BEFORE THE ARIZONA MEDICAL BOARD

IN THE STATE OF ARIZONA

In the Matter of

JOSE ALVAREZ-HERNANDEZ, M.D.

Holder of License No. **21702**
For the Practice of Medicine
In the State of Arizona.

Board Case No. MD-00-0004

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand)

This matter was considered by the Arizona Medical Board ("Board") at its public meeting on August 8, 2002. Jose Alvarez-Hernandez, M.D., ("Respondent") appeared before the Arizona Medical Board ("Board") with legal counsel, Dan Jantsch, for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). 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. 21702 for the practice of medicine in the State of Arizona.

3. The Board initiated case number MD-00-0004 after receiving a complaint regarding Respondent's care and treatment of a female patient ("T.A."). On November 25, 1999 Respondent performed a cesarean section ("C-section") on T.A. During the C-section T.A. lost 2000 c.c. of blood. Immediately following the procedure T.A. was returned to the Post Anesthesia Care Unit with unstable vital signs, a heart rate of 157 and blood pressure of 90 over 67.

4. The complaint alleged that after Respondent had left the hospital, nursing staff repeatedly contacted him and requested that he authorize T.A.'s transfer to the Intensive Care Unit ("ICU"). According to the nursing notes Respondent was contacted at 11:35 p.m. and told that that T.A.'s blood pressure was 81 over 56 and her heart rate was 150. Respondent was contacted again at 12:00 a.m. and told that T.A.'s blood pressure was 78 over 52 and her heart rate was 171. T.A. later suffered a cardiac pulmonary arrest. T.A. was resuscitated and taken to the operating room where Respondent performed an emergency hysterectomy to control the bleeding. Respondent attempted to transfer T.A. to another health care facility because the reserve blood bank was insufficient at the hospital where T.A. was being treated. T.A. coded in the ambulance upon transfer and was returned to the emergency room where she was pronounced dead.

5. An outside Medical Consultant reviewed the case and opined that it was improper for Respondent to have left the hospital with T.A. unstable, waiting for a second unit of blood and tachycardic.

6. Respondent testified that T.A. remained in the recovery room until 11:00 p.m. and that he was with her until 10:40. Respondent testified that T.A. had received one unit of blood and was receiving the second unit of blood when he left at 10:40. Respondent stated that T.A.'s documented blood pressure at that time was 120 over 80, pulse of 130. Respondent stated that T.A. was awake and asking about seeing her baby. Respondent testified that he thought T.A. was improving and that she was not bleeding at that time.

7. Respondent testified that the 11:35 p.m. call from nursing staff was a request for pain management. Respondent testified that he went over the vital signs at that time and the nurse reported that T.A.'s blood pressure was 90 over 60. Respondent

ordered a complete blood count ("CBC"). Respondent stated that he called back 10 to 15 minutes later and was told the CBC results were not back. Respondent stated that he received a second call at 12:05 a.m. reporting that T.A. was deteriorating.

8. Respondent was asked about the nursing notes that indicate that at 9:50 p.m. another physician asked if T.A. needed an ICU bed; noted that the fundus was boggy; that vaginal bleeding continued and that Respondent was aware of this. Respondent was also asked about the nursing notes indicating that at 10:10 p.m. Respondent stated that T.A. should go to the obstetrics department, but the R.N. house supervisor questioned T.A.'s stability. Respondent was asked if he still maintained that T.A. was no longer bleeding.

9. Respondent stated that at the time he left the patient neither he nor the anesthesiologist was concerned about the bleeding. Respondent stated that he did not recall the nurses speaking to him in the recovery room about their concerns. Respondent stated that when he left at 10:40 p.m. he believed T.A. was stable and instructed the nurses that if T.A. continued to be stable she could be transferred to the obstetrics unit. Respondent was asked about a nurse's note that indicated the vaginal pad was saturated and that he stated that T.A. could go to OB. Respondent was asked if that note indicated that T.A. was still bleeding. Respondent stated that he did not believe T.A. was bleeding enough at that time to be concerned.

10. Respondent was asked about T.A.'s heart rate being documented at 175 and remaining between 140 and 145 following the C-section and post-anesthesia care. Respondent was asked to address this consistently high heart rate in a young person. Respondent stated that when T.A. came in she had a pulse of 111 even before surgery started and that he did not receive any other calls for an hour after he left from anyone at the hospital that any of the changes were happening to T.A. Respondent stated that T.A.

experienced an amniotic embolism, a catastrophic event with an 85 percent mortality rate.

11. The nursing notes indicate that Respondent called the hospital questioning the need to transfer T.A. to the ICU and was told by the nursing staff that they were not comfortable keeping T.A. in their unit. The notes also indicate that the nurse who was initially speaking with Respondent gave the phone to her nursing supervisor.

12. The standard of care for a surgeon who is called after a procedure and given a report of a patient who is hypotensive and shocky requires that the surgeon immediately respond and not delay for approximately 40 minutes.

13. Respondent fell below the standard of care because he failed to immediately respond to a hypotensive shocky patient after surgery.

14. T.A. suffered potential harm, because although an amniotic embolism has a high mortality rate, Respondent's delayed response deprived T.A. of the opportunity to survive the embolism.

CONCLUSIONS OF LAW

1. The Arizona Medical Board 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 4 through 13 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(q) "[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the pubic."

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for deviating from the standard of care and failing to respond to a hypotensive shocky patient after surgery.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing or review must be filed with the Board's Executive Director within thirty 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 or review. Service of this order is effective five days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective thirty-five days after it is mailed to Respondent.

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

DATED this 3rd day of October, 2002.

ARIZONA MEDICAL BOARD

By [signature]
BARRY A. CASSIDY, Ph.D, PA-C
Executive Director

ORIGINAL of the foregoing filed this 3rd day of October, 2002 with:

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

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Executed copy of the foregoing
mailed by U.S. Certified Mail this
3RD day of October, 2002, to:

Daniel Jantsch
Olson, Jantsch & Bakker, PA
7243 N. 16th St.
Phoenix, Arizona 85728-9832

Executed copy of the foregoing
mailed by U.S. Mail this
3RD day of October, 2002, to:

Jose Alvarez-Hernandez, M.D.
2400 S. Avenue, Suite A
Yuma, Arizona 85364-7170

Copy of the foregoing hand-delivered this
3RD day of October, 2002, to:

Christine Cassetta
Assistant Attorney General
Sandra Waitt, Management Analyst
Lynda Mottram, Senior Compliance Officer
Investigations (Investigation File)
Arizona Medical Board
9545 East Doubletree Ranch Road
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