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Individual Rights and Communicable Diseases in Light of the Coronavirus

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While the United States values individual rights, extraordinary circumstances such as the Coronavirus enable HHS/CDC statutory authority to protect the U.S. public.

According to the American Medical Association (AMA), "[r]espect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity." In fact, the general rule is that a patient, who has capacity, has a right to autonomy and to provide informed consent or to decline treatment against medical advice.

In the U.S., we value individual rights and the right of privacy and autonomy. Yet, the framers of America set forth latitude to address the general welfare in the preamble of the United States Constitution:

> We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, **promote the general Welfare**, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America. (emphasis added.)

It is undisputed that COVID-19 (aka "Coronavirus") is a communicable disease and that a pandemic was declared by the World Health Organization (WHO) on March 11, 2020, followed by a declaration of a National Emergency by the President of the United States. Therefore, the question is begged, how are individual rights and the right to patient autonomy balanced against "promot[ing] the general Welfare" of American Citizens?

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MISSION STATEMENT

The Nevada State Board of Medical Examiners protects the public and serves the state of Nevada by ensuring that only well-qualified, competent physicians, physician assistants, respiratory therapists and perfusionists receive licenses to practice in Nevada. The Board responds with expediency to complaints against our licensees by conducting fair, complete investigations that result in appropriate action. In all Board activities, the Board shall place the interests of the public before the interests of the medical profession and encourage public input and involvement to help educate the public as we improve the quality of medical practice in Nevada.

BOARD NEWS

At the direction of Governor Sisolak, the Nevada State Board of Medical Examiners office will be closed to the public until further notice. For assistance during this time, please email nsbme@medboard.nv.gov.

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NOTIFICATION OF ADDRESS CHANGE, PRACTICE CLOSURE AND LOCATION OF RECORDS

Pursuant to NRS 630.254, all licensees of the Board are required to "maintain a permanent mailing address with the Board to which all communications from the Board to the licensee must be sent." A licensee must notify the Board in writing of a change of permanent mailing address within 30 days after the change. Failure to do so may result in the imposition of a fine or initiation of disciplinary proceedings against the licensee.

Please keep in mind the address you provide will be viewable by the public on the Board's website.

Additionally, if you close your practice in Nevada, you are required to notify the Board in writing within 14 days after the closure, and for a period of 5 years thereafter, keep the Board apprised of the location of the medical records of your patients.

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There are three potential scenarios, which could arise relating to a patient refusing treatment after being diagnosed with the Coronavirus in a hospital setting or at a physician office. First, a patient could take the advice of the healthcare professional, stay or become admitted to a hospital or other designated healthcare facility and accept the prescribed course of treatment, including isolation. Second, the individual could refuse treatment, but go home and agree to remain quarantined at home. Thirdly, an individual could refuse treatment and then refuse to remain quarantined at home; thereby posing a risk to others and the "general Welfare."

In the first two scenarios, the individual is not actively harming others. His/her right to autonomy, as part of the decisional rights inherent in the United States (and other countries) is balanced against the harm to others. Deciding to follow the course of treatment at a hospital or other healthcare facility or going home and remaining self-quarantined while denying care in a healthcare setting does not spread the disease and is in keeping with Centers for Disease Control and Prevention (CDC) and other directives about staying at home and not infecting others.

The last scenario is the most problematic because it affects the general health and welfare of other individuals. In January 2017, the CDC and the Department of Health and Human Services (HHS) issued a Final Rule "to amend its regulations governing its domestic (interstate) and foreign quarantine regulations to best protect the public health of the United States." 82 Fed. Reg. 6890 (January 19, 2017). HHS/CDC already had statutory authority pursuant to 42 U.S.C. 264, 265 to "promulgate regulations that protect U.S. public health from communicable diseases, including quarantinable communicable diseases as specified in [various Executive Orders stemming back to 2003]." While there is a lot in this final rule to digest, including the health monitoring of individuals through electronic or internet-based applications, one item is clear – "In implementing quarantine, isolation, or other public health measures under this Final Rule, HHS/CDC will seek to use the least restrictive means necessary to prevent the spread of communicable disease."

In applying the Final Rule to the third scenario—a patient both refuses treatment and refuses to self-quarantine—HHS/CDC added a requirement that the CDC "arrange for adequate food and water, appropriate accommodation, appropriate medical treatment, and means of necessary communication for individuals who are apprehended or held in quarantine or isolation." The least restrictive means include home quarantine or isolation versus confinement in a guarded facility; however, it is based on the individual's willingness to follow all necessary precautions and "the individual's history of compliance with public health recommendations." 82 Fed. Reg. at 6912. This is substantiated by *Yin v. California***,** 95 F.3d 864, 870 (9th Cir. 1996) (recognizing that in searches and seizures justified by special needs, the government does not have to use the least restrictive means to further its interests); *Stockton v. City of Freeport, Texas***,** 147 F.Supp.2d 642, 647 (S.D. Tex. 2001) (recognizing that the Fourth Amendment does

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not require that a search or seizure be conducted through the least restrictive means, but rather that the alleged personal invasion be reasonable under all of the circumstances). Therefore, when an individual is identified as a threat to the health and welfare of others, such as when a patient refuses medical treatment at a healthcare facility and refuses to self-quarantine, the government may take the individual into custody.

In sum, these are trying times. The individual in the third scenario is ego-centric and selfish. By putting other members of society in harm's way and impacting the "general Welfare" of others, the CDC and other government agencies may place the good of the many over the rights of an individual. Had the individual fallen into scenario 1 or 2, it would be a different set of facts and circumstances where the least restrictive means was appropriately used. Social justice can only be achieved in relation to the Coronavirus when people are realistic and do what is right for the good of society.

https://www.physicianspractice.com/health-law-policy/individual-rights-and-communicable-diseases-light-coronavirus

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CDC: Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)

Summary of Recent Changes

Revisions were made on April 3, 2020, to reflect the following:

- New information about asymptomatic and pre-symptomatic infections
- Non-steroidal anti-inflammatory drugs, angiotensin-converting enzyme inhibitors, and angiotensin receptor blockers and risk of infection or infection severity
- Information about COVID-19 and potential for SARS-CoV-2 reinfection
- Possibility of infection with both SARS-CoV-2 and other respiratory viruses
- Additional laboratory and imaging findings in COVID-19
- Updated guidelines from the World Health Organization and the Surviving Sepsis Campaign
- Inclusion of new resource: Information for Clinicians on Therapeutic Options for COVID-19 Patients

This interim guidance is for clinicians caring for patients with confirmed infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes coronavirus disease 2019 (COVID-19). CDC will update this interim guidance as more information becomes available.

Clinical Presentation

Incubation period

The incubation period for COVID-19 is thought to extend to 14 days, with a median time of 4-5 days from exposure to symptoms onset.[1-3] One study reported that 97.5% of persons with COVID-19 who develop symptoms will do so within 11.5 days of SARS-CoV-2 infection.[3]

Presentation

The signs and symptoms of COVID-19 present at illness onset vary, but over the course of the disease, most persons with COVID-19 will experience the following[1,4-9]:

- Fever (83–99%)
- Cough (59–82%)
- Fatigue (44–70%)
- Anorexia (40–84%)
- Shortness of breath (31–40%)
- Sputum production (28–33%)
- Myalgias (11–35%)

Atypical presentations have been described, and older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.[10,11] In one study of 1,099 hospitalized

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patients, fever was present in only 44% at hospital admission but later developed in 89% during hospitalization.[1] Headache, confusion, rhinorrhea, sore throat, hemoptysis, vomiting, and diarrhea have been reported but are less common (<10%).[1,4-6] Some persons with COVID-19 have experienced gastrointestinal symptoms such as diarrhea and nausea prior to developing fever and lower respiratory tract signs and symptoms.[9] Anosmia or ageusia preceeding the onset of respiratory symptoms has been anecdotally reported[12], but more information is needed to understand its role in identifying COVID-19.

Several studies have reported that the signs and symptoms of COVID-19 in children are similar to adults and are usually milder compared to adults.[13-17] For more information on the clinical presentation and course among children, see Information for Pediatric Healthcare Providers.

Asymptomatic and Pre-Symptomatic Infection

Several studies have documented SARS-CoV-2 infection in patients who never develop symptoms (asymptomatic) and in patients not yet symptomatic (pre-symptomatic).[14,16,18-28] Since asymptomatic persons are not routinely tested, the prevalence of asymptomatic infection and detection of pre-symptomatic infection is not well understood. One study found that as many as 13% of RT-PCR-confirmed cases of SARS-CoV-2 infection in children were asymptomatic.[14] Another study of skilled nursing facility residents infected with SARS-CoV-2 from a healthcare worker demonstrated that half were asymptomatic or pre-symptomatic at the time of contact tracing evaluation and testing.[26] Patients may have abnormalities on chest imaging before the onset of symptoms.[20,21] Some data suggest that pre-symptomatic infection tended to be detected in younger individuals and was less likely to be associated with viral pneumonia.[20,21]

Asymptomatic and Pre-Symptomatic Transmission

Epidemiologic studies have documented SARS-CoV-2 transmission during the pre-symptomatic incubation period[20,29-31], and asymptomatic transmission has been suggested in other reports.[22,23,32] Virologic studies have also detected SARS-CoV-2 with RT-PCR low cycle thresholds, indicating larger quantities of viral RNA, and cultured viable virus among persons with asymptomatic and pre-symptomatic SARS-CoV-2 infection.[19,24,26,33] The exact degree of SARS-CoV-2 viral RNA shedding that confers risk of transmission is not yet clear. Risk of transmission is thought to be greatest when patients are symptomatic since viral shedding is greatest at the time of symptom onset and declines over the course of several days to weeks.[33-36] However, the proportion of SARS-CoV-2 transmission in the population due to asymptomatic or pre-symptomatic infection compared to symptomatic infection is unclear.[37]

Clinical Course

Illness Severity

The largest cohort of >44,000 persons with COVID-19 from China showed that illness severity can range from mild to critical[38]:

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- Mild to moderate (mild symptoms up to mild pneumonia): 81%
- Severe (dyspnea, hypoxia, or >50% lung involvement on imaging): 14%
- Critical (respiratory failure, shock, or multiorgan system dysfunction): 5%

In this study, all deaths occurred among patients with critical illness and the overall case fatality rate was 2.3%.[38] The case fatality rate among patients with critical disease was 49%.[38] Among children in China, illness severity was lower with 94% having asymptomatic, mild or moderate disease, 5% having severe disease, and <1% having critical disease.[14] Among U.S. COVID-19 cases with known disposition, the proportion of persons who were hospitalized was 19%.[39] The proportion of persons with COVID-19 admitted to the intensive care unit (ICU) was 6%.[39]

Clinical Progression

Among patients who developed severe disease, the medium time to dyspnea ranged from 5 to 8 days, the median time to acute respiratory distress syndrome (ARDS) ranged from 8 to 12 days, and the median time to ICU admission ranged from 10 to 12 days.[5,6,10,11] Clinicians should be aware of the potential for some patients to rapidly deteriorate one week after illness onset. Among all hospitalized patients, a range of 26% to 32% of patients were admitted to the ICU.[6,8,11] Among all patients, a range of 3% to 17% developed ARDS compared to a range of 20% to 42% for hospitalized patients and 67% to 85% for patients admitted to the ICU.[1,4-6,8,11] Mortality among patients admitted to the ICU ranges from 39% to 72% depending on the study.[5,8,10,11] The median length of hospitalization among survivors was 10 to 13 days.[1,6,8]

Risk Factors for Severe Illness

Age is a strong risk factor for severe illness, complications, and death.[1,6,8,10,11,38-41] Among more than 44,000 confirmed cases of COVID-19 in China, the case fatality rate was highest among older persons: ≥80 years: 14.8%, 70–79 years: 8.0%, 60–69 years: 3.6%, 50–59 years: 1.3%, 40–49 years: 0.4%, <40 years: 0.2%.[38,42] Early U.S. epidemiologic data suggests that the case fatality was highest in persons aged ≥85 years (range 10%–27%), followed by 3%–11% for ages 65–84 years, 1%–3% for ages 55–64 years, and <1% for ages 0–54 years.[39]

Patients in China with no reported underlying medical conditions had an overall case fatality of 0.9%, but case fatality was higher for patients with comorbidities: 10.5% for those with cardiovascular disease, 7.3% for diabetes, and approximately 6% each for chronic respiratory disease, hypertension, and cancer.[42] Heart disease, hypertension, prior stroke, diabetes, chronic lung disease, and chronic kidney disease have all been associated with increased illness severity and adverse outcomes.[1,6,10,11,38,42,43] Accounting for differences in age and prevalence of underlying condition, mortality associated with COVID-19 in the United States was similar to China.[39,40,44]

Medications

It has been hypothesized that angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) may increase the risk of SARS-CoV-2 infection and COVID-19 severity.[45] ACE inhibitors and

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ARBs increase the expression of angiotensin-converting enzyme 2 (ACE2). SARS-CoV-2 uses the ACE2 receptor to enter into the host cell. There are no data to suggest a link between ACE inhibitors or ARBs with worse COVID-19 outcomes. The American Heart Association (AHA), the Heart Failure Society of America (HFSA), and the American College of Cardiology (ACC) released a statement recommending continuation of these drugs for patients already receiving them for heart failure, hypertension, or ischemic heart disease.[46]

It has also been hypothesized that non-steroidal anti-inflammatory drugs (NSAIDs) may worsen COVID-19. Currently, there are no data suggesting an association between COVID-19 clinical outcomes and NSAID use. More information can be found at Healthcare Professionals: Frequently Asked Questions and Answers.

Reinfection

There are no data concerning the possibility of re-infection with SARS-CoV-2 after recovery from COVID-19. Viral RNA shedding declines with resolution of symptoms, and may continue for days to weeks.[11,33,34] However, the detection of RNA during convalescence does not necessarily indicate the presence of viable infectious virus. Clinical recovery has been correlated with the detection of IgM and IgG antibodies which signal the development of immunity.[36,47-49]

Diagnostic Testing

Diagnosis of COVID-19 requires detection of SARS-CoV-2 RNA by reverse transcription polymerase chain reaction (RT-PCR). Detection of SARS-CoV-2 viral RNA is better in nasopharynx samples compared to throat samples.[33,50] Lower respiratory samples may have better yield than upper respiratory samples.[33,50]. SARS-CoV-2 RNA has also been detected in stool and blood.[13,34,47,51] Detection of SARS-CoV-2 RNA in blood may be a marker of severe illness.[52] Viral RNA shedding may persist over longer periods among older persons and those who had severe illness requiring hospitalization. (median range of viral shedding among hospitalized patients 12–20 days).[11,33-36]

Infection with both SARS-CoV-2 and with other respiratory viruses has been reported, and detection of another respiratory pathogen does not rule out COVID-19.[53]

For more information about testing and specimen collection, handling and storage, visit Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19) and Frequently Asked Questions on COVID-19 Testing at Laboratories.

Laboratory and Radiographic Findings

Laboratory Findings

Lymphopenia is the most common lab finding in COVID-19 and is found in as many as 83% of hospitalized patients.[1,5] Lymphopenia, neutrophilia, elevated serum alanine aminotransferase and aspartate aminotransferase levels, elevated lactate dehydrogenase, high CRP, and high ferritin levels may be associated

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with greater illness severity.[1,5,6,8,11,54] Elevated D-dimer and lymphopenia have been associated with mortality.[8,11] Procalcitonin is typically normal on admission, but may increase among those admitted to the ICU.[4-6] Patients with critical illness had high plasma levels of inflammatory makers, suggesting potential immune dysregulation.[5,55]

Radiographic Findings

Chest radiographs of patients with COVID-19 typically demonstrate bilateral air-space consolidation, though patients may have unremarkable chest radiographs early in the disease.[1,5,56] Chest CT images from patients with COVID-19 typically demonstrate bilateral, peripheral ground glass opacities.[4,8,38,56-65] Because this chest CT imaging pattern is non-specific and overlaps with other infections, the diagnostic value of chest CT imaging for COVID-19 may be low and dependent upon interpretations from individual radiologists.[57,66] One study found that 56% of patients who presented within 2 days of diagnosis had a normal CT[58]. Conversely, other studies have also identified chest CT abnormalities in patients prior to the detection of SARS-CoV-2 RNA.[56,67] Given the variability in chest imaging findings, chest radiograph or CT alone is not recommended for the diagnosis of COVID-19. The American College of Radiology also does not recommend CT for screening or as a first-line test for diagnosis of COVID-19. (See American College of Radiology Recommendations).

Clinical Management and Treatment

Mild to Moderate Disease

Patients with a mild clinical presentation (absence of viral pneumonia and hypoxia) may not initially require hospitalization, and many patients will be able to manage their illness at home. The decision to monitor a patient in the inpatient or outpatient setting should be made on a case-by-case basis. This decision will depend on the clinical presentation, requirement for supportive care, potential risk factors for severe disease, and the ability of the patient to self-isolate at home. Patients with risk factors for severe illness (see People Who Are at Higher Risk for Severe Illness) should be monitored closely given the possible risk of progression to severe illness in the second week after symptom onset.[5,6,10,11]

For information regarding infection prevention and control recommendations, please see Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings.

Severe Disease

Some patients with COVID-19 will have severe disease requiring hospitalization for management. No specific treatment for COVID-19 is currently FDA approved. Corticosteroids have been widely used in hospitalized patients with severe illness in China[6,8,10,11]; however, the benefit of corticosteroid use cannot be determined based upon uncontrolled observational data. By contrast, patients with MERS-CoV or influenza who were given corticosteroids were more likely to have prolonged viral replication, receive mechanical ventilation, and have higher mortality.[68-72] Therefore, corticosteroids should be avoided unless indicated for

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other reasons, such as management of chronic obstructive pulmonary disease exacerbation or septic shock. More information can be found at Healthcare Professionals: Frequently Asked Questions and Answers.

Inpatient management revolves around the supportive management of the most common complications of severe COVID-19: pneumonia, hypoxemic respiratory failure/ARDS, sepsis and septic shock, cardiomyopathy and arrhythmia, acute kidney injury, and complications from prolonged hospitalization including secondary bacterial infections, thromboembolism, gastrointestinal bleeding, and critical illness polyneuropathy/myopathy.[1,4-6,10,11,38,73-76]

The Infectious Diseases Society of America has released guidelines on the treatment and management of patients with COVID-19. For more information, please visit: Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19 Infection.

The World Health Organization and the Surviving Sepsis Campaign have both released comprehensive guidelines for the inpatient management of patients with COVID-19, including those who are critically ill. For more information visit: Interim Guidance on Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected (WHO) and Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19).

For more information on the management of children, see Information for Pediatric Healthcare Providers and the Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children.

Investigational Therapeutics

No FDA-approved drugs have demonstrated safety and efficacy in randomized controlled trials for patients with COVID-19. Use of investigational therapies for treatment of COVID-19 should ideally be done in the context of enrollment in randomized controlled trials. Several clinical trials are underway testing multiple drugs with in-vitro antiviral activity against SARS-CoV-2 and/or immunomodulatory effects that may have clinical benefit. For the latest information, see Information for Clinicians on Therapeutic Options for COVID-19 Patients. For the information on registered trials in the U.S., see ClinicalTrials.gov.

Discontinuation of Transmission-Based Precautions or Home Isolation

Patients who have clinically recovered and are able to discharge from the hospital but who have not been cleared from their Transmission-Based Precautions may continue isolation at their place of residence until cleared. For recommendations on discontinuation of Transmission-Based Precautions or home isolation for patients who have recovered from COVID-19 illness, please see: Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19, Interim Guidance for Discontinuation of In-Home Isolation for Patients with COVID-19, and Discontinuation of In-Home Isolation for Immunocompromised Persons with COVID-19.

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Additional resources:

- Information for Pediatric Healthcare Providers
- Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)
- Frequently Asked Questions on COVID-19 Testing at Laboratories
- Healthcare Professionals: Frequently Asked Questions and Answers
- Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) or in Healthcare Settings
- World Health Organization. Interim Guidance on Clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected
- Surviving Sepsis Campaign: Guidelines on the Management of Critically Ill Adults with Coronavirus Disease 2019 (COVID-19)
- Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016
- Surviving Sepsis Campaign International Guidelines for the Management of Septic Shock and Sepsis-Associated Organ Dysfunction in Children
- Diagnosis and Treatment of Adults with Community-acquired Pneumonia. An Official Clinical Practice Guideline of the American Thoracic Society and Infectious Diseases Society of America
- ACR Recommendations for the use of Chest Radiography and Computed Tomography (CT) for Suspected COVID-19 Infection
- Infectious Diseases Society of America Guidelines on the Treatment and Management of Patients with COVID-19 Infection

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Content source: National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases

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WHOM TO CALL IF YOU HAVE QUESTIONS

Management:	Edward O. Cousineau, JD Executive Director
	Sarah A. Bradley, JD, MBA Deputy Executive Director
	Donya Jenkins Finance Manager
Administration:	Laurie L. Munson, Chief
Legal:	Robert Kilroy, JD General Counsel
Licensing:	Lynnette L. Daniels, Chief
Investigations:	Ernesto Diaz, Chief

2020 BME MEETING & HOLIDAY SCHEDULE

January 1 – New Year's Day
January 20 – Martin Luther King, Jr. Day
February 17 – Presidents' Day
March 6 – Board meeting
May 25 – Memorial Day
June 5 – Board meeting
July 3 – Independence Day (observed)
September 7 – Labor Day
September 11 – Board meeting
October 30 – Nevada Day
November 11 – Veterans' Day
November 26 & 27 – Thanksgiving Day & Family Day
December 4 – Board meeting (Las Vegas)
December 25 – Christmas

Nevada State Medical Association
5355 Kietzke Lane
Suite 100
Reno, NV 89511
775-825-6788
http://www.nvdoctors.org

Clark County Medical Society
2590 East Russell Road
Las Vegas, NV 89120
702-739-9989 phone
702-739-6345 fax
http://www.clarkcountymedical.org

Washoe County Medical Society
5355 Kietzke Lane
Suite 100
Reno, NV 89511
775-825-0278 phone
775-825-0785 fax
http://www.wcmsnv.org

Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy, Ste. 206
Reno, NV 89521
775-850-1440 phone
775-850-1444 fax
http://bop.nv.gov/
pharmacy@pharmacy.nv.gov

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Ste. 210
Henderson, NV 89074
702-732-2147 phone
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www.bom.nv.gov

Nevada State Board of Nursing
Las Vegas Office
4220 S. Maryland Pkwy, Bldg. B, Suite 300
Las Vegas, NV 89119
702-486-5800 phone
702-486-5803 fax
Reno Office
5011 Meadowood Mall Way, Suite 300,
Reno, NV 89502
775-687-7700 phone
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www.nevadanursingboard.org

Unless otherwise noted, Board meetings are held at the Reno office of the Nevada State Board of Medical Examiners and videoconferenced to the conference room at the offices of the Nevada State Board of Medical Examiners/Nevada State Board of Dental Examiners, 6010 S. Rainbow Blvd., Building A, Suite 1, in Las Vegas.

DISCIPLINARY ACTION REPORT

FONTE, Carlos E., M.D. (6114)
Las Vegas, Nevada

Summary: Alleged failure to maintain appropriate medical records relating to his treatment of a patient.

Charges: NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient].

Disposition: On March 6, 2020, the Board accepted a Settlement Agreement by which it found Dr. Fonte violated NRS 630.3062(1)(a), as set forth in the First Amended Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $2,000.00 fine; (3) 10 hours of continuing medical education (CME), in addition to his statutory CME requirements for licensure; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

LUSS, Rosner P., M.D. (8699)
Las Vegas, NV

Summary: Alleged malpractice, failure to maintain appropriate medical records related to Dr. Luss' treatment of a patient, and engaging in conduct in violation of standards of practice established by regulation of the Board of Medical Examiners.

Charges: One violation of NRS 630.301(4) [malpractice]; one violation of NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; one violation of NRS 630.306(1)(b)(2) [engaging in conduct which the Board has determined is a violation of the standards of practice established by regulation of the Board].

Disposition: On March 6, 2020, the Board accepted a Settlement Agreement by which it found Dr. Luss violated NRS 630.306(1)(b)(2), as set forth in Count III of the First Amended Complaint, and imposed the following discipline against him: (1) public reprimand; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Counts I and II of the First Amended Complaint were dismissed with prejudice.

MIRCHOU, Rafael, M.D. (9244)
Las Vegas, Nevada

Summary: Alleged failure to retain the health care records of his patients for the period of time required by statute and continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing, practicing in the same specialty or field.

Charges: One violation of NRS 629.051 [each custodian of health care records shall retain the health care records of patients as part of the regularly maintained records of the custodian for 5 years after their receipt or production]; one violation of NRS 630.306(1)(g) [continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field].

Disposition: On March 6, 2020, the Board accepted a Settlement Agreement by which it found Dr. Mirchou violated NRS 630.306(1)(g), as set forth in Count II of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $500.00 fine; (3) 3 hours of continuing medical education (CME), in addition to his statutory CME requirements for licensure (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count I of the Complaint was dismissed with prejudice.

SIEMS, Jon L., M.D. (9250)
Las Vegas, NV

Summary: Alleged failure to maintain appropriate medical records related to Dr. Siems' treatment of two patients and terminating the medical care of those patients without making other arrangements for the continued care of the patients.

Charges: Two violations of NRS 630.3062(1)(a) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; two violations of NRS 630.304(7) [terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient].

Disposition: On March 6, 2020, the Board accepted a Settlement Agreement by which it found Dr. Siems violated NRS 630.3062(1)(a) (2 counts), as set forth in Counts I and III of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) total fines in the amount of $1,000.00; (3) 4 hours of continuing medical education (CME), in addition to his statutory CME requirements for licensure; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Counts II and IV of the Complaint were dismissed with prejudice.

WITTNER, Seth H., PA (PA903)
Henderson, NV

Summary: Conviction of a sexually related crime and engaging in conduct that brings the medical profession into disrepute.

Charges: One violation of NRS 630.301(11)(d) [conviction of sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime]; one violation of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute].

Disposition: On March 6, 2020, the Board accepted a Settlement Agreement by which it found Mr. Wittner violated NRS 630.301(11)(d), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) revocation of Mr. Wittner's license to practice as a physician assistant in Nevada, and Mr. Wittner may not apply for reinstatement of his license for a period of three years; (2) public reprimand; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter, with the order for reimbursement of fees and costs stayed until such time as Mr. Wittner reapplies for licensure. Count II of the Complaint was dismissed with prejudice.

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Public Reprimands Ordered by the Board

March 30, 2020

Carlos Enrique Fonte, M.D.
c/o David J. Mortensen, Esq.
Messner Reeves LLP
8945 W. Russell Road, Suite 300
Las Vegas, NV 89148

Re: In the Matter of Charges and Complaint Against Carlos Enrique Fonte, M.D.
BME Case No. 18-9800-1

Dr. Fonte:

On March 6, 2020, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal First Amended Complaint filed against you in the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.3062(1)(a), failure to maintain timely, legible, accurate and completed medical records. For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter. You shall pay a fine of $2,000.00, be publicly reprimanded, and you shall take ten (10) hours of continuing medical education (CME). The aforementioned hours of CME shall be in addition to any CME requirements that are regularly imposed upon you as a condition of licensure in the State of Nevada.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

March 13, 2020

Rosner Patrick Luss, M.D.
c/o Anthony D. Lauria, Esq.
Lauria, Tokunaga, Gates & Linn, LLP
1755 Creekside Oaks Drive, Suite 240
Sacramento, CA 95833

Re: In the Matter of Charges and Complaint Against Rosner Patrick Luss, M.D.
BME Case No. 19-10860-1

Dr. Luss:

On March 6, 2020, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal First Amended Complaint filed against you in the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(1)(b)(2), violation of Standards of Practice established by regulation. For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter and you shall be publicly reprimanded.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

March 13, 2020

Rafael Mirchou, M.D.
c/o Michael F. Bohn, Esq.
Law Office of Michael F. Bohn, Esq.
2260 Corporate Circle, Suite 480
Henderson, NV 89074

Re: In the Matter of Charges and Complaint Against Rafael Mirchou, M.D.
BME Case No. 19-10416-1

Dr. Mirchou:

On March 6, 2020, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(1)(g), continual failure to exercise diligence regarding records retention. For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter, pay a fine of $500.00, be publicly reprimanded, and you shall take 3 hours of continuing medical education (CME), in addition to the statutory CME requirements of licensure.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

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March 13, 2020

Jon L. Siems, M.D.
8230 West Sahara Avenue, Suite 111
Las Vegas, NV 89117

Re: In the Matter of Charges and Complaint Against Jon L. Siems, M.D.
BME Case No. 19-13009-1

Dr. Siems:

On March 6, 2020, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated two counts of Nevada Revised Statute 630.3062(1)(a), failure to maintain proper medical records. For the same, you shall pay the costs and expenses related to the investigation and prosecution of this matter, pay a fine of $1,000.00, be publicly reprimanded, and you shall take 4 hours of continuing medical education (CME), in addition to the statutory CME requirements for licensure.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

March 13, 2020

Seth H. Wittner, PA
c/o Cristina A. Hinds, Esq.
Hinds Injury Law Las Vegas
600 S. 8th Street
Las Vegas, NV 89101

Re: In the Matter of Charges and Complaint Against Seth H. Wittner, PA
BME Case No. 19-30184-1

Mr. Wittner:

On March 6, 2020, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in the aforementioned case.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(11)(d), conviction of a sexually related crime, and ordered your license to practice as a physician assistant in Nevada to be immediately revoked. You may not apply for reinstatement of your license for a period of three years. For the same, you shall be publicly reprimanded and pay the costs and expenses related to the investigation and prosecution of this matter, with the order for reimbursement of costs stayed until such time as you reapply for licensure.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Rachakonda D. Prabhu, M.D., President
Nevada State Board of Medical Examiners

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

9600 Gateway Drive

Reno, NV 89521