

1                                   **BEFORE THE BOARD OF MEDICAL EXAMINERS**  
2                                   **OF THE STATE OF NEVADA**

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5   **In the Matter of Charges and Complaint**

Case No. 26-9093-1

6   **Against:**

**FILED**

7   **BRIAN EDGAR JUELL, M.D.,**

**APR 21 2026**

8   **Respondent.**

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS  
By: \_\_\_\_\_

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10                                   **COMPLAINT**

11           The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners  
12 (Board), by and through William P. Shogren, Deputy General Counsel and attorney for the IC,  
13 having a reasonable basis to believe that Brian Edgar Juell, M.D. (Respondent) violated the  
14 provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC)  
15 Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's  
16 charges and allegations as follows:

17           1.       Respondent was at all times relative to this Complaint an MD holding an active license  
18 to practice medicine in the State of Nevada (License No. 5075). Respondent was originally licensed  
19 by the Board on August 4, 1984.

20           2.       Upon information and belief, including information publicly available on the  
21 Board's website, Respondent lists his specialties as General Surgery and Critical Care. Additional  
22 information publicly available on the Board's website shows that Respondent completed an  
23 internship and residency in General Surgery. This information does not indicate that Respondent  
24 completed an internship, residency, or fellowship in Cardiothoracic Surgery, nor does he list  
25 Cardiothoracic Surgery as his specialty.

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28           <sup>1</sup> 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 Nick M. Spirtos, M.D., F.A.C.O.G., Ms. Maggie  
Arias-Petrel, and Carl N. Williams, Jr., M.D., FACS.

1           3.       Respondent is certified by the American Board of Surgery, which is a member Board  
2 of the American Board of Medical Specialties (ABMS), with a specialty in surgery and a  
3 subspecialty in surgical critical care. Respondent is not certified by any other ABMS Board.

4           4.       Patient A<sup>2</sup> was a fifty (50) year-old male at the time of the events at issue.

5           5.       On or about March 10, 2023, Patient A was admitted to Renown Regional Medical  
6 Center (Renown) with a large pericardial effusion, which is a dangerous accumulation of fluid  
7 around the heart, causing pressure on the heart.

8           6.       Patient A had a history of malignant lymphoma treated with mantle radiation in 1995.  
9 Patient A also underwent a partial nephrectomy in 2022 to address renal cell carcinoma.

10          7.       On March 10, 2023, Patient A underwent a pericardiocentesis procedure to drain the  
11 fluid that was accumulating around his heart. After this procedure, a cardiologist examined  
12 Patient A and referred him to a cardiothoracic surgeon for consideration of a pericardial window to  
13 drain fluid from Patient A's heart.

14          8.       However, on March 11, 2023, Respondent, a General Surgeon and not a  
15 Cardiothoracic Surgeon, evaluated Patient A and planned to perform the laparoscopic pericardial  
16 window procedure. Respondent noted that Patient A had a malignant pericardial effusion although  
17 there was no diagnosis of malignancy determined at that time.

18          9.       On March 12, 2023, Respondent performed the planned procedure on Patient A.  
19 During the procedure, an arterial line was not placed prior to the induction. Further, Respondent  
20 failed to utilize a transesophageal echocardiogram (TEE) probe to confirm complete drainage of the  
21 effusion.

22          10.       During the procedure, Respondent inadvertently entered Patient A's chest cavity, or  
23 pleural space, which contributed to later complications, including fluid accumulation in the chest.

24          11.       Patient A was discharged after the procedure. In the weeks following discharge,  
25 Patient A experienced worsening shortness of breath.

26          12.       On April 27, 2023, Patient A was readmitted to Renown with a recurrence of the  
27 pericardial effusion and a large complex fluid collection in the chest.

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<sup>2</sup> 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           13.    On April 28, 2023, Patient A underwent an echocardiogram that revealed he had a  
2 small pericardial effusion without evidence of hemodynamic compromise.

3           14.    On April 28, 2023, and April 29, 2023, Patient A underwent additional procedures  
4 to drain fluid from both the chest and the pericardial space.

5           15.    On April 28, 2023, a consulting cardiologist recommended evaluation by a cardiac  
6 surgeon for further management, including consideration of a repeat pericardial window.

7           16.    On May 1, 2023, Respondent saw Patient A and recommended left video-assisted  
8 thoroscopic surgery (VATS) with decortication and a repeat pericardial window anterior to the  
9 phrenic.

10          17.    At that time, Patient A's condition was complex, including recurrent fluid  
11 accumulation around the heart, loculated (compartmentalized) fluid collections, and a history of  
12 prior radiation therapy affecting the chest.

13          18.    These factors increased the difficulty and risk of any further procedure involving the  
14 heart and surrounding structures.

15          19.    Further, pericardial window procedures are a core privilege of Cardiothoracic  
16 Surgeons and not a core privilege of General Surgeons.

17          20.    Despite these factors, Respondent, a General Surgeon with no formal training or  
18 certification in Cardiothoracic Surgery, proceeded to manage Patient A's surgical care without  
19 direct involvement of a Cardiothoracic Surgeon.

20          21.    On May 2, 2023, Respondent performed the VATS procedure with decortication of  
21 the pleural space and repeat pericardial window.

22          22.    Prior to the procedure, Respondent did not establish adequate invasive monitoring,  
23 including placement of an arterial line before induction of anesthesia.

24          23.    Respondent further did not prepare Patient A with a modified decubitus position with  
25 the pelvis at a forty-five (45) degree angle.

26          24.    Respondent also did not utilize real-time cardiac imaging, such as a TEE probe, at  
27 the outset of the procedure to guide safe entry into the pericardial space.

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1 41. As demonstrated by, but not limited to the above-outlined facts, Respondent  
2 performed a complex cardiac-related surgical procedure on May 2, 2023, which was beyond the  
3 scope of his training as a General Surgeon and/or which Respondent knew or had reason to know  
4 was outside the scope of his competence as a General Surgeon.

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

7 **WHEREFORE**, the IC prays:

8 1. That the Board give Respondent notice of the charges herein against him and give  
9 him notice that he may file an answer to the Complaint herein as set forth in  
10 NRS 630.339(2) within twenty (20) days of service of the Complaint;

11 2. That the Board set a time and place for a formal hearing after holding an Early Case  
12 Conference pursuant to NRS 630.339(3);

13 3. That the Board determine what sanctions to impose if it determines there has been a  
14 violation or violations of the Medical Practice Act committed by Respondent;

15 4. That the Board award fees and costs for the investigation and prosecution of this case  
16 as outlined in NRS 622.400;

17 5. That the Board make, issue and serve on Respondent its findings of fact, conclusions  
18 of law and order, in writing, that includes the sanctions imposed; and

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

21 DATED this 21<sup>st</sup> day of April, 2026.

22  
23 INVESTIGATIVE COMMITTEE OF THE  
24 NEVADA STATE BOARD OF MEDICAL EXAMINERS

25 By:



26 WILLIAM P. SHOGREN

27 Deputy General Counsel

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Reno, NV 89521

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28 *Attorney for the Investigative Committee*

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**VERIFICATION**


STATE OF NEVADA        )  
                                  : ss.  
COUNTY OF CLARK        )

Nick M. Spirtos, M.D., F.A.C.O.G., 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 21<sup>st</sup> day of April, 2026.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

  
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NICK M. SPIRTOS, M.D., F.A.C.O.G.  
*Chairman of the Investigative Committee*