BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In the Matter of Charges and Complaint Against	**Case No. 20-19605-1**
SYED F. RAHMAN, M.D.,	FILED
Respondent.	MAR 1 1 2021
	NEVADA STATE BOARD OF MEDICAL EXAMINERS
	By:

FIRST AMENDED COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert Kilroy, Esq., General Counsel and attorney for the IC, having a reasonable basis to believe that Syed F. Rahman, 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 First Amended Complaint (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. 10030). Respondent was originally licensed by the Board on November 17, 2001.

2. On June 18, 2015, Patient A[2] was transferred from Sunrise Hospital (Sunrise) to AMG Specialty Hospital (AMG) for long-term acute care, including, but not limited to, ongoing management of ventilator-dependent respiratory failure with associated encephalopathy. Respondent was the attending physician for Patient A, who was receiving all nourishment and non-intravenous medication through a gastric feeding tube (PEG tube), which was administered at Sunrise.

[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.

[2] 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 First Amended Complaint.

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3. On July 5, 2015, Patient A's PEG tube was displaced, and an attempt was made to replace the PEG tube with a Foley catheter placed into the site from which this PEG tube had been displaced. Tube feedings were discontinued, as Respondent ordered a Total Parental Nutrition (TPN), and a gastroenterology (GI) consult. Patient A's blood urea nitrogen (BUN) was 24 and the Creatinine (Cr) was at 0.94, and that ratio (BUN/CR) reflects adequate hydration and proper renal function.

4. On July 9, 2015, the GI consultant ordered to continue to hold all tube feedings, and continue with the previously ordered TPN. This TPN was the sole source of nutrition and hydration for Patient A.

5. Under Respondent's care from July 10, 2015 through July 18, 2015, Patient suffered from worsening dehydration and renal function:.

a. On July 10, 2015, Patient A's BUN was 39, and the Cr was 0.89, indicating less hydration; On July 12, 2015, the BUN was 45, and the Cr was 0.87, indicating inadequate hydration; On July 14, 2015, the BUN was 53, and the Cr was 1.03, indicating worsening hydration and renal degradation in function; On July 15, 2015, Patient's PEG tube malfunctioned; Gastroenterology was consulted and Patient was placed on a NPO and the IV TPN was implemented; On July 16, 2015, the BUN was 66, and the Cr was 1.21; On July 17, 2015, the BUN was 86, and the Cr was 1.57, indicating worsening renal function or failure due to the rising BUN/Cr ratio of greater than 50. CT Scan of Patient A's abdomen indicated the gastrostomy tube was not in the stomach. This tube was located outside the stomach between the interior pole of the liver and the superior wall of the distal stomach.

6. On July 18, 2015, Patient A was transferred back to Sunrise. Patient A's BUN was 105 and the Cr was 2.19. Respondent's transfer note incorrectly states "On 7/18/2015, he had a PEG malfunction. Foley catheter was placed. However, it shows that the Foley catheter to be in the place in the right position." Respondent's cited date of "7/18/2015" is incorrect as this CT Scan occurred earlier as the aforementioned date is the date of Patient's transfer.

7. Under Respondent's care, Patient A's renal function worsened, suffered from malnutrition and dehydration as evidence by the rising BUN/Creatinine Ratio of 25 on July 5, 2015;

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the rising BUN/Creatinine Ratio of 43.8 was indicated on July 10, 2015; and, the BUN/Creatinine Ratio was greater than 50 from July 12, 2015 through July 18, 2015.

COUNT I

NRS 630.301(4) (Malpractice)

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

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

11. 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.

12. 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 he provided medical services to Patient A based upon his inadequate management and resolution of the PEG tube, his inadequate management of worsening renal failure as indicated by the rising BUN/Cr Ratio from July 10, 2015 through July 18, 2015, which was the day Patient A was transferred from Respondent's care and returned back to Sunrise.

13. 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)(a) (Failure to Maintain Complete Medical Records)

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

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

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

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

COUNT III

NRS 630.306(1)(b)(2) (Violation of Standards of Practice Established by Regulation)

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

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

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

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

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

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 make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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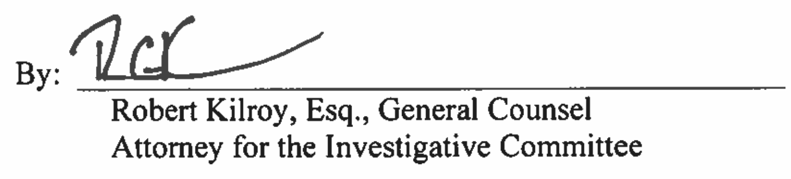
5. That the Board take such other and further action as may be just and proper in these premises.

DATED this 11 day of March, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



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

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Mr. M. Neil Duxbury, 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 11th day of March, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

M. Neil Duxbury

Mr. M. Neil Duxbury, Chairman

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