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 SEAN PHONG-QUOC SU M.D., Respondent	**Case No. 13-11344-1**

COMPLAINT

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board), composed at the time of filing of Theodore B. Berndt, M.D., Chairman, Valerie J. Clark, BSN, RHU, LUTCF, Member, and Michael J. Fischer, M.D., Member, by and through Edward O. Cousineau, Esq., Deputy Executive Director and attorney for the IC, having a reasonable basis to believe that Sean Phong-Quoc Su, 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 formal Complaint, stating the IC's charges and allegations as follows:

A. Status of Respondent's Nevada Medical License

1. Respondent was licensed by the Board to practice medicine in the state of Nevada on July 1, 1999 (License No. 9013).

2. On or about March 5, 2010, the status of Respondent's license to practice medicine in the state of Nevada was changed from active-restricted to active-probation. Respondent's license to practice medicine is presently in active-probation status.

B. Respondent's Treatment of Patient A

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3. Patient A was a thirty (30)-year-old male at the commencement of the incidents in question. His true identity is not disclosed in this Complaint to protect his identity, but his identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

4. The progress notes contained in Patient A's chart are illegible. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

C. Respondent's Treatment of Patient B

5. Patient B was a thirty-seven (37)-year-old female at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

6. From on or about September 29, 2010 through December 2, 2011, Respondent prescribed Patient B Phentermine, an appetite suppressant, on at least nine (9) separate visits. The patient's medical records do not demonstrate that the patient's weight threatened her health.

7. The Nevada Prescription Monitoring Program shows that while Patient B was being treated by Respondent she was also receiving prescription medication, including but not limited to controlled substances, from eight (8) different physicians.

8. The progress notes contained in Patient B's chart are inaccurate, illegible, incomplete and/or untimely.

D. Respondent's Treatment of Patient C

9. Patient C was a fifty-nine (59)-year-old female with a history of atrial fibrillation and heart valve disease at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

10. In November 2010, Respondent treated fatigue in Patient C with thyroid medication. Respondent adjusted Patient C's thyroid medication every three (3) weeks, which failed to allow the thyroid medication to achieve a steady state.

11. Respondent was also prescribing the thyroid medication to treat Patient C's obesity. Thyroid medication should never be used for weight control, especially when the patient has a history of atrial fibrillation and heart valve disease.

12. The progress notes contained in Patient C's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

E. Respondent's Treatment of Patient D

13. Patient D was a thirty-nine (39)-year-old female at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

14. On or about February 9, 2012, Patient D presented to Respondent's office to establish as a patient. The patient was treated by Respondent on February 9, 2012, February 14, 2012 and March 13, 2012.

15. The progress notes contained in Patient D's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

F. Respondent's Treatment Patient E

16. Patient E was a thirty-four (34)-year-old female with a history of neuropathy and anxiety at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

17. During the time that Respondent treated Patient E, Respondent treated Patient E with the Fenphen protocol using Phentermine and Fluoxetine despite warnings from the medical community that the Fenphen protocol resulted in serious cardiac side effects.

18. Respondent also administered B-12 injections to Patient E despite the fact that the patient's chart lacked any laboratory evidence that the patient suffered from pernicious anemia.

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19. The progress notes contained in Patient E's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

G. Respondent's Treatment of Patient F

20. Patient F was a fifty-five (55)-year-old female at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

21. The progress notes contained in Patient F's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

H. Respondent's Treatment of Patient G

22. Patient G was a fifty-one (51)-year-old female with a history of diabetes, hyperlipidemia and hypertriglyceridemia at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

23. Respondent treated Patient G from approximately September 2010 through October 2011.

24. During his treatment of Patient G, Respondent repeatedly prescribed Patient G Soma, Vicroprofen and Norco.

25. The patient's medical records do not contain urine/serum medication levels screening, pain contracts and/or written treatment plans.

26. The Nevada Prescription Monitoring Program shows that while Patient G was being treated by Respondent she was also receiving prescription medication, including but not limited to controlled substances, from five (5) different physicians.

27. Further, the progress notes contained in Patient G's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

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I. Respondent's Treatment of Patient H

28. Patient H was a twenty-four (24)-year-old female with a history of headaches at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

29. Respondent treated Patient H from on or about August 12, 2008 through on or about April 21, 2010.

30. During his treatment of Patient H, Respondent wrote Patient H prescriptions for Lortab and Soma.

31. The Nevada Prescription Monitoring Program shows that while Patient H was being treated by Respondent she was also receiving Hydrocodone prescriptions from multiple physicians.

32. The patient's medical records do not document the ailment for which the prescription medication was prescribed.

33. The patient's medical records do not document that Respondent performed a physical examination on Patient H.

34. Further, the progress notes contained in Patient H's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

J. Respondent's Treatment of Patient I

35. Patient I was a forty-seven (47)-year-old female at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

36. The progress notes contained in Patient I's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

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K. Respondent's Treatment of Patient J

37. Patient J was a forty-one (41)-year-old female with panic disorder at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

38. Respondent also treated Patient J with very large doses of Lasix and Hydrochlorothiazide for bloating. However, the patient's medical records do not substantiate the basis for the large doses of Lasix and Hydrochlorothiazide.

39. Further, the progress notes contained in Patient J's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

L. Respondent's Treatment of Patient K

40. Patient K was a forty-two (42)-year-old female suffering from anemia, asthma, hypothyroidism, osteoporosis and vaginal bleeding at the commencement of the incidents in question. Her true identity is not disclosed in this Complaint to protect her identity, but her identity is disclosed in the Patient Designation contemporaneously served on Respondent with this Complaint.

41. Respondent treated Patient K from on or about June 6, 2002 through November 4, 2011.

42. During that time, Respondent treated Patient K's asthma with injectable parenteral steroids, which are known to worsen osteoporosis. Respondent also failed to recognize that Patient K's vaginal bleeding was a side effect of the parenteral steroids he prescribed to the patient to treat her asthma.

43. Further, the progress notes contained in Patient K's chart are inaccurate, illegible, incomplete and/or untimely. It cannot be determined from the patient's medical records what medical condition(s) Respondent treated and what treatment plan(s) Respondent utilized.

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COUNT I

(Medical Records Violation – Eleven Counts)

44. All of the allegations in the above paragraphs are hereby incorporated as if fully set forth herein.

45. NRS 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 discipline against a licensee.

46. Respondent failed to maintain accurate and/or complete medical records relating to the diagnosis, treatment and care of Patients A through K when he failed to maintain timely, legible, accurate and complete medical records for Patients A through K.

47. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

(Malpractice – Eight Counts)

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

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

50. 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.

51. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use reasonable care, skill or knowledge ordinarily used under similar circumstances when treating Patient B, Patient C, Patient D, Patient E, Patient G, Patient H, Patient J and Patient K.

52. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

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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 the sanctions it will impose if it finds Respondent violated the Medical Practice Act;

4. That the Board make, issue and serve on Respondent, in writing, its findings of fact, conclusions of law and order, which shall include the sanctions imposed; and

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

DATED this 21st day of August, 2013.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Edward O. Cousineau, Esq.
Deputy Executive Director
Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Theodore B. Berndt, 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, he believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

Dated this 21st day of August, 2013.

Theodore B. Berndt

Theodore B. Berndt, M.D.

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on 21st day of August 2013; I served a filed copy of the COMPLAINT & PATIENT DESIGNATION, via USPS e-certified return receipt to the following:

Sean Phong-Quoc Su, M.D.
2451 Professional Ct., #110
Las Vegas, NV 89128

Dated this 21st day of August, 2013.

Angelia L. Donohoe
Legal Assistant

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