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

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In The Matter of Charges and Complaint Against STEVE WONG, M.D. Respondent.	**Case No. 10-12651-1**

COMPLAINT

The Investigative Committee of the Nevada State Board of Medical Examiners, composed at the time filing of Charles N. Held, M.D., Chairman, Theodore B. Berndt, M.D., Member, and Valerie J. Clark, Member, having a reasonable basis to believe that Steve Wong, M.D., hereinafter referred to as 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 is currently licensed in active status (License No. 9020), and has been so licensed since July 1, 1999 by the Nevada State Board of Medical Examiners pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes.

2. Patient A was a twenty-three year old (23) male at the time of the incidents in question. His true identity is not disclosed to protect his privacy, but his identity is disclosed in the Patient Designation served on Respondent along with a copy of this Complaint.

3. Patient A suffered from pain and swelling of his jaw along with difficulty swallowing. He was admitted to the hospital on May 27, 2008. He was found to have submandibular/sublingual cellulitis. As a result, the oral surgeon decided to extract the lower right and lower left wisdom teeth. Respondent was to be the anesthesiologist for the surgery.

4. A CT scan of the neck on May 27, 2008 showed severe wisdom tooth infection with impending Ludwig's angina and swelling present in multiple areas of the oropharynx and

neck. Another CT scan of the neck on May 30, 2008 clearly showed diffuse progression of sublingual abscess, new progression into the submandibular space, fluid collections consistent with abscesses in the left supraclavicular and retropharyngeal areas from C2 to C5, and anterior neck inferiorly along strap muscles to the level of the anterosuperior mediastinum, and true Ludwig's Angina.

5. This clinical scenario along with the physical exam were clear red flags that airway protection could easily be jeopardized during the planned surgery. Loss of a controlled airway would lead to hypoxia and hypercarbia. Respondent also missed the significance of the second CT scan and thought that it showed essentially the same things as the initial CT scan.

6. At the time of surgery, Respondent utilized an LMA airway device instead of an Endotracheal tube. The use of an LMA does not provide optimal airway protection as it does not enter the trachea and has no cuff to ensure adequate seal. The LMA use as an airway device was strongly contraindicated because of the presence of Patient A's multiple oropharyngeal abscesses with Ludwig's angina, Patient A's morbid obesity and the identification of preoperative trismus.

7. The surgery was performed on May 31, 2008. As the LMA was removed by Respondent at the end of the surgery, Patient A began moving around a lot requiring four people to restrain him. The pulse Oxygen was not picking up signal and was without a good wave form on the pletysmograph.

8. Bradycardia began concurrently with removal of the LMA, and asystole quickly followed. Patient A coded and was without an open airway for eleven (11) minutes into the code process. Respondent finally placed an Endotracheal tube on Patient A eleven (11) minutes into the code process. By the time Patient A arrived at the ICU, his neurological status was documented and consistent with severe anoxic injury.

9. The prolonged and severe anoxic event at the close of surgery on May 31, 2008 led to severe brain injury. Patient A suffered brain death on June 10, 2008.

10. Additionally, the record keeping of events immediately following surgery and during the anoxic event was poor. The vital signs monitoring machine records were not produced

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or made available. Respondent, moreover, admits that the LMA was removed for six to eight (6-8) minutes in his letter to the Board. There is no mention of this in the OR notes.

Count I

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

12. Nevada Administrative Code Section 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.

13. Nevada Revised Statute Section 630.301(4) provides that malpractice is grounds for initiating disciplinary action against a licensee.

14. Respondent failed to use the reasonable care, skill, or knowledge ordinarily used under the same or similar circumstances when he elected to use the LMA as an airway device for Patient A.

15. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

Count II

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

17. Nevada Revised Statute 630.3062(1) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating disciplinary action against a licensee.

18. Respondent failed to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of Patient A immediately following surgery and during the anoxic event.

19. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in Section 630.352 of the Nevada Revised Statutes.

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WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners 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 Section 630.339 of the Nevada Revised Statutes within twenty (20) days of service of the Complaint.

2. That the Nevada State Board of Medical Examiners set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS §630.339(3);

3. That the Nevada State Board of Medical Examiners determine what sanctions it determines to impose if it determines there has been a violation or violations of the Medical Practice Act (Nevada Revised Statutes Chapter 630) committed by Respondent; and

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

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 28th day of June, 2010.

THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Bradley O. Van Ry, Esq.
Deputy General Counsel and Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF DOUGLAS)

Charles N. Held, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered during the course of the investigation into a complaint against Respondent, that he believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate, and correct.

Dated this 29th day of June, 2010.

CHARLES N. HELD, M.D.

CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 29th day of June 2010; I served a file copy of the Complaint, Patient Designation and Fingerprint Information by mailing via USPS certified return receipt mail to the following:

Steve Wong, M.D.
10624 S. Eastern Ave., Ste. A345
Henderson, NV 89052

Dated this 29th day of June 2010.

Angelia L. Donohoe
Legal Assistant

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