BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

IN THE MATTER OF:

DANIEL ROYAL, D.O.
License No. 512,

Respondents.

Case No. AD1207005
COMPLAINT FOR DISCIPLINARY ACTION

The Nevada State Board of Osteopathic Medicine, by and through its investigating board member James Anthony, D.O. (hereinafter IBM), hereby makes the following complaint for disciplinary action against Dr. Daniel Royal (License No. 512) pursuant to NRS 633.541(3) and 622A.300(1). This complaint is made and based upon the following facts and causes of action.

BACKGROUND FACTS

I.

On March 30, 1990, Daniel Royal, D. O. was licensed by the Board to practice osteopathic medicine in Nevada (License No. 512).

II.

Dr. Royal is the primary and responsible physician at a practice called Royal Medical Clinic located at 9065 South Pecos Road #250 in Henderson, Nevada (RMC).

III.

The Board’s records show that until 2005, Dr. Royal was AOA board-certified specialist in family and general practice medicine. Dr. Royal publicly represents himself and his practice as specializing in or providing, among other things, pain management even though no physician employed at the practice is board-certified in pain management.

IV.

In March 2013, the Board’s staff initiated an investigation into the practices of Dr. Royal at RMC. In furtherance of the investigation and at the request of Board staff, in April 2013, Dr. Royal provided the medical files for seven patients selected by the IBM, and in October 2013, Dr. Royal provided medical files for fifteen additional patients.
V.

The Board’s staff reviewed medical records produced by Dr. Royal, including having the records reviewed by two medical experts, one a board-certified endocrinologist and the other a board-certified specialist in pain medicine. The review of the records indicated that there were concerns regarding the practices engaged in by Dr. Royal. Therefore, on February 24, 2014, Ms. Longo sent a letter to Dr. Royal pursuant to NRS 233B.127(3) requesting responses from them regarding concerns noted in the record review (233B Letter).

VI.

On May 12, 2014, Dr. Royal, through his counsel, submitted a response to the 233B Letter.

VII.

On June 6, 2014, the Board received a patient complaint referred to the Board from the Nevada State Board of Medical Examiners. Subsequent to the receipt of the complaint, Dr. Royal provided medical files for three patients related to the patient complaint.

FIRST CAUSE OF ACTION

VIII.

A review of the various records provided by Dr. Royal and RMC showed that the practices of Dr. Royal were below the standard of care for a specialist in or practitioner of pain management or pain medicine or the standard of care for a general practitioner practicing pain management and pain medicine. While each of the medical files reviewed contained unique concerns and issues, the records also demonstrated general concerns and issues demonstrating that Dr. Royal’s pain medicine and pain management fell below the standard of care such as: inadequate patient histories; inadequate diagnostics; questionable diagnoses; inadequate or no treatment plans; inadequate or no assessment of the treatment provided; inappropriate prescribing of opioids, sometimes to opiate-naïve patients or in such doses as to present or create risks of serious harm to the patients; inadequate consideration of treatment options besides high-dose opioids; inadequate or no monitoring of the drugs being used by patients; failure to address patients whose monitoring demonstrated use of illicit drugs or who were failing to use the opioids prescribed by Dr. Royal; failure to make accurate and adequate records to demonstrate and support the medical reasoning underlying the therapy ordered; and failure to obtain reports from the
Nevada Prescription Controlled Substance Abuse Prevention Task Force database when legally required or appropriate.

IX.

The Board’s investigation determined that in the case involving the patient whose surviving mother complained on June 6, 2014, the patient died from opioid toxicity, which consisted of a combination of heroin and the opioids provided by Dr. Royal and RMC. Dr. Royal’s failure to meet the standard of care as outlined in averment VIII may have contributed to the death of the patient.

X.

As one claiming special expertise in or offering pain management and pain medicine or as a general practitioner who provided pain management and pain medicine, the treatment provided by Dr. Royal as documented in the medical records reviewed by the Board and with the issues set out in averment VIII constitute violations by Dr. Royal of NRS 633.511(1), and/or NRS 633.511(5), and/or NRS 633.131(1)(f)(2), and/or NRS 633.131(g), and/or NRS 633.131(k), and/or NAC 633.287(1)(f), and/or NAC 633.289(1), and/or NAC 633.289(2)(c), and/or NAC 633.350(1)(e) and/or NAC 633.350(1)(f).

SECOND CAUSE OF ACTION

XI.

A review of the various records provided by Dr. Royal and RMC showed that the practices of Dr. Royal were below the standard of care for a specialist in and practitioner of family and general medicine. While each of the medical files reviewed contained unique concerns and issues, a significant number of the records also demonstrated general concerns and issues demonstrating that Dr. Royal’s practice of general medicine fell below the standard of care where Dr. Royal made inappropriate and dangerous use of corticosteroid therapy, usually involving the drug Cortef, for patients where there would be no appropriate medical use for the patient and where, in many cases, the use of the corticosteroid would be contraindicated and endangering to the patient’s health, safety, and welfare. In some of the patients in which Dr. Royal inappropriately used corticosteroid therapy, Dr. Royal failed to adequately address the development of negative symptomology that was likely related to the corticosteroid therapy, thus further endangering the patient’s health, safety, and welfare. Additionally, Dr. Royal’s records made and kept
regarding the use corticosteroids were inadequate, confusing, and often devoid of medical reasoning for the therapy ordered.

XII.

As a specialist in and practitioner of general and family medicine, the treatment provided by Dr. Royal as documented in the medical records reviewed by the Board and with the issues set out in averment X constitute violations by Dr. Royal of NRS 633.511(1), and/or NRS 633.511(5), and/or NRS 633.131(1)(c)(2), and/or NRS 633.131(g), and/or NRS 633.131(k), and/or NAC 633.287(1)(f), and/or NAC 633.289(1), and/or NAC 633.289(2)(c), and/or NAC 633.350(1)(e) and/or NAC 633.350(1)(f).

THIRD CAUSE OF ACTION

XIII.

A review of the various records provided by Dr. Royal and RMC showed that the practices of Dr. Royal were below the standard of care because the records were insufficient. While there are specific concerns regarding some of the medical files reviewed, generally, the medical records showed: inadequate or no patient histories; inadequate or no diagnosis sufficient to support the therapies ordered; inadequate or no diagnostics to establish or support diagnoses where they were made; inadequate or no medical reasoning demonstrated; inadequate or no treatment plans; and inadequate or no assessment and monitoring of treatments provided. In making and maintaining medical records that were inadequate, confusing, unreliable, and inaccurate, Dr. Royal violated NRS 633.511(1) and 633.131(1)(m).

Wherefore, it is hereby requested that appropriate discipline be entered against Dr. Royal based upon this Complaint pursuant to NRS 633.651 and NAC 633.287.

Signed this ___ day of September, 2014.

By: [Signature]

James Anthony, D.O.
Investigating Board Member
NOTICE OF HEARING AND
STATEMENT OF RESPONDENT’S RIGHTS

As the Respondent in this action, you have the following rights:

1. A hearing regarding this matter will be held before Hearing Officer Jill Greiner at the following date and place:

   October 27, 28, and 29, 2014 at 9:00 a.m. or as soon thereafter as possible
   
   Board Conference Room
   901 American Pacific Drive, Unit 180
   Henderson, Nevada 89014

   The intent of the hearing of this matter is to determine whether the allegations made against you in the above Complaint have been proven by a preponderance of the evidence, and if so, what discipline is appropriate. All documents you wish to file in this matter must be filed with the Board’s office located at 901 American Pacific Drive, Unit 180, Henderson, Nevada 89014.

2. You may appear at the hearing of this matter. You may be represented by your counsel of choice. The hearing shall be conducted at an open and public hearing of the Board and shall be conducted in conformance with NRS chapters 233B, 622A, and 633 and NAC chapter 633, including your right to present testimony and evidence in support of your case and your right to cross-examine witnesses presented by the Board’s staff.

3. Pursuant to NRS 622A.320(1), you may file an Answer to the above Complaint in this matter. To do so, you must file your Answer in writing with the Board’s office within 20 days of your receipt of the above Complaint. Your failure to timely file an Answer to the Complaint may be deemed by the Hearing Officer or the Board to be an admission to the contents of the Complaint.

4. You may request that the Board issue subpoenas to compel the attendance of witnesses or the production of evidence at the hearing of the matter pursuant to NRS 633.281.

5. Should you choose not to appear at the hearing of the matter, the Board may enter a default against you and still proceed with the hearing of the matter in your absence pursuant to NRS 622A.350.

6. You may seek to negotiate a settlement regarding this matter. If you desire to discuss a potential settlement of the matter, you may contact Louis Ling, Board Counsel, at (775) 233-9099 or at louisling@me.com.
CERTIFICATE OF SERVICE

I certify that I am an employee of the Nevada State Board of Osteopathic Medicine and that on this day I deposited for certified mailing at Henderson, Nevada, postage prepaid, a true and correct copy of the foregoing document addressed to the following:

Dated this ___ day of September, 2014.

[Signature]

[Address]