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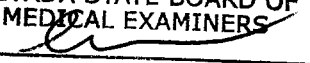
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**BEFORE THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF NEVADA**

\* \* \* \* \*

**In the Matter of Charges and  
Complaint Against  
ANNE O'NEILL, M.D.,  
Respondent.**

Case No. 20-34134-1

**FILED**  
JUN - 5 2020  
NEVADA STATE BOARD OF  
MEDICAL EXAMINERS  
By: 

**COMPLAINT**

The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners ("Board") hereby issues this formal Complaint against Anne O'Neill, M.D. (hereinafter referred to as Respondent), a licensed physician in Nevada. After investigating this matter, the IC has a reasonable basis to believe that Respondent has violated provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act).

The IC alleges the following facts:

1. Respondent is currently, and was at all times relevant to this Complaint, licensed in active status (License No. 12894). Respondent was issued her license from the Board on September 22, 2008, pursuant to the provisions of NRS Chapter 630.

**Patient A**

2. Patient A was a 41-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 upon Respondent along with a copy of this Complaint.

3. On February 10, 2016, Respondent saw Patient A for an initial consultation and recommended prophylactic bilateral mastectomies.

<sup>1</sup> The Investigative Committee of the Nevada State Board of Medical Examiners, at the time the filing of this Complaint was approved, was composed of Wayne Hardwick, M.D., Mr. M. Neil Duxbury, and Aury Nagy, M.D.

1           4.       On March 5, 2016, Respondent performed a right total mastectomy and sentinel  
2 lymph node biopsy, left total mastectomy and sentinel lymph node biopsy, and immediate breast  
3 reconstruction with allograft placement and tissue expanders on Patient A.

4           5.       On March 21, 2016, Patient A presented for her second post-operative visit, where  
5 Respondent noted draining from the right breast and drainage from the right after drain removal.  
6 Respondent also recommended a follow-up visit in one week for wound check.

7           6.       On April 6, 2016, Patient A presented for her third post-operative visit where  
8 Respondent documented drainage from the incision site and planned to follow up for inflations.

9           7.       On April 18, 2016, Patient A present for her fourth post-operative visit where  
10 Respondent mentioned drainage from the incision site and that the expander was exposed on the  
11 left side, and planned to remove the left tissue expander.

12           8.       On April 22, 2016, Patient A was taken into the operating room and underwent  
13 removal of her left breast tissue expander. The operative report stated that “the old incision site  
14 was opened completely until the expander was fully exposed.” “The expander was then grasped  
15 with an Allis clamp and removed from the cavity.” However, there was no mention of the  
16 appearance of the surgical field or mention of the appearance of the previously implanted  
17 allograft. No cultures of the wound were taken.

18           9.       Respondent followed Patient A’s wound and recommended wound care from  
19 April 27, 2016 until August 1, 2016.

20           10.      On August 1, 2016, Respondent noted a “left open breast wound” and  
21 recommended replacement of the left tissue expander and allograft.

22           11.      On August 31, 2016, Patient A was taken again to the operating room and  
23 underwent placement of a left breast allograft and placement of a left breast tissue expander.  
24 However the operative report makes no mention of the appearance of the wound or the presence  
25 of the previously implanted allograft.

26           12.      On September 12, 2016, at patient A’s second postoperative appointment after her  
27 extender replacement, respondent noted a swollen left breast and performed an in-office seroma  
28 aspiration. No cultures of the fluid were taken.

1           13.     On September 19, 2016, respondent noted that the left incision site was clean, dry  
2 and intact, swollen, and erythema. Respondent recommended antibiotic therapy and follow up for  
3 possible drainage.

4           14.     On September 21, 2016, at another post-operative visit, Respondent documented  
5 “left slightly swollen, wound sealed,” and recommended follow up on Thursday for a wound  
6 check.

7           15.     On September 26, 2016, at another post-operative appointment, Respondent’s  
8 examination revealed that left side was not swollen, no erythema, and draining on right side, and  
9 that Respondent will remove the expander in office on Thursday, if it is still draining. Respondent  
10 also recommended to continue dressing change and complete antibiotic therapy.

11           16.     On September 29, 2016, the next postoperative appointment, Respondent’s  
12 documented clinical examination revealed slight draining on the right side, redressing of wound,  
13 and recommended follow up in one week.

14           17.     Patient A was not seen again until one and one half months later on November 7,  
15 2016. At that appointment, Respondent did not document a physical exam but did note removal  
16 of the left expander in the office that day, and recommended follow up for a wound check in one  
17 week and another follow up in one month.

18           18.     On February 2, 2017, three months later, Patient A returned for a postoperative  
19 appointment. Respondent noted that the left wound had healed, had no odor, and recommended a  
20 left tissue expander and allograft placement.

21           19.     On February 21, 2017, Patient A went for her fifth operative procedure, and  
22 underwent a left tissue expander placement with allograft. In her operative report, Respondent did  
23 not mention the appearance of the wound or the appearance or excision of the previous allograft,  
24 but did make mention of suturing into place another allograft. No cultures were taken.

25           20.     On February 28, 2017, at Patient A’s one-week post-operative appointment,  
26 Respondent noted “left breast seroma present” and that she performed a “U/S guided FNA of left  
27 breast seroma.”  
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1           21.     On March 2, 2017, at Patient A's next appointment, Respondent noted that the left  
2 breast was slightly swollen, no erythema, and recommended to continue antibiotics and follow up  
3 for wound check.

4           22.     On March 6, 2017, Respondent noted the left wound had slight drainage and  
5 recommend follow up.

6           23.     On March 11, 2017, Patient A and her family began emailing Respondent with  
7 concerns about her left breast wound.

8           24.     On March 12, 2017, the next day, Patient A presented to the emergency department  
9 with complaints of left breast pain and induration. Patient A was admitted into the hospital, where  
10 an infectious disease specialist was consulted, who recommended broad spectrum antibiotics and  
11 surgical consultation.

12           25.     On March 13, 2017, Patient A received a wound care consult and the physician  
13 documented a 3 x 1 x 2 centimeter wound, tunnels 6 centimeters at 2 o'clock and 8 centimeters at  
14 9 o'clock. Under the staples Patient A had a lot of drainage and some slough in the wound, and  
15 moderate drainage coming out of the wound.

16           26.     Also on March 13, 2017, one of Respondent's partners saw Patient A, who  
17 recommended outpatient follow up with Respondent for left breast expander removal, and to  
18 continue antibiotics.

19           27.     On March 14, 2017, the wound care physician documented that the expander could  
20 be visualized in the wound, and tissue expander removal was recommended. Patient A expressed  
21 interest in a second surgical opinion.

22           28.     On March 17, 2017, Patient A was discharged on IV antibiotics.

23           29.     On March 22, 2017, Patient A was readmitted because she was not tolerating the  
24 outpatient antibiotics. She was seen once again by Respondent's partner, who recommended  
25 tissue expander removal.

26           30.     On March 23, 2017, Patient A was taken back to the operating room and underwent  
27 excision of her allograft and tissue expander. The corresponding note mentions that the wound  
28

1 had serous fluid but no purulence and documented excision of the allograft as well as the tissue  
2 expander.

3 31. On April 24, 2017, Patient A went to the emergency room for complaints related to  
4 right breast pain and was subsequently seen by Respondent's partner, who referred her to a plastic  
5 surgeon.

6 32. On May 16, 2017, Patient A was seen by a plastic surgeon, who documented that  
7 the right tissue expander was in place without malposition or fluid collection; that the incision was  
8 clean, dry and intact; that there was "excess tissue present on the right in the lower and lateral  
9 poles;" that the right tissue expander was underinflated; that the left breast had a contracted lower  
10 pole and open wound in center of previous incision with tracking superiorly and minor drainage;  
11 and "no surrounding cellulitis or purulence."

12 **COUNT I**

13 **NRS 630.301(4) (Malpractice)**

14 33. All of the allegations in the above paragraphs are hereby incorporated by reference  
15 as though fully set forth herein.

16 34. NRS 630.301(4) provides that malpractice by a physician is grounds for initiating  
17 disciplinary action against a licensee.

18 35. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient,  
19 to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

20 36. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed  
21 to use the reasonable care, skill or knowledge ordinarily used under similar circumstances in  
22 treating Patient A, and more specifically the deficiency in post-operative care.

23 37. By reason of the foregoing, Respondent is subject to discipline by the Board as in  
24 NRS 630.352.

25 **COUNT II**

26 **NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)**

27 38. All of the allegations in the above paragraphs are hereby incorporated by reference  
28 as though fully set forth herein.

1           39.     NRS 630.3062(1)(a) provides that failure to maintain timely, legible, accurate and  
 2 complete medical records relating to the diagnosis, treatment and care of a patient constitutes  
 3 grounds for initiating disciplinary action against a licensee.

4           40.     Respondent failed to maintain proper medical records, operative and post-  
 5 operative, in the treatment of Patient A.

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

8           **WHEREFORE**, the Investigative Committee prays:

9           1.     That the Nevada State Board of Medical Examiners give Respondent notice of the  
 10 charges herein against her and give her notice that she may file an answer to the Complaint herein  
 11 as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

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

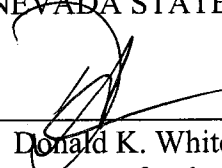
14          3.     That the Nevada State Board of Medical Examiners determine what sanctions to  
 15 impose if it determines there has been a violation or violations of the Medical Practice Act  
 16 committed by Respondent;

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

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

22          DATED this 5<sup>th</sup> day of June, 2020.

23                                 INVESTIGATIVE COMMITTEE OF  
 24                                 THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

25                                 By:   
 26                                 Donald K. White, Esq., Deputy General Counsel  
 27                                 Attorney for the Investigative Committee

VERIFICATION

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STATE OF NEVADA        )  
                                  : ss.  
COUNTY OF WASHOE    )

Mr. M. Neil Duxbury, 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 5<sup>th</sup> day of June, 2020.

INVESTIGATIVE COMMITTEE OF THE NEVADA  
STATE BOARD OF MEDICAL EXAMINERS

*M. NEIL DUXBURY*

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M. Neil Duxbury, Chairman