

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint

Case No. 25-44712-1

Against:

FILED

MICHAEL BRADLEY LILYQUIST, M.D.,

JUL 10 2025

Respondent.

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: 

COMPLAINT

The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners (Board), by and through Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Michael Bradley Lilyquist, 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. 16371). Respondent was originally licensed by the Board on March 22, 2016.

2. Patient A² was a fifty-nine (59) year-old male at the time of the events at issue.

3. Patient A suffered a work-related crush injury to the ring finger of his left hand and a right shoulder injury in or about November 2020.

4. Upon information and belief, Patient A first presented to Respondent in or about 2021 when Respondent worked for Great Basin Orthopaedics.

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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 Chowdhury H. Ahsan, M.D., Ph.D., FACC, Ms. Pamela J. Beal, and Irwin B. Simon, M.D., FACS.

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.

1 5. Patient A was then seen by a different doctor at Swift Institute beginning January 31,
2 2023, for his left arm pain, hand pain, and this physician performed spinal surgery for Patient A.

3 6. A referral to Respondent was given by the spinal surgeon for a surgical consultation
4 of Patient A's left-hand injury after several non-surgical options for his left hand were explored
5 without successful pain relief.

6 7. On May 25, 2023, Patient A saw Respondent, this time, at Swift Institute where
7 Respondent was now employed. Respondent reviewed his physical exam findings and discussed
8 treatment options, to which Patient A opted for a partial amputation of his left ring finger.

9 8. On June 12, 2023, Patient A presented for partial amputation of his left ring finger.

10 9. Respondent drew out the surgical incision on the left ring finger and confirmed with
11 Patient A the location of the amputation.

12 10. Patient A was then taken to the operating room where he was placed in a supine
13 position and given general endotracheal anesthesia.

14 11. Respondent performed a time-out with all those in attendance in the operating room,
15 confirming the proper surgical site and surgery to be performed.

16 12. Patient A's hand was positioned palm up during the time-out. Respondent then
17 turned the hand over to the face down position and redrew the surgical incision markings because
18 he believed the first markings had faded.

19 13. Respondent then performed a partial amputation of Patient A's left middle finger
20 instead of removing part of his left ring finger, resulting in a wrong-site surgery on the left hand.

21 14. Once Respondent realized his error, he then consulted Patient A's wife who called
22 their daughter to discuss what happened. Patient A's family consented for Respondent to continue
23 with the partial amputation of the correct left ring finger.

24 15. Respondent then performed the partial amputation of Patient A's left ring finger, the
25 correct finger.

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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 he performed a wrong-site partial amputation of Patient A's left middle finger instead of the left ring finger.

20. 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 gives 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;

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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OFFICE OF THE GENERAL COUNSEL

Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

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

3 DATED this 10th day of July, 2025.

4 INVESTIGATIVE COMMITTEE OF THE
5 NEVADA STATE BOARD OF MEDICAL EXAMINERS

6 By: 

7 DONALD K. WHITE
8 Senior Deputy General Counsel
9 9600 Gateway Drive
10 Reno, NV 89521
11 Tel: (775) 688-2559
12 Email: dwhite@medboard.nv.gov
13 Attorney for the Investigative Committee

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 10th day of July, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:



CHOWDHURY H. AHSAN, M.D., PH.D., FACC
Chairman of the Investigative Committee