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: **OVIDIU BRESCAN, M.D.,** **Respondent.**	**Case No. 25-11878-1**

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 Ovidiu Brescan, 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. 8359). Respondent was originally licensed by the Board on August 14, 1997, and has a specialty in anesthesiology.

2. Patient A[2] was a fifty-two (52) year-old male at the time of the events at issue.

3. On November 27, 2017, Patient A presented to Summerlin Hospital for a vitrectomy of the left eye with plans for anesthesia to be administered by Respondent, an anesthesiologist.

4. Prior to the procedure, Respondent noted several potential anesthesia problems for Patient A, including morbid obesity and a Mallampati IV scored airway, which is the highest

[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.

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difficulty of an airway. Respondent further noted that Patient A had sleep apnea, hypertension, and diabetes mellitus type I.

5. On the morning of November 27, 2017, Patient A entered the operating room for the vitrectomy. When Respondent began induction of the anesthesia, Patient A became hypoxic with bradycardia and the eye procedure was aborted.

6. Respondent attempted to intubate Patient A with an endotracheal tube, and then used a laryngeal mask airway. Respondent took approximately forty-five (45) minutes to intubate Patient A. During this time, Respondent administered multiple doses of atropine and epinephrine.

7. Also, during this time, Patient A developed hypotension and his oxygen saturation was recorded between approximately 70% and 80%.

8. After Patient A's airway was secured, at approximately 8:30 a.m., Patient A was brought to the Post Anesthesia Care Unit (PACU) intubated and sedated, with plans to admit Patient A to the intensive care unit (ICU).

9. After arriving in the PACU, Patient A underwent an arterial blood gas (ABG) test at approximately 8:41 a.m., which demonstrated a low Ph level of 7.3, an elevated partial carbon dioxide (PCO2) level of 60.1, a partial oxygen (PO2) level of 390, and a bicarbonate (HCO3) level of 29.3.

10. Patient A's ABG results collectively were indicative of acute, non-compensated hypercapnia[3] and respiratory acidosis[4].

11. Further, Patient A's PO2 level at this time was falsely elevated due to mechanical ventilation with 100% fraction of inspired oxygen (FiO2).

12. Respondent performed a post-anesthesia evaluation at approximately 9:22 a.m. and then left the PACU.

13. According to Respondent's notes, approximately ten (10) minutes after leaving the PACU, a nurse called Respondent back to assess Patient A. The nurse told Respondent that

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[3] Hypercapnia is defined by abnormally elevated carbon dioxide levels in the blood.

[4] Respiratory acidosis occurs when blood becomes too acidic due to the lungs failing to remove enough carbon dioxide.

Patient A was awake, and Respondent evaluated Patient A and found that Patient A followed Respondent's commands.

14. Patient A's recent ABG results indicating acute, non-compensated hypercapnia and respiratory acidosis, and Patient A's history of significant obesity and comorbidities, suggested that Patient A likely would have suffered respiratory failure without the aid of ventilatory support at this time, due to the probable inability to expel carbon dioxide and normalize acid base status.

15. Respondent extubated Patient A on November 27, 2017, at approximately 9:32 a.m.

16. Prior to extubation, Respondent failed to take steps to ensure Patient A met the criteria for extubation at this time, such as performing a spontaneous breathing trial, including repeat ABG tests, to ensure that Patient A had normal respiratory mechanics.

17. Further, Patient A did not have a stable clinical picture prior to the extubation, due to possible pulmonary conditions caused by recent and significant periods of hypoxia, hypotension, and extreme hypertension due to multiple doses of epinephrine and atropine. Respondent's decision to extubate Patient A did not allow for further time to assess Patient A's pulmonary conditions under the controlled environment of a ventilated airway.

18. Respondent further did not discuss the plan to extubate Patient A with the wider medical team of ICU physicians who had yet to evaluate Patient A, prior to extubating Patient A.

19. Patient A's first post-extubation ABG was drawn at approximately 10:30 a.m., showing a Ph level of 7.31, PCO2 level of 44, a PO2 level of 54, 85% oxygen saturation, and an HCO3 level of 29.3. Another post-extubation ABG was drawn at 11:56 a.m., showing a Ph level of 7.31, a PCO2 level of 50, a PO2 level of 73, 93% oxygen saturation, and an HCO3 level of 25.

20. At approximately 12:09 p.m., on November 27, 2017, PACU staff noted that Patient A was not following commands and was desaturating. A pulmonary ICU team arrived at the PACU and determined that Patient A was in acute hypoxic respiratory failure. The ICU team then intubated Patient A.

21. Over the next several hours, Patient A developed a fever and a clinical picture consistent with aspiration pneumonia, as well as altered mental status concerning for

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anoxic/hypoxic brain injury, both scenarios which could be directly related to Patient A's challenging intraoperative course and subsequent failure to remain extubated in the PACU.

22. Patient A thereafter underwent a prolonged hospital course. On December 8, 2017, Patient A passed away, with his cause of death listed as acute cardiopulmonary arrest due to severe sepsis, pneumonia, and unknown etiology.

COUNT I

NRS 630.301(4) – Malpractice

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

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

25. 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."

26. 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 treating Patient A on November 27, 2017, by prematurely extubating Patient A, when Patient A's recent ABG test results, medical history, and recent difficult intraoperative course indicated that Patient A should have remained intubated at the time.

27. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation

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

29. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

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30. NAC 630.210 requires a physician to "seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."

31. On November 27, 2017, Respondent failed to seek consultation with another health care provider, such as an ICU physician, in a doubtful or difficult case, prior to extubating Patient A. Such a consultation may have enhanced the quality of medical care provided to Patient A with regard to the decision to extubate Patient A.

32. 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;

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 19th day of May, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Will Shogren

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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 19th day of May, 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