BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: MICHAEL SCOTT MALL, M.D., Respondent.	Case No. 23-8666-3

FILED
SEP - 5 2023
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Michael Scott Mall, 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 Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 6074). Respondent was originally licensed by the Board on July 1, 1990.

2. Patient A[2] was a fifty-nine (59) year-old female at the time of the events at issue.

3. On March 30, 2016, Patient A underwent J-Plasma facial and neck resurfacing performed by Respondent.

4. J-Plasma was not, at the time of this event and is not currently, FDA approved for use in dermal resurfacing.

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Bret W. Frey, M.D., Col. Eric D. Wade, USAF (Ret.), and Carl N. Williams, Jr., M.D., FACS.

[2] Patient A's 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.

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5. Patient A had follow-up visits with Respondent on April 7, 2016, and April 13, 2016, and the records indicate redness and oozing was observed, but also indicated Patient A's "skin is healing great." No burn treatments were initiated on those dates.

6. On April 21, 2016, Patient A had another follow-up visit with Respondent and the records noted tenderness and oozing on her neck. Patient A was not referred to a burn or wound care specialist and Respondent did not acknowledge the extent or severity of the injury to Patient A's neck.

7. On April 28, 2016, Patient A was still experiencing redness, but no oozing and Respondent's records indicated "follow up skin look[s] great." Respondent referred Patient A for hyperbaric oxygen treatment, but again, she was not referred to a burn or wound care specialist.

8. May 5, 2016, and June 2, 2016, Patient A's records indicate that she was "healing great." Once again, Respondent did not acknowledge the extent or severity of Patient A's injury to her neck and she was not referred to a burn or wound care specialist.

9. On July 7, 2016, Patient A was prescribed a steroid cream and was injected with steroids after she complained of redness and tightness on the skin of her neck area.

10. On September 1, 2016, Patient A received hydrocortisone shots and a Genesis treatment for her hypertrophic scar. This treatment regimen, along with Intense Pulse Light (IPL) treatments beginning in March 2017 went on for several visits. Patient A discontinued her treatment with Respondent in September 2017.

11. After several treatments by Respondent, Patient A was left with severe scarring on her neck.

COUNT I

NRS 630.301(4) - Malpractice

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

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

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14. 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."

15. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A, when he burned Patient A's neck with a J-Plasma device and then did not refer her to a burn or wound care specialist.

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

COUNT II

NRS 630.306(1)(b)(2) - Violation of Standards of Practice Established by Regulation

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

18. Violation of a standard of practice adopted by the Board is grounds for disciplinary action pursuant to NRS 630.306(1)(b)(2).

19. NAC 630.210 requires a physician to "seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services."

20. Respondent failed to timely seek consultation with regard to Patient A's medical condition from on or about April 2016 to on or about August 2017 when Respondent should have consulted with an appropriate care provider, such as a burn or wound care specialist, to address the burns, wounds and scarring to Patient A's neck from the J-Plasma treatments. A timely consultation may have confirmed or denied a diagnosis and may have enhanced the quality of medical care provided to Patient A.

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

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COUNT III

NRS 630.306(1)(e) - Practice Beyond Scope of License

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

23. NRS 630.306(1)(e) provides that practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform, or which are beyond the scope of his or her training constitutes grounds for initiating disciplinary action.

24. J-Plasma is not an FDA approved device for dermal resurfacing and Respondent knew or should have known this information while utilizing the device with patients and should not have used this particular device on Patient A's neck.

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

COUNT IV

NRS 630.306(1)(g) - Continual Failure to Exercise Skill or Diligence

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

27. Continual failure by the Respondent to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field is grounds for disciplinary action against a licensee pursuant to NRS 630.306(1)(g)

28. Respondent continually failed to exercise skill or diligence as demonstrated by the repeated use of a J-Plasma device, that was not FDA approved, causing burns on Patient A's neck. Respondent demonstrated repeated inability to appreciate and acknowledge the severity of Patient A's wounds and burns and her need to visit a burn or wound care specialist from in or about April 2016 through in or about September 2016.

29. 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 what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

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

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

DATED this 5th day of September, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

DONALD K. WHITE
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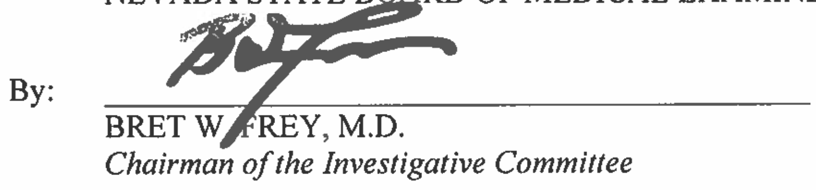
VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., 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 5th day of September, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS



By: ______________________________
BRET W. FREY, M.D.
Chairman of the Investigative Committee