

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

3                                   \*\*\*\*\*

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

Case No. 24-30257-1

6   **Against:**

**FILED**

7   **JEFFREY YONG RYU, M.D.,**

**FEB 23 2024**

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 Donald K. White, Senior Deputy General Counsel and attorney for the  
13 IC, having a reasonable basis to believe that Jeffrey Yong Ryu, M.D. (Respondent) violated the  
14 provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code  
15 (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating  
16 the IC's charges and 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. 11350). Respondent was  
19 originally licensed by the Board on March 3, 2005.

20           2.       Patient A<sup>2</sup> was a forty-seven (47) year-old female at the time of the events at issue.

21           3.       On or about January 1, 2019, Patient A presented to Mountain View Hospital's  
22 emergency room via ambulance with a complaint of pain over her entire body. It was determined,  
23 through conversations with Patient A's family, that she was suffering from an alcohol withdrawal  
24 and was currently under the influence of opioid medication and had fallen and cut her face.

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27           <sup>1</sup> The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal  
28 Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Col. Eric D. Wade,  
USAF (Ret.), and Carl N. Williams, Jr., M.D.

<sup>2</sup> Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient  
Designation served upon Respondent along with a copy of this Complaint.

1 4. Patient A was given one (1) liter of saline treatment before any routine bloodwork  
2 was performed.

3 5. Results of a serum sodium lab test showed Patient A had hyponatremia, or a low  
4 sodium concentration.

5 6. Between approximately 1:00 p.m. and 2:21 p.m., Patient A's serum sodium level  
6 began at 107 and raised to 110, which is considered a rapid correction. Despite the rapid  
7 correction, the saline treatment was not stopped after the lab reports were received.

8 7. Later in the day on January 1, 2019, another physician admitted Patient A to the  
9 hospital and despite the rapid correction, continued the saline treatment until she could be  
10 transferred to Mountain's Edge Hospital.

11 8. Upon admission to Mountain's Edge Hospital, Patient A was displaying multiple  
12 symptoms of rapid correction, but another serum sodium lab test was not taken until  
13 approximately midnight on January 1, 2019, and the level had risen again from 109 to 118,  
14 amounting to a 9 mEq correction in a ten (10) hour span.

15 9. Respondent assumed care of Patient A on January 2, 2019. The hospitalist APRN  
16 on duty was notified that Patient A's serum sodium level was at 122 at approximately 3:30 a.m.,  
17 but a nephrology consult was not requested until 4:30 p.m. by Respondent.

18 10. The sodium infusion was not discontinued until 6:08 p.m. on January 2, 2019.  
19 After cessation of the fluids Patient A's sodium serum continued to rise to a level of 130.

20 **COUNT I**

21 **NRS 630.301(4) - Malpractice**

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

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

26 13. NAC 630.040 defines malpractice as "the failure of a physician, in treating a  
27 patient, to use the reasonable care, skill, or knowledge ordinarily used under similar  
28 circumstances."

1 14. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed  
2 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when  
3 Respondent did not adhere to the standard of care for a patient with hyponatremia by not  
4 recognizing Patient A had started rapid correction or that the patient was at risk for rapid  
5 correction.

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

8 **COUNT II**

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

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

12 17. Violation of a standard of practice adopted by the Board is grounds for disciplinary  
13 action pursuant to NRS 630.306(1)(b)(2).

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

17 19. Respondent failed to timely seek consultation with regard to Patient A’s medical  
18 condition and rapid correction on January 2, 2019, and Respondent should have consulted with an  
19 appropriate care provider to address the doubtfulness of the diagnosis of Patient A’s medical  
20 condition and such a timely consultation would have confirmed or denied such a diagnosis and  
21 may have enhanced the quality of medical care provided to Patient A regarding treatment of her  
22 hyponatremia. A nephrology consult was requested, but long after Patient A had been exhibiting  
23 symptoms of rapid correction in her serum sodium levels.

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

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**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 award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

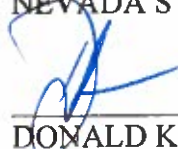
5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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

DATED this 23<sup>rd</sup> day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: \_\_\_\_\_

  
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*Attorney for the Investigative Committee*

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**VERIFICATION**

STATE OF NEVADA        )  
                                  : ss.  
COUNTY OF WASHOE    )

Bret W. Frey, M.D., 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 \_\_\_ day of February, 2024.

INVESTIGATIVE COMMITTEE OF THE  
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:   
\_\_\_\_\_  
BRET W. FREY, M.D.  
*Chairman of the Investigative Committee*