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:

TIMOTHY THOMAS HAMILTON, M.D.,

Respondent.

Case No. 25-32628-1

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Timothy Thomas Hamilton, 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. 12249). Respondent was originally licensed by the Board on April 23, 2007. Respondent's specialty listed on the Board's website is cardiothoracic surgery.

2. Patient A[2] was a sixty-six (66) year-old female at the time of the events at issue.

3. On October 6, 2021, Patient A was hospitalized following a severe allergic reaction, requiring intubation.

4. On October 22, 2021, Respondent was consulted for a tracheostomy, and placement of a percutaneous endoscopic gastronomy, or PEG, tube.

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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 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 October 27, 2021, underwent a percutaneous tracheostomy and PEG tube placement performed by Respondent. During the placement of the PEG tube, Respondent failed to perform trans-illumination through the endoscopic light, endoscopic confirmation of the positioning of the internal PEG tube button, along with other procedural safeguards to ensure appropriate placement of the PEG tube. Respondent pulled the guidewire utilized to place the tube through the stomach and into the transverse colon. Respondent then pulled the PEG tube all the way through the stomach, pinching a segment of the transverse colon to the abdominal wall.

6. Following the PEG tube insertion, feedings commenced, and Patient A began to exhibit abdominal distention and vomiting without bowel movement.

7. On October 30, 2021, a computed tomography (CT) scan demonstrated free air within the abdominal cavity, and malplacement of the PEG tube.

8. The following day on October 31, 2021, Patient A underwent an abdominal exploration that was performed by Respondent which revealed colon perforation with necrosis, along with several liters of the tube feed in the abdominal cavity. No perforation of the stomach could be demonstrated.

9. Patient A developed an infection and sepsis, underwent multiple additional procedures, and ultimately expired on December 7, 2021.

10. On December 14, 2022, a civil Summons and Complaint was served upon Respondent. Respondent failed to report the Summons and Malpractice Complaint to the Board within forty-five (45) days as required by NRS 630.3067.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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13. 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."

14. 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 by failing to appropriately verify the placement of the PEG tube during the October 27, 2021, procedure.

15. 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)(e) - Failure to Report Civil Action Within Forty-Five (45) Days

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

17. NRS 630.3062(1)(e) provides that the failure of a licensee to comply with the requirements of NRS 630.3068 is grounds for initiating disciplinary action or denying licensure.

18. NRS 630.3068(1)(a) provides that a physician shall report to the Board within forty-five (45) days any action for malpractice after the physician receives a summons and complaint for the action.

19. Respondent did not report to the Board within forty-five (45) days after being served with the Complaint and Summons on December 14, 2022, in Clark County District Court Case No. A-22-862230-C.

20. By reason of the foregoing, Respondent is subject to discipline by the Nevada 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;

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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

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

DATED this 26th day of June, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

IAN J. CUMINGS
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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 26th day of June, 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

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