

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

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4
5 **In the Matter of Charges and Complaint**
6 **Against**
7 **SYED F. RAHMAN, M.D.,**
8 **Respondent.**

Case No. 20-19605-1

FILED

JUL 14 2020

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

By: _____

9
10 **COMPLAINT**

11 The Investigative Committee¹ (IC) of the Nevada State Board of Medical Examiners
12 (Board), by and through Robert Kilroy, Esq., General Counsel and attorney for the IC, having a
13 reasonable basis to believe that Syed F. Rahman, M.D. (Respondent) violated the provisions of
14 Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630
15 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and
16 allegations as follows:

17 1. Respondent was at all times relative to this Complaint a medical doctor holding an
18 active license to practice medicine in the State of Nevada (License No. 10030). Respondent was
19 originally licensed by the Board on November 17, 2001.

20 2. Patient A's true identity is not disclosed herein to protect his privacy, but is
21 disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

22 3. On June 18, 2015, Patient A was transferred from Sunrise Hospital (Sunrise) to
23 AMG Specialty Hospital (AMG) for long-term acute care, including, but not limited to, ongoing
24 management of ventilator-dependent respiratory failure with associated encephalopathy.

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28 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 Wayne Hardwick, M.D., Chairman, Mr. M. Neil Duxbury, and Aury Nagy, M.D.

1 Respondent was the attending physician for Patient A, who was receiving all nourishment and
2 non-intravenous medication through a gastric feeding tube (PEG tube), which was administered at
3 Sunrise.

4 4. On July 5, 2015, Patient A's PEG tube was displaced, and an attempt was made to
5 replace the PEG tube with a Foley catheter placed into the site from which this PEG tube had been
6 displaced. Tube feedings were discontinued, as Respondent ordered a Total Parental Nutrition (TPN),
7 and a gastroenterology (GI) consult. Patient A's blood urea nitrogen (BUN) was 24 and keratinize
8 (Cr) was 0.94, reflective of an adequate hydration level, and of proper renal function.

9 5. On July 9, 2015, the GI consultant ordered to continue to hold all tube feedings, and
10 continue with the previously ordered TPN.

11 6. On July 10, 2015, the BUN was 39, and the Cr was 0.89, indicating less hydration.

12 7. On July 12, 2015, the BUN was 45, and the Cr was 0.87, indicating inadequate
13 hydration.

14 8. On July 14, 2015, the BUN was 53, and the Cr was 1.03, indicating worsening
15 hydration and possible renal degradation in function.

16 9. On July 16, 2015, the BUN was 66, and the Cr was 1.21.

17 10. On July 17, 2015, the BUN was 86, and the Cr was 1.57, indicating worsening renal
18 function or failure due to the rising BUN/Cr ratio of greater than 50. TPN was the sole source of
19 nutrition and hydration for Patient A.

20 11. On July 18, 2015, Patient A was transferred back to Sunrise. Patient A's BUN was
21 105 and the Cr was 2.19. Under Respondent's care, Patient A's renal function worsened, suffered
22 from malnutrition and dehydration.

23 **COUNT I**

24 **NRS 630.301(4) (Malpractice)**

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

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

1 14. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient,
2 to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

3 15. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed
4 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when
5 he provided medical services to Patient A based upon his inadequate management and resolution
6 of the PEG tube, his inadequate management of worsening renal failure as indicated by the rising
7 BUN/Cr Ratio.

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

10 **COUNT II**

11 **NRS 630.3062(1)(a)**

12 **(Failure to Maintain Complete Medical Records)**

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

15 18. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate
16 and complete medical records relating to the diagnosis, treatment and care of a patient is grounds
17 for initiating disciplinary action against a licensee.

18 19. Respondent failed to maintain complete medical records relating to the diagnosis,
19 treatment and care of Patient A, by failing to document his actions when he treated Patient A,
20 whose medical records were not timely, legible, accurate, and complete.

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

23 **COUNT III**

24 **NRS 630.306(1)(b)(2)**

25 **(Violation of Standards of Practice Established by Regulation)**

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

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

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

6 24. Respondent failed to timely seek consultation with regard to Patient A's medical
7 condition of dehydration and of renal failure, and Respondent should have consulted with an
8 appropriate care provider to address the aforementioned worsening conditions, and such a
9 consultation could have enhanced Patient A's declining medical condition of renal failure and
10 dehydration.

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

13 **WHEREFORE**, the Investigative Committee prays:

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

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

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

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4. 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

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

DATED this 14 day of July, 2020.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

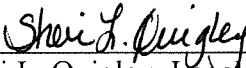
By: 
Robert Kilroy, Esq., General Counsel
Attorney for the Investigative Committee

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 10th day of July, 2020, I served a filed copy of the formal COMPLAINT, via USPS e-certified, return receipt mail to the following:

**Syed F. Rahman, M.D.
Oasis Medical Associates
10410 South Eastern Avenue, Suite #100
Henderson, NV 89109**

Dated this 14th day of July, 2020.



Sheri L. Quigley, Legal Assistant

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