BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **JAMES DONALD SULLIVAN, M.D., Respondent.**	**Case No. 25-46737-1**

FILED
OCT - 1 2025
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 Ian J. Cumings, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that James Donald Sullivan, 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 medical doctor holding an active license to practice medicine in the State of Nevada (License No. 17038). Respondent was originally licensed by the Board on March 27, 2017.

2. Patient A[2] was a fifty-five (55) year-old male at the time of the events at issue.

3. On June 25, 2018, Patient A presented to the hospital with complaints of intermittent nausea and shortness of breath for a period of three (3) days. Patient A had a history of nonischemic cardiomyopathy, congestive heart failure with an ejection fraction of 22 percent, and hypertension. Patient A's home medications were noted as carvedilol, lisinopril,

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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 Victor M. Muro, M.D., Chowdhury H. Ahsan, M.D., Ph.D., FACC, and Ms. Pamela Beal.

[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 Complaint.

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spironolactone, Lasix, and was noted to be taking digoxin prior to his admission. Patient A's digoxin level was not measured upon his admission.

4. After evaluation in the emergency department (ER), Patient A was documented as hypotensive with a blood pressure of 103/86mmHg. Additionally, Patient A had supraventricular tachycardia with a heart rate of 168 beats per minute, with atrial flutter after being administered with adenosine, an antidysrhythmic. After his initial presentation to the ER and dosage with adenosine, Patient A's heart rhythm converted to atrial fibrillation, and amiodarone was then administered.

5. On June 25, 2018, Patient A was admitted to the hospital with the Respondent as his attending physician. Respondent did not order a digoxin level blood test to determine the present level of digoxin in the patient.

6. On June 26, 2018, at or about 10:50 a.m. Respondent ordered 250mcg of digoxin but was unaware of an ordered verapamil infusion. At 12:30 p.m., Patient A experienced an asystole cardiopulmonary arrest.

COUNT I

NRS 630.301(4) - Malpractice

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

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

9. 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."

10. 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 by failing to obtain a digoxin blood test, and/or failing to review the cardiologist notes and consider digoxin toxicity as an alternate diagnosis prior to prescribing digoxin.

11. 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

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

13. 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.

14. 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 as evidenced by his failure to review and note other medications Patient A was prescribed by different providers before prescribing Patient A additional digoxin.

15. 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 1st day of October, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF CLARK)

Chowdhury H. Ahsan, M.D., Ph.D., FACC, 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 1st day of October, 2025.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
CHOWDHURY H. AHSAN, M.D., PH.D., FACC
Chairman of the Investigative Committee

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