

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

In The Matter of an Investigation)

Case No. 09-11344-1

Regarding)

FILED

SEAN PHONG-QUOC SU, M.D.,)
License No. 9013)

JUL 27 2009

Respondent.)

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

ORDER FOR SUMMARY SUSPENSION AND FOR FURTHER INVESTIGATION

On July 24, 2009, Board Staff presented preliminary evidence to a quorum of the members of the Board who constitute the Investigative Committee in this case, consisting of Charles N. Held, M.D., Benjamin Rodriguez, M.D., and Jean Stoess, M.A., Board Members. The Investigative Committee members were present telephonically. Based upon the presentation by Board Staff, the Investigative Committee hereby immediately suspends Dr. Sean Phong-Quoc Su's license (License No. 9013) pursuant to NRS 233B.127(3) and NRS 630.311 based upon the following preliminary findings:

1. Dr. Su is a physician licensed to practice medicine in the State of Nevada. Dr. Su's primary practice in Nevada is located at the Skin Body Institute, 2451 Professional Court, #110, Las Vegas, Nevada and 7020 North Durango Drive Las Vegas, NV. Though Dr. Su's medical training was in Family Practice and Obstetrics, he advertises and operates his practice at the Skin Body Institute as a cosmetic medical practice and himself as a cosmetic surgeon.

FACTS RELATED TO PATIENT A

2. On April 16, 2009, Dr. Su performed a breast augmentation procedure in his office at the Skin Body Institute upon Patient A. Patient A had won the breast augmentation procedure after hearing about a makeover wish contest through her health club and entering online. The breast augmentation procedure involved the placement of saline implants in Patient A's breasts under local anesthesia. Board Staff's investigation showed that Patient A was only the third woman upon whom Dr. Su had performed such a procedure.

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
1105 Terminal Way #301
Reno, Nevada 89502
(775) 688-2559

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

1 3. Board Staff's investigation showed that Dr. Su did not perform Patient A's breast
2 augmentation procedure safely or competently. The procedure took over eight hours to perform,
3 during which time the local anesthetic waxed and waned in effectiveness, thus resulting in Patient
4 A suffering considerable discomfort and pain throughout the procedure. Board Staff's
5 investigation also found that the breast pocket created by Dr. Su on Patient A may not have been
6 large enough to accommodate the implant he used in the procedure.

7 4. On June 3, 2009, Patient A returned to the Skin Body Institute to have Dr. Su
8 repair the breast augmentation procedure earlier performed by him. Specifically, the implant in
9 Patient A's right breast was visible or may have begun extruding from her breast at the incision
10 site. Dr. Su performed a repair surgery, again in his office at the Skin Body Institute and again
11 under local anesthesia, on Patient A's right breast. The repair surgery was not performed safely
12 or competently. The repair surgery was performed only on Patient A's right breast yet again took
13 over eight hours to perform, during which time the local anesthetic again waxed and waned in
14 effectiveness, resulting again in Patient A suffering considerable discomfort and pain throughout
15 the procedure. In this procedure Dr. Su reinserted the original implant into the breast pocket
16 which was still too small for the size of implant used.

17 5. On June 15, 2009, Patient A went to Sunrise Hospital complaining of
18 symptomology consistent with infection in her right breast. The implant in Patient A's right
19 breast was again visible and may have begun extruding through the incision at the inframammery
20 fold. Patient A was admitted to Sunrise Hospital.

21 6. On June 16, 2009, Drs. Sohn and Hankins, both Plastic Surgeons, performed
22 bilateral implant removal surgery, as well as irrigation, debridement and wound closure of the
23 patient's right breast upon Patient A at Sunrise Hospital to repair the work performed by Dr. Su.
24 The surgery performed by Drs. Sohn and Hankins was performed under general anesthesia. In
25 the course of the surgery, Drs. Sohn and Hankins noted that the incisions performed by Dr. Su
26 were over three times longer (approximately 10 cm. long instead of the 2-3 cm. that the incisions
27 should have been) than appropriate. The incision on the right breast was notably and visibly
28

1 jagged and uneven. At the time of surgery, the incision on the right breast was open for several
2 centimeters and a portion of the implant was visibly extruding out of the opening in the incision.
3 Once the right breast implant was removed, Drs. Drs. Sohn and Hankins discovered an
4 inexplicable mass of sutures in tissue along Patient A's chest wall, and neither Drs. Sohn nor
5 Hankins could explain the clinical necessity or cause for the mass of sutures inside Patient A's
6 breast. Drs. Sohn and Hankins removed the inexplicable sutures from Patient A's right breast,
7 removed the implant from Patient A's left breast, and thoroughly cleaned the tissues of both
8 breasts to remove any source of future infection in Patient A's breasts.

9 7. The surgery by Drs. Sohn and Hankins was successful in controlling the infection
10 in Patient A's breast resultant from Dr. Su's two breast augmentation surgeries.

11 **FACTS RELATED TO PATIENT B**

12 8. On January 6, 2009, Dr. Su performed a cosmetic procedure intended to enhance
13 Patient B's upper and lower eyelids and immediate area around the eye. Dr. Su performed the
14 procedure using a Smartlipo laser liposuction technique as well as made an incision along the
15 underside of patient B's lower eye lids. Dr. Su performed the procedure in his office at the Skin
16 Body Institute under local anesthetic.

17 9. Dr. Su did not perform the eyelid enhancement procedure correctly. In particular,
18 it appears that Dr. Su's technique resulted in overexposure of the effected tissues due to the
19 intense laser light generated by the Smartlipo laser, resulting in what appears to be permanent
20 damage to the tissues and permanent redness and discoloration around both of Patient B's eyes.
21 Patient B also experienced bleeding at the incision site under her right eye following the
22 procedure.
23

24 **FACTS RELATED TO INVESTIGATIVE DIFFICULTIES**

25 10. Upon receipt of the complaints regarding Patients A and B, Board Staff
26 commenced an investigation into the allegations related to Dr. Su's treatment of Patients A and B
27 at the Skin Body Institute.
28

1 11. In furtherance of the investigation, Board Staff attempted to obtain documents and
2 evidence at the Skin Body Institute that was uniquely and solely within the control of Dr. Su. In
3 particular, on June 30, 2009, Investigator Monica Gustafson presented Dr. Su with a subpoena
4 for the entire healthcare records for all patients on whom he had performed breast augmentation
5 surgery. Dr. Su advised Investigator Gustafson that the request was too much for him to provide
6 at that time. Investigator Gustafson then served Dr. Su with a subpoena for just a list of all
7 patients on whom he had performed breast augmentation surgery. After hours of waiting, Dr.
8 Su's staff provided Investigator Gustafson with a list of three patients. Notably this list did not
9 include Patient A, on whom Dr. Su had also performed breast augmentation surgery.

10 12. On July 1, 2009, Investigator Gustafson and Investigator Rice presented Dr. Su with
11 a subpoena for the entire healthcare record for all patients upon whom he had performed breast
12 augmentation surgery. At that time Dr. Su provided the records for the three patients included on
13 the list provided by Dr. Su's staff on June 30, 2009. Dr. Su again omitted the medical record for
14 Patient A. On July 1, 2009, Investigator Gustafson and Investigator Rice served Dr. Su with an
15 additional subpoena for the entire healthcare record for Patient A. Dr. Su then directed his staff
16 member to provide the chart to Investigator Rice, and Dr. Su immediately left the building and
17 was observed leaving out the back door by Investigator Gustafson. Dr. Su's staff was unable to
18 locate the chart for Patient A on this date.

19 13. On July 2, 2009 Investigator Rice returned to Dr. Su's office and was immediately
20 provided the medical record for Patient A. Due to the difficulty encountered in this case in
21 obtaining medical records from Dr. Su on this case and previous cases prior to service of the
22 subpoena for medical records for patient B, Chief of Investigations Douglas Cooper called Dr. Su
23 on July 15, 2009 and advised him that Investigator Andreas and Investigator Hielt would be
24 serving a subpoena for the records for Patient B that same day and encouraged his cooperation.
25 Upon arrival at Dr. Su's office on July 15, 2009, the chart for Patient B was provided by Dr. Su's
26 staff upon presentation of the subpoena by Investigator Andreas and Investigator Hielt.
27
28

1 14. Also on July 2, 2009, the Department of Health and Human Services, Health
2 Division, Bureau of Health Care Quality and Compliance (BHCQC) issued and served upon Dr.
3 Su an "Official Notice to Cease Operation Without a License." The Notice from the BHCQC
4 was based upon its concern that Dr. Su was operating the Skin Body Institute as an unlicensed,
5 and hence unlawful, ambulatory surgical center. The Notice from the BHCQC remains in effect.

6 15. Upon review of the evidence finally obtained from Dr. Su, it appears that some of the
7 records and evidence produced by Dr. Su may not be authentic, original, accurate, and
8 contemporaneously made with the incidents at issue. Substantial additional investigation will be
9 necessary to ascertain the validity of the records and evidence produced by Dr. Su.

10 **FACTS RELATED TO THE THREAT TO THE PUBLIC HEALTH, SAFETY, AND**
11 **WELFARE RELATED TO DR. SU AND THE SKIN BODY INSTITUTE**

12 16. Board Staff's investigation remains ongoing and incomplete, but the preliminary
13 information obtained and derived by Board Staff gives rise to serious and substantial concerns
14 regarding Dr. Su's competence and ability to safely serve patients in Nevada. In particular, the
15 evidence of the threat to the public health, safety, and welfare presented by Dr. Su's practice of
16 medicine include: (1) Dr. Su's treatment of Patient A; (2) Dr. Su's treatment of Patient B; (3) Dr.
17 Su's lack of cooperation with a lawful investigation being conducted by the Board; (4) Dr. Su's
18 production to Board Staff of documents and evidence that preliminarily appear not be to
19 authentic, original, accurate, and contemporaneously made with the incidents at issue; and (5) Dr.
20 Su's operating Skin Body Institute as a potentially unlicensed ambulatory surgical center
21 necessitating a cease and desist order from the BHCQC.

22 Because the Investigative Committee's investigation is not yet complete; and because the
23 Investigative Committee believes that Dr. Su possesses substantial and necessary evidence that
24 will further the investigation; and because Dr. Su's conduct throughout the early stages of this
25 investigation raises real and substantial concerns regarding Dr. Su's trustworthiness and that
26 crucial evidence regarding the investigation may be removed, destroyed, altered, or otherwise
27 made unavailable to the Investigative Committee as attempts to further its investigation; and
28 because Dr. Su's acts and practices constitute real, substantial, and obvious risks of harm to the

1 public health, safety, and welfare of patients and citizens of the State of Nevada; and because the
2 Investigative Committee believes that only an immediate and emergency suspension of Dr. Su's
3 license can effectuate the protection of the public health, safety, and welfare and can assure the
4 fullest and fairest investigation regarding Dr. Su's practices in Nevada; now therefore, pursuant
5 to NRS 233B.127 and NRS 630.311(1):

6 **IT IS HEREBY ORDERED** that Dr. Su's license to practice medicine in Nevada
7 (License No. 9013) is suspended until further order of the Investigative Committee; and

8 **IT IS FURTHER ORDERED** that Dr. Su may not see or treat patients in Nevada as
9 long as his license to practice medicine in Nevada is suspended; and

10 **IT IS FURTHER ORDERED** that neither Dr. Su nor any person employed by or
11 otherwise affiliated with or under the control of Dr. Su shall remove, alter, destroy, or otherwise
12 affect the records related to Dr. Su's practice in Nevada until further order of the Investigative
13 Committee; and

14 **IT IS FURTHER ORDERED** that Dr. Su shall cooperate fully with the investigation
15 being conducted by the Investigative Committee, including responding to any subpoenas or
16 document requests that may be issued by the Investigative Committee or Board Staff in
17 furtherance of the investigation of this matter; and

18 **IT IS FURTHER ORDERED** that any failure by Dr. Su to comply with the terms of this
19 Order shall constitute cause for disciplinary action against Dr. Su pursuant to NRS
20 630.3065(2)(a) and may also result in criminal penalties pursuant to NRS 630.405.

21 Dated this 24th day of July, 2009.

22
23
24
25
26
27
28

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 
Charles N. Held, Chairman
Investigative Committee