BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **SZU NIEN YEH, M.D.,** **Respondent.**	**Case No. 24-11596-1**

FILED
APR - 2 2024
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Szu Nien Yeh, 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 Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a physician holding an active license to practice medicine in the State of Nevada (License No. 8126). Respondent was originally licensed by the Board on March 18, 1997, and his specialty is listed as anesthesiology.

2. Patient A[2] was a fifty-seven (57) year-old female at the time of the events at issue.

3. On July 7, 2021, Patient A presented to Summerlin Hospital Medical Center for a laparoscopic assisted hysterectomy and a bilateral salpingo-oophorectomy (removal of the ovaries and fallopian tubes).

4. Respondent was the acting anesthesiologist for the procedure, and Patient A was brought to the operating room at approximately 7:45 a.m. on July 7, 2021.

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[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 Aury Nagy, M.D., Ms. Maggie Arias-Petrel, and Nick M. Spirtos, M.D., F.A.C.O.G.

[2] 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.

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5. Anesthesia was introduced shortly thereafter, with Propofol 200mg, Fentanyl 100mcg, and Rocuronium 50mg; a sedative, analgesic, and paralytic, respectively.

6. During the procedure, Respondent also used a Sevoflurane (Sevo) vaporizer, an inhalation agent, in conjunction with the aforementioned medications.

7. A fundamental part of an anesthesiologist's responsibilities are to inspect the medical devices they are going to use to administer anesthesia before a procedure commences. As such, the Sevo vaporizer needs to be examined prior to use, thus ensuring that it contains a sufficient amount of Sevo for adequate delivery throughout the operation.

8. The preliminary check of the Sevo amount in the vaporizer is easily verified when looking at the device, which prominently displays the amount of Sevo it contains. Furthermore, this information can again be verified by the expired percentage of Sevo ("end tidal concentration"), which is displayed and refreshes with an updated reading every six (6) seconds.

9. During the procedure, Respondent initially set the (Sevo) vaporizer at a 3% percent setting; however, the Sevo only rose to 2% and quickly declined after fifteen (15) minutes. This should have immediately put Respondent on alert that the vaporizer was empty, or near empty, which was later found to be the case. Further, the end tidal concentrations showed amounts well below this rate throughout the duration of the operation.

10. At 8:30 a.m., a surgical incision was performed. At this time, the end tidal concentration of the Sevo was .74%. Over the next thirty (30) minutes the end tidal concentration varied between .65% and .90%. These dips in Sevo concentration, reaching as low as .65%, made it possible for Patient A to become conscious during the procedure.

11. During this same period, Patient A experienced several episodes of hypotension, and it appears that Respondent responded to this by further lowering the Sevo concentration. This resulted in a return of normal blood pressure: however, as a result of the Sevo concentration being too low, it also caused Patient A to regain consciousness.

12. When Patient A regained consciousness she was unable to move because of the muscle relaxant Rocuronium that she was given.

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13. Respondent eventually switched to another inhaled agent, Desflurane, at approximately 9:10 a.m., and also added 2mg of Versed, a powerful amnestic, indicating that he was aware the end tidal concentrations were too low, and changes needed to be made to ensure deep sedation; however, Patient A had been under-sedated for almost an hour.

14. Patient A later notified nursing staff of this incident and it was recorded that she informed the nurse that she had awoken during the procedure; however, there is no documentation of Respondent ever following up with Patient A or documenting this adverse event.

COUNT I

NRS 630.301(4) - Malpractice

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

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

17. 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."

18. 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 rendering medical services to Patient A, when he failed to confirm the accurate amount of Sevo in the vaporizer before inducing anesthesia, which was later found to be empty, and when he failed to recognize that Patient A's end tidal concentrations were too low to ensure deep sedation.

19. 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

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

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21. 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" constitute grounds for initiating discipline against a licensee.

22. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete, when Respondent failed to document the adverse event during Patient A's procedure, and failed to provide any follow-up notes documenting any discussion with Patient A after her procedure.

23. 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 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

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

DATED this 2nd day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Alexander S. Hinman

ALEXANDER J. HINMAN
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Aury Nagy, 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 2nd day of April, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

AURY NAGY, M.D.
Chairman of the Investigative Committee

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