BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **ERIC HAZELRIGG, M.D.** Holder of License No. **20772** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-00-0534 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand and Probation)

This matter was considered by the Arizona Board of Medical Examiners ("Board") at its public meeting on February 6, 2002. Eric Hazelrigg, M.D., ("Respondent") appeared before the Board with legal counsel, Dan Jantsch, for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(I). After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 20772 for the practice of medicine in the State of Arizona.

3. The Board initiated case number MD-00-0534 after receiving notification of a medical malpractice settlement involving Respondent's care and treatment of a patient ("Patient").

4. Patient, a 26 year-old female, first presented to Respondent for treatment when she was twelve weeks pregnant. Patient's obstetrical history included infertility, three previous miscarriages and recent use of Clomid and Progesterone. Patient's

prenatal course progressed uneventfully until her blood pressure began to rise at 37 weeks gestation. At 39 and a half weeks Patient had 2 plus pitting edema and a blood pressure of 140 over 90.

5. Because he was concerned about pregnancy-induced hypertension Respondent obtained Patient's consent to induce labor. The induction began at Desert Samaritan Hospital ("Hospital") on April 8, 1999.

6. On April 9, 1999, Patient was administered epidural anesthesia and Respondent artificially ruptured the membranes.

7. Over the course of time the fetal monitoring tracing developed patterns of intermittent fetal hypoxia and, although the tracings repeatedly recovered, they returned to non-reassuring status.

8. An outside medical consultant ("Medical Consultant") reviewed Patient's records and noted that the tracings were concerning at 1740 hours and that by 1840 hours a cesarean section should have been recommended. However, Patient was continued on Pitocin.

9. Patient finally reached complete cervical dilation, but did not deliver and remained undelivered for approximately six hours. The Medical Consultant opined that at 1850 hours the tracings were "bad;" at 2019 hours they were "terrible;" and they were pre-terminal at 2030 hours on April 10, 1999. Patient's infant was not delivered until 0600 hours on April 10, 1999. The infant later expired.

10. The Medical Consultant opined that he could not directly attribute the infant's death to the mismanaged labor because the death may have occurred as a result of trauma in utero before labor began. The medical consultant identified Respondent's failure to accurately interpret the electronic fetal heart rate tracing; failure to identify a

deteriorating fetal condition and the failure to perform a cesarean section despite evidence of a fetal intolerance to labor as a departure from the standard of care.

11. At the formal interview the Board queried Respondent as to when he first noticed abnormalities in the fetal monitoring pattern. Respondent noted that he first identified the abnormalities at approximately 1700 on April 9, 1999. Respondent stated that the abnormality noted was three late decelerations of the fetal heart rate, which indicate some fetal intolerance to labor. Respondent indicated that his options at that point to try to correct the problems were to perform some sort of maneuver, either moving the patient on her side or placing oxygen on the patient.

12. Respondent testified that the late deceleration was slowing after the contraction indicating some sort of uteroplacental insufficiency as far as blood flow into the uterus to the baby. In other words, the blood flow was diminished during the contraction.

13. Respondent was queried about the Medical Consultant's statements that by 1840 the Medical Consultant would have reached his tolerance limit and would have asked Patient for permission to perform a cesarean section, not because the baby was about to die, but because delivery was not imminent and he would have been afraid to continue labor with such a disquieting monitor tracing.

14. Respondent testified that although he agrees with the Medical Consultant that every physician has a certain level of tolerance to fetal heart tracings, he believes that the American College of Obstetrics and Gynecology ("ACOG") Guidelines should be the base for tolerance, not individual preference. Respondent agreed that there were areas of intermittent non-reassuring areas of fetal heart tracings, but in each case the baby recovered and following these episodes there were areas of recovery and fetal reassurance.

15. According to Respondent the ACOG Guidelines in terms of non-reassuring tracings state that if there is a non-reassuring heart tracing then measures should be taken to correct the abnormal heart rate tracing and if theses measures do not result in resolution of the abnormal heart rate, delivery is indicated.

16. Respondent testified that in Patient's case he continued the induction and in an effort to ameliorate Patient's condition, he had her change position and administered oxygen. Respondent stated that, after having Patient change her position and receive oxygen, non-reassuring fetal heart rate patterns resolved and a more normal fetal heart tracing resumed.

17. Respondent indicated that he did not agree with the Medical Consultant's conclusion that after these measures were taken the tracings continued to deteriorate. Respondent did agree that there were intermittent areas of non-reassuring heart rate tracings, but that in each case where there was an intermittent non-reassuring fetal heart rate tracing there was a resolution and subsequent recovery of the baby.

18. The Medical Consultant also voiced surprise that when Respondent inserted an intrauterine pressure catheter to better monitor the strength of the contractions that he did not also attach a fetal scalpel electrode which the Medical Consultant felt was needed to improve the tracings interpretation. Respondent testified that he felt that the fetal scalp electrode was not indicated because there were no problems in monitoring the fetal heart rate. Respondent also indicated that nursing staff were free to place a fetal scalpel electrode at any time they believed it to be necessary.

19. Respondent testified that he left the Hospital at approximately 8:00 p.m. and returned at 3:00 or 4:00 a.m. According to Respondent, while he was away from the Hospital, Patient continued to progress slowly in labor and finally reached complete dilation sometime around 1:00 a.m. and the nurses allowed her to rest, rather than push

immediately. Respondent did not remember whether he had been in contact with the nursing staff during the time he was away from the Hospital. Patient ultimately delivered her baby at approximately 6:00 a.m.

20. The Board queried Respondent as to whether he believed it was within ACOG Guidelines to allow Patient to reach cervical dilation and remain undelivered for approximately 5-6 hours. Respondent noted that the ACOG Guidelines state for women without an epidural that two hours is reasonable and for women with an epidural three hours is reasonable. Respondent testified that at the Hospital staff uses a practice called "passive fetal descent" wherein a mother who has had an epidural and is in her second stage of labor she will be allowed to rest during the first portion of the second stage of labor and not push for a significant period of time allowing passive descent of the baby into the birth canal.

21. Respondent testified that because non-reassuring fetal heart rate tracings are only an indication to proceed to cesarean section and that if the efforts taken to correct the abnormal, non-reassuring fetal heart rate patterns are not successful, then a cesarean section is indicated. If the corrections and methods are successful, then labor is allowed to continue.

22. Respondent also testified that at the time of the birth of Patient's baby the baby did not have the degree of acidosis that ACOG states is necessary for the development of fetal neurological injury. Respondent indicated that he did not know what caused the rapid development of acidosis in the baby immediately following its delivery, nor did he know what caused the baby's neurological problems. Respondent stated that he knows at the time he delivered the baby that the baby was not acidotic.

23. Respondent's conduct fell below the standard of care.

CONCLUSIONS OF LAW

1. The Board of Medical Examiners of the State of Arizona possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances above in paragraphs 7 through 10, 16 and 20 constitute unprofessional conduct pursuant to A.R.S. § § 32-1401(25)(q) "[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;" and 32-1401(25)(ll) "[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient."

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that:

1. Respondent is issued a Letter of Reprimand for failing to properly monitor and treat a deteriorating fetal condition.

2. Respondent is placed on probation for two years or until he has provided satisfactory proof that he has completed a Board Staff pre-approved Category I Continuing Medical Education (CME) course from the American College of Obstetrics and Gynecology in intrapartum management. Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to those hours required for biennial renewal of Respondent's medical license.

RIGHT TO PETITION FOR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing must be filed

with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing is required to preserve any rights of appeal to the Superior Court.

DATED this 11th day of April, 2002.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

By Claudia Foutz
CLAUDIA FOUTZ
Executive Director

ORIGINAL of the foregoing filed this
15th day of APRIL, 2002 with:

The Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Certified Mail this
15th day of APRIL, 2002 to:

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Executed copy of the foregoing mailed this
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Copy of the foregoing hand-delivered this
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