BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In The Matter of Charges and Complaint Against SEAN PHONG-QUOC SU, M.D., Respondent.	**Case No. 09-11344-1**

COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners (Board), composed of Charles N. Held, M.D., Ms. Jean Stoess, M.A., and Benjamin J. Rodriguez, M.D., by and through Edward Cousineau, General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Sean Phong-Quoc Su, M.D., (Respondent), has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Respondent was licensed in active status to practice medicine in the state of Nevada on July 1, 1999, by the Nevada State Board of Medical Examiners, pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes, and at all times addressed herein was so licensed.

Patient A

2. Patient A was a twenty-nine-year-old female at the time of the events at issue. Her true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. On April 16, 2009, Patient A underwent a breast augmentation procedure in Respondent's office at the Skin Body Institute which is located in Las Vegas. Patient A had won the breast augmentation procedure after hearing about a "Makeover Wish" program whereby it is

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understood that Respondent's professional fees were to be waived in exchange for a positive testimonial from Patient A.

4. Respondent did not perform Patient A's breast augmentation procedure safely or competently. Of import, the procedure took over eight hours to perform and it was performed under local anesthetic. Medical records indicate that the patient suffered significant and on-going pain and anxiety throughout the procedure. Moreover, Respondent used improper and excessive suture materials, both of which increased the potential for infection and dehiscence in Patient A., and as noted earlier, the procedure was performed in Respondent's medical office, which is an unlicensed surgical facility.

5. Respondent documented concerns with the healing of Patient A's right breast within the first post-operative week. Over the next several weeks, Respondent attempted various remedial measures including placing Patient A on a new antibiotic regimen and replacing some sutures when Respondent noted a pending implant extrusion. By June 2, 2009, Patient A's right side implant had extruded and on June 3, 2009, Patient A returned to the Skin Body Institute to have Respondent repair the breast augmentation procedure earlier performed by him. Respondent performed a repair surgery, again in his office at the Skin Body Institute and again under local anesthesia. The repair surgery was performed only on Patient A's right breast and yet again took over eight hours to perform and with local anesthetic which waned in effectiveness, resulting again in Patient A suffering considerable anxiety and pain throughout the procedure. Moreover, during this procedure Respondent reused the original implant after irrigating the infected breast pocket and implant with antibiotic solution.

6. On June 15, 2009, Patient A presented to Sunrise Hospital complaining of symptoms consistent with infection in her right breast. Specifically, Patient A complained of fever, pain, and puffiness in her breasts. The implant in Patient A's right breast was again visible and may have begun extruding through the incision at the inframammery fold. Patient A was immediately admitted to Sunrise Hospital. On June 16, 2009, two physicians performed bilateral implant removal surgery, as well as irrigation, debridement and wound closure of the patient's right breast. The surgery was performed under general anesthesia. In the course of the surgery,

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the physicians noted that the incisions performed by Respondent were over three times longer than appropriate for this type of surgical procedure. At the time of surgery, the incision on the right breast was open for several centimeters and a portion of the implant was visibly extruding out of the opening in the incision. After the right breast implant was removed, the physicians discovered an inexplicable mass of sutures in tissue along Patient A's chest wall. The physicians removed the inexplicable sutures from Patient A's right breast, removed the implant from Patient A's left breast, and thoroughly cleaned the tissues of both breasts to remove any source of future infection in Patient A's breasts.

Patient B

7. Patient B was a sixty-four-year-old female at the time of the events at issue. Her true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

8. On January 6, 2009, Respondent performed a cosmetic procedure intended to tighten Patient B's lax skin and cosmetically enhance her lower eyelids and immediate area around the eyes, in his office at the Skin Body Institute under local anesthetic. Respondent performed the procedure using a Smartlipo laser liposuction technique.

9. Patient B was not an appropriate candidate for a laser skin tightening procedure given the degree of excess skin surrounding Patient B's eyes. Further, Respondent did not perform the eyelid enhancement procedure correctly. In particular, it appears that Respondent's technique resulted in overexposure of the effected tissues due to the intense laser light generated by the Smartlipo laser. The application of 450 joules per eye/cheek was excessive and resulted in permanent damage to the tissues and permanent redness and discoloration around both of Patient B's eyes. And, as noted earlier, the procedure was performed in Respondent's medical office, which is an unlicensed surgical facility.

Patient C

10. Patient C was a twenty-five-year-old female at the time of the events at issue. Her true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

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11. On November 28, 2008, Patient C underwent a breast augmentation procedure in Respondent's office at the Skin Body Institute which is located in Las Vegas. Evidence in possession of the Board indicates that this is the first breast augmentation procedure Respondent had ever performed independently.

12. Respondent did not perform Patient C's breast augmentation procedure safely or competently. The procedure took over eight hours to perform and it was performed under local anesthetic. Medical records indicate that the patient suffered general anxiety throughout the procedure and that the procedure was performed in Respondent's medical office, which is an unlicensed surgical facility.

13. Thereafter, Patient C developed complications from the augmentation procedure approximately three weeks postoperatively, complications which included extrusion of the left implant, delayed wound healing, and infection. In response, Respondent removed and replaced the surgical sutures on Patient C's left breast. Patient C did eventually recover from the aforementioned extrusion and infection after months of treatment by Respondent, but she later suffered from breast encapsulation, which most likely resulted from the chronic inflammation and scar tissue resulting from the initial surgical procedure.

Recordkeeping and Related Deceptive Conduct

14. Upon receipt of the complaints regarding Patients A and B, Board Staff commenced an investigation into the allegations related to Respondent's treatment of Patients A and B at the Skin Body Institute.

15. In furtherance of the investigation, Board Staff attempted to obtain documents and evidence at the Skin Body Institute that was uniquely and solely within the control of Respondent. In particular, on June 30, 2009, Investigator Monica Gustafson presented Respondent with a subpoena for the entire healthcare records for all patients on whom he had performed breast augmentation surgery. Respondent advised Investigator Gustafson that the request was too much for him to provide at that time. Investigator Gustafson then served Respondent with a subpoena for just a list of all patients on whom he had performed breast augmentation surgery. After hours of waiting, Respondent's staff provided Investigator

Gustafson with a list of three patients, one of whom was Patient C. Notably this list did not include Patient A, on whom Respondent had also performed breast augmentation surgery.

16. On July 1, 2009, Investigator Gustafson and Investigator Shawna Rice presented Respondent with a subpoena for the entire healthcare record for all patients upon whom he had performed breast augmentation surgery. At that time, Respondent provided the records for the three patients included on the list provided by Respondent's staff on June 30, 2009. Respondent again omitted the medical record for Patient A. On July 1, 2009, Investigator Gustafson and Investigator Rice served Respondent with an additional subpoena for the entire healthcare record for Patient A. Respondent then directed his staff member to provide the chart to Investigator Rice, and Respondent immediately left the building and was observed leaving out the back door by Investigator Gustafson. This disobliging conduct resulted in Respondent's staff only being able to locate the chart for Patient C, as they were unable to locate the chart for Patient A on this date.

17. On July 2, 2009 Investigator Rice returned to Respondent's office and was immediately provided the medical record for Patient A. Due to the difficulty encountered in this case in obtaining medical records from Respondent on this case and previous cases prior to service of the subpoena for medical records for patient B, Chief of Investigations Douglas Cooper called Respondent on July 15, 2009 and advised him that Investigator Don Andreas and Investigator Trent Hiett would be serving a subpoena for the records for Patient B that same day and encouraged his cooperation. Upon arrival at Respondent's office on July 15, 2009, the chart for Patient B was provided by Respondent's staff upon presentation of the subpoena by Investigator Andreas and Investigator Hiett.

18. Upon review of the documents finally obtained from Respondent and in view of the circumstances surrounding the production of the documents, including but not limited to the circumstances regarding the absence and then sudden appearance of the chart for Patient A, it appears that some of the records and evidence produced by Respondent may not be authentic, original, accurate, and contemporaneously made with the incidents at issue.

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Unethical Behavior Related to Patient A

19. Respondent solicited patients for breast augmentations through a contest that Respondent openly advertised. Respondent invited patients to submit written statements describing why they wanted breast augmentation and how receiving a free breast augmentation procedure would have positively affected their lives. Respondent called this contest his "Makeover Wish" program.

20. Patient A submitted information to Respondent in response to his "Makeover Wish" contest. Pertinent to this matter, in her submittal to Respondent, Patient A described how she suffered from low self-esteem related to difficult marital and personal relationships, and that she believed that she would never be able to afford breast augmentation with her restricted means and circumstances. Based upon this information, Respondent informed Patient A that she had won his contest and that he would provide her with a free breast augmentation procedure.

21. According to Respondent's chart regarding Patient A, on April 8, 2009, he elicited from Patient A an extensive personal history involving being the victim of spousal abuse, infidelity by her husband, her personal depression and anxiety, attempted suicide by a daughter, and various physical complaints. Respondent also documented that Patient A was working while going to cosmetology school and was also the mother of two children. Based upon the interview, Respondent ordered for Patient A an EKG, a PAP smear, ultrasound of her abdomen, a Doppler duplex scan of her carotid artery, and an echocardiogram. Respondent's chart also indicated that as part of the treatment plan he would consider prescribing an SSRI for Patient A for her depression and anxiety.

22. As part of his pre-operative examination of Patient A, Respondent took photographs of Patient A's breasts. The photographs show that Patient A had glandular and nipple ptosis, more on the left breast than the right. The ptosis and shape of Patient A's breasts indicated that she was not a good candidate for breast augmentation alone and that a satisfactory result would also have required a breast lift to obtain elevation of the lower pole of the breast. There is no indication in Respondent's charts that he ever discussed these issues with Patient A.

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23. Respondent's chart regarding Patient A shows that he required Patient A to sign various documents related to her free breast augmentation procedure. One of these documents informed Patient A that she would provide testimonials on Respondent's behalf after the procedures were performed. Another of the documents Respondent provided to Patient A explained post-operative instructions that informed Patient A not to resume any exercise other than walking for the first seven days post-operation and that for one to four weeks post-operation she was to refrain fro weight-bearing exercise, twisting or lifting anything over her head, or any exercise that might cause a lot of bounce. Another of the documents informed Patient A that if she complained about the services that Respondent was providing, she would be required to pay him for the full costs of the services rendered.

24. Respondent scheduled Patient A for in-office breast augmentation surgery to occur on April 16, 2009 that would be performed at his office at the Skin Body Institute under only local anesthetic. Respondent's chart indicates that on April 15, 2009, Patient A had indicated to him that she was anxious about the results from the tests he had ordered and that she was worried about her family and job.

25. As is amply shown in Respondent's chart regarding Patient A, she was not a good candidate for an in-office breast augmentation surgery. The glandular and nipple ptosis and shape of Patient A's breasts indicated that Patient A would not have a satisfactory result from breast augmentation alone. Patient A indicated numerous times her anxiety, depression, and emotionally difficult personal situation. Patient A indicated that her job situation and family situation were such that she could not afford time away from work and her schooling and that, since she was caring for her children with little support, he would know that she would be expected to engage almost immediately in physical activities that Respondent was instructing Patient A to avoid.

26. Respondent's breast augmentation surgery on Patient A demonstrates that he violated Patient A's trust and exploited his relationship with her for his financial or other personal gain. The medical records make clear that Patient A would not receive a satisfactory result from augmentation surgery, but Respondent did not speak with Patient A about additional

surgery, presumably because such additional surgery was beyond his capabilities and the terms of his "Makeover Wish" contest. Patient A was emotionally fragile, and most especially, prone to anxiety so much so that Respondent was recommending that Patient A begin SSRI therapy, and yet later Respondent would blame the extremely prolonged surgery times in his surgical notes on Patient A's anxiety about which he had always known. Respondent only wanted to use Patient A as an exemplar of his "generosity" through his "Makeover Wish" contest, and then to exploit his "generosity" by turning Patient A into a testimonial shill for his services.

COUNT I

27. All of the above paragraphs are incorporated by reference as though fully set forth herein.

28. The facts and circumstances indicate that Respondent's care and treatment of Patient A constitutes malpractice. Section 630.301(4) of the Nevada Revised Statutes provides that malpractice, defined as the failure to use the reasonable knowledge, skill and expertise ordinarily used in similar circumstances, is grounds for discipline.

29. By reason of the foregoing, Respondent committed malpractice in the course of providing care and treatment to Patient A and is subject to discipline as provided in NRS 630.352.

COUNT II

30. All of the above paragraphs are incorporated by reference as though fully set forth herein.

31. The facts and circumstances indicate that Respondent's care and treatment of Patient B constitutes malpractice. Section 630.301(4) of the Nevada Revised Statutes provides that malpractice, defined as the failure to use the reasonable knowledge, skill and expertise ordinarily used in similar circumstances, is grounds for discipline.

32. By reason of the foregoing, Respondent committed malpractice in the course of providing care and treatment to Patient B and is subject to discipline as provided in NRS 630.352.

COUNT III

33. All of the above paragraphs are incorporated by reference as though fully set forth herein.

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The facts and circumstances indicate that Respondent's care and treatment of Patient C constitutes malpractice. Section 630.301(4) of the Nevada Revised Statutes provides that malpractice, defined as the failure to use the reasonable knowledge, skill and expertise ordinarily used in similar circumstances, is grounds for discipline.

34. By reason of the foregoing, Respondent committed malpractice in the course of providing care and treatment to Patient C and is subject to discipline as provided in NRS 630.352.

COUNT IV

35. All of the above paragraphs are incorporated by reference as though fully set forth herein.

36. The facts and circumstances regarding the records produced by Respondent as part of the investigation of this matter show either that Respondent did not maintain timely, legible, accurate, and complete medical records or, worse yet, that he had actually altered medical records of his patients. The failure to maintain timely, legible, accurate, and complete medical records relating to the diagnosis, treatment, and care of a patient constitutes grounds for initiating disciplinary action pursuant to NRS 630.3062(1). The altering of the medical records of a patient constitutes grounds for initiating disciplinary action pursuant to NRS 630.3062(2).

37. By reason of the foregoing, Respondent failed to maintain timely, legible, accurate, and complete medical records and altered of the medical records of Patients A and B and is subject to discipline as provided by NRS 630.352.

COUNT V

38. All of the above paragraphs are incorporated by reference as though fully set forth herein.

39. The facts and circumstances regarding how, when, and what records Respondent provided in response to the various subpoenas served by Board Staff as part of the investigation in this matter demonstrate that Respondent had engaged in conduct intended to deceive Board Staff. In particular, Respondent's representations that the three files regarding breast augmentations were all that he had was untrue, should have been known to him to be untrue at the time he made the representations, and was proven to be untrue only after the persistence of

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Board Staff forced Respondent to produce the fourth chart. The facts and circumstances surrounding the production and content of the fourth chart, Patient A's chart, indicate that some of the contents of the chart may not be true, accurate, and correct. The engaging in any conduct which is intended to deceive constitutes a ground for initiating disciplinary action pursuant to NRS 630.306(2)(a).

40. By reason of the foregoing, Respondent has engaged in conduct which is intended to deceive and is subject to discipline as provided by NRS 630.352.

COUNT VI

41. All of the above paragraphs are incorporated by reference as though fully set forth herein.

42. The facts and circumstances indicate that Respondent put these personal interests of his ahead of the interests in providing optimal patient counsel and care to Patient A. In so doing, he violated Patient A's trust in him and exploited his relationship with Patient A for his financial and other personal gain. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain constitutes a ground for initiating disciplinary action pursuant to NRS 630.301(7).

43. By reason of the foregoing, Respondent has engaged in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain and is subject to discipline as provided by NRS 630.352.

COUNT VII

44. All of the above paragraphs are incorporated by reference as though fully set forth herein.

45. The facts and circumstances also indicate that Respondent failed to offer appropriate procedures or studies to Patient A regarding the glandular ptosis and shape of her breasts before performing the breast augmentation because his doing so would have negatively affected his financial well-being either by his having to pay for her to have the breast lift that her condition indicated was needed or by losing the benefit of her testimonial for which he was

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willing to pay at the cost of a free breast augmentation surgery, and, thus, violated NRS 630.301(8).

46. By reason of the foregoing, Respondent failed to offer appropriate procedures or studies and failed to refer Patient A to appropriate providers with the intent of positively influencing his financial well-being and is subject to discipline as provided by NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;

2. That the Nevada State Board of Medical Examiners give Respondent notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;

3. That the Board determine what sanctions it deems appropriate to impose for the violation committed by Respondent; and

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

DATED this 18th day of September, 2009.

By: _____
Edward Cousineau
Attorney for the Investigative Committee of the
Nevada State Board of Medical Examiners

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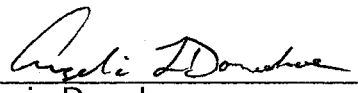
CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 18th day of September 2009, I served a file copy of the COMPLAINT, PATIENT DESIGNATION, Fingerprint Information, by mailing via USPS certified return receipt mail to the following:

Kristopher Rath, Esq.
HUTCHISON & STEFFEN
10080 West Alta Dr. Ste. 200
Las Vegas, NV 89145

Dated this 18th day of September 2009.



Angie Donohoe
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