.

Respondent, Dr. Horsley, performed a successful biopsy procedure on Patient A and sent the excised tissue to pathology. An initial pathology report and two addenda to the pathology report were produced by Aurora Diagnostics and several pathologists. The initial pathology report noted some concerning findings but did not contain a conclusive diagnosis. The first addendum and the second addendum confirmed lymphoma in Patient A. Dr. Horsley never communicated the results of the first and second addenda directly to Patient A but did direct the results of the pathology addenda be sent to Patient A's primary care physician. He assumed that Patient A would be told about the lymphoma by the primary care physician.

Dr. Horsley examined Patient A after the lymph node surgery. He determined there was no infection at the incision site, told Patient A that the results of the colonoscopy were of no concern, and explained that only preliminary pathology was available concerning the excised lymph node. He told Patient A, there were "cells of concern," but that more testing was being done. Dr. Horsley directed his staff to send the initial and at least the first amended pathology reports to Dr. White, Patient A's primary care physician. No admissible exhibits confirm Dr. Horsley or Dr. White (Patient A's primary care doctor) communicated to Patient A about the troubling results of those tests until June of 2021—approximately 7 months after the surgery.[1]

Dr. Murray, the IC's witness, says it is standard practice—and definitely his personal practice—to communicate patients about pathology results. All three pathology reports from Aurora Diagnostics were addressed to Respondent. Dr. Horsley and Durango Outpatient Surgery Center are listed on those reports as "client." Dr. Murray's considerable experience with thousands of biopsies and pathology reports provides a basis for him to describe an appropriate standard of practice for patient communication. As established by Dr. Murray, the reason for performing a biopsy on a swollen lymph gland is to obtain pathology. That points to the importance of making sure the pathology results are communicated to the patient.

[1] Dr. Horsley admitted during cross examination there was no communication between Patient A and Dr. Horsley or Patient A and Dr. White until June [of 2021].

Dr. Murray relies on Exhibit 9, the article from the Joint Commission, which discusses the importance of multiple parties in the health care system working together to hand off tests and communicate with the patient—to close the loop of communications. However, as established on cross-examination, the article itself is not meant to be a medical standard. It is therefore not given much weight as evidence.

Dr. Murray also provided the Board an excerpt of the AMA Code of Medical Ethics about reporting clinical test results. It provides, in part, "Patients should be able to be confident that they will receive the results of clinical tests in a timely fashion. Physicians have a corresponding obligation to be considerate of patient concerns and anxieties and ensure that patients receive test results within a reasonable time frame." NSBME 120. The code acknowledges that when and how clinical results are conveyed to patients can vary considerably, but emphasizes physicians should have policies and procedures in place that ensure patients are properly informed about test results.

Dr. Murray could not find any medical records involving Patient A establishing that Dr. Horsley handed off Patient A's case to Dr. White or any other physician such as an oncologist. Whether due to his understanding of long-standing practices of physicians to communicate test results to patients, or the AMA Code of Ethics, Dr. Murray's opinion is that Dr. Horsley departed from the standard of practice in failing to communicate to Patient A the ultimate diagnosis of grade 1 or 2 lymphoma. Dr. Murray's opinion must be considered in light of other evidence about the standard of care. The only source for that is the testimony of Dr. Horsley. There were no other witnesses.

Dr. Horsley has considerable experience as a surgeon. He has performed over 100 biopsies per year for over 17 years. With his experience and training and the extra training he gets as a Board Certified surgeon, Dr. Horsley cannot recall ever once being instructed about the standard of care in reporting test results to patients. There is no evidence, outside the case involving Patient A, that Dr. Horsley has ever had a problem with patients being informed of test results. In this case, Dr. Horsley is relying on his experience and training. And Dr. Murray is relying on his experience and at least on authority that instructs physicians to have policies and procedures in place to ensure that patients are properly informed about test results.

Dr. Horsley does have a system to forward test results he receives to other doctors. An electronic button in his electronic medical records system allows him to indicate that he has reviewed a medical record like a pathology report, but does not clearly include the date the records were reviewed. The "screen grab" evidence described during Dr. Horsley's testimony bears this out. The electronic records system further allows Dr. Horsley to direct that pathology reports he reviews be forwarded directed to other physicians like a primary care doctor. He used this system in Patient A's case to direct copies of the Aurora Diagnostics reports (at least two of them anyway) be sent to Dr. White. Dr. Horsley's system ensured the reports *were sent to another doctor*, but the standard of care is that they be *communicated to the patient*. That is the shortfall. There is no proof that Dr. Horsley communicated to Patient A about the results of the first and second addenda of the pathology report confirming the lymphoma diagnosis.[2]

Dr. Horsley may have satisfied his duty of patient communication by clearly and verifiably transferring responsibility for communication with Patient A to Dr. White. There is no evidence that happened. Patient A did not learn of the diagnosis of low-grade lymphoma from the excised lymph node until June of 2021 proving the lack of timely patient communication. Dr. Horsley admits this unfortunate fact.

When Dr. Horsley sent the excised tissue to pathology, he could have directed the results to be sent to Dr. White or some other physician. That would be consistent with a belief that the primary care doctor was the appropriate physician to follow-up with the patient. That did not happen, and the pathology reports were sent exclusively to Dr. Horsley. Dr. Horsley knew that Dr. White had a long-standing professional relationship with Patient A and felt the potentially distressing communication about the diagnosis of lymphoma was better coming from Dr. White. This shows commendable concern for Patient A's welfare. But, it should have been the cause for a communication between Dr. Horsley and Dr. White to confirm that Dr. White should be the one to most compassionately deliver

[2] After learning of the failure in communications with Patient A, Respondent immediately took action to ensure proper communication with patients about test results occurred going forward. In civil litigation, evidence of remedial measures is usually not admissible to show a breach of duty. This encourages correction of unsafe or unsatisfactory conditions immediately rather than after litigation. Dr. Horsley took the risk that testifying about the corrective actions he installed to prevent future communication failures could be seen as proof that his actions in the Patient A case were deficient. That shows a laudable concern for better future outcomes. The remedial measures Dr. Horsley took are not necessary to establish that Dr. Horsley failed to communicate tests results to Patient A.

the results of the pathology reports confirming the diagnosis. There is no evidence of that communication.[3]

The preponderance of the evidence establishes that Dr. Horsley committed malpractice by his failure to use the reasonable care, skill, or knowledge ordinarily used under the circumstances in the treatment of Patient A.

B. Failure to Maintain Records.

Dr. Horsley admits that his medical records could have been better and did not adequately reflect the efforts he believes he made regarding Patient A. He offered no evidence to refute the allegations in Count 2.

V. RECOMMENDATION

A hearing officer appointed by the Board is responsible for submitting written findings and recommendations to the Board. NRS 622A.380(1)(l).

A claim of malpractice by a practitioner can be established by a preponderance of evidence. NRS 630.301(4). It is the recommendation of the undersigned hearing officer that a preponderance of the evidence establishes that, as alleged in the Complaint and with regard to Patient A, the Board should find: (1) Respondent, Dr. Stephen Horsley, committed malpractice under NRS 630.301(4) for the failure of a physician in treating a patient to use reasonable care skill or knowledge ordinarily used under similar circumstances; and (2) Respondent, Dr. Stephen Horsley, failed under NRS 3062(1)(a) to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.

DATED this 11th day of November, 2024.

Hearing Officer

Paul A. Lipparelli
Tel: 775-771-6927
Email: paul.lipparelli@gmail.com

[3] Dr. Horsley lost half the employees of his medical office during the COVID pandemic which undoubtedly affected the flow of work and the handling of records. Dr. Horsley believes that Dr. White experienced similar employee loss. Perhaps if both medical offices were at full strength, the records processing and the communications would have been better. It is ultimately the duty of the licensed professional to carry out the duty of patient communication.

CERTIFICATE OF SERVICE

I certify that on this day, I served by personally delivering or mailing, postage pre-paid, a true and correct file-stamped copy of the foregoing **FINDINGS AND RECOMMENDATIONS/SYNOPSIS OF RECORD** to the following parties:

William P. Shogren
Deputy General Counsel
Nevada State Board of Medical Examiners
9600 Gateway Drive
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Stephen Brent Horsley, M.D.
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Certified Mail No.: 9171 9690 0935 0255 7004 55

DATED this 19th day of November, 2024.

Signature

Mercedes Fuentes
Printed Name

Legal Assistant
Title