BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

CAYETANO S. MUNOZ, M.D.

Holder of License No. **9506**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-02-0248

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Decree of Censure)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 11, 2003. Cayetano S. Munoz, M.D., ("Respondent") appeared before the Board with legal counsel, Dan Ballecer, 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. 9506 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0248 as a result of information developed during an investigation into another physician ("Physician"). The information concerned Respondent's care and treatment of a 70 year-old female patient ("R.C.") during a surgical procedure performed by Physician on April 5, 2001, at Havasu Regional Medical Center ("Medical Center").

4. R.C. had a history of chronic obstructive pulmonary disease and hypertension. She was admitted to Medical Center on April 3, 2001 for evaluation of non-resolving, progressive pneumonitis of unknown etiology. R.C.'s history and physical

indicated that her "chest X-ray and CAT (computed axial tomography) scan shows marked cavitation destruction of most of the right lung."

5. During R.C.'s surgical procedure, Respondent performed general endotracheal intubation with a single lumen 7.0mm endotracheal tube. During the procedure, R.C. became extremely hypotensive and changes were noted on her electrocardiogram and the medical personnel had difficulty "bagging her." Intraoperative cardiopulmonary resuscitation was performed, but was unsuccessful, and R.C. died approximately one hour and forty-five minutes into surgery.

6. An outside anesthesia consultant ("Consultant") found that Respondent's failure to use a double lumen tube for endotracheal intubation was problematic and the Consultant also criticized Respondent's recording of inaccurate physical findings.

7. Respondent testified that he was aware of massive consolidation on R.C.'s right lung as indicated in the x-ray report. Respondent was asked to explain why, if he was aware of the massive consolidation, he noted in R.C.'s medical records that her lungs were clear. Respondent stated that what he meant by "clear" was that he did not hear any rales and noted that he mentioned in his preoperative study that it was clear, but with diminished motion and poor aeration. The Board noted that another physician, who did not have access to the radiology report might conclude that R.C. had clear lungs, when in actual fact she had consolidation and shift in the mediastinum. Respondent stated that he used a poor choice of words.

8. Respondent testified that he was aware R.C. had terrible pneumonia on the right side and that he mentioned in his records decreased motion on right side and poor aeration and that Physician's preoperative notes concur. Respondent testified that if he had the same situation today he would use a double lumen tube to intubate the patient.

Respondent stated that he is now confident in using the double lumen tube and noted that, at the time of R.C.'s surgery, Medical Center used single lumen tubes.

9. Respondent testified that he believed the cause of R.C.'s death was cardiac arrest or pulmonary embolism. Respondent was asked where the lumen tube was located when R.C. arrested. Respondent stated that the tube was above the trachea, not in the left side. Respondent testified that he tried to push it to the left side using a bronchoscope, but was not successful. Respondent then removed the single lumen tube and put in a double lumen tube.

10. Respondent was asked if he had ever been successful in using a bronchoscope inside the endotracheal tube to advance the tube from the trachea into the main stem bronchus. Respondent testified that he had not and admitted that the human anatomy is such that the tube always goes to the right. The Board noted that this makes it even more imperative that there be some way of protecting the left main stem bronchus, which is by using the double lumen tube.

11. Respondent was asked what evidence he had that R.C.'s death was not a hypoxic death. Respondent stated that he did not believe R.C. underwent an hypoxic event that contributed to her death because he made a record of the sudden change and was bagging the patient easily, when all of a sudden, it got tight and the blood pressure started dropping and there were arrhythmias. Respondent stated that he believed R.C. had some type of acute event.

12. Respondent was asked what it meant to him when it suddenly becomes hard to ventilate a patient. Respondent stated that either there is an obstruction or a consolidation somewhere else. Respondent was asked what happens when you have a patient with significant comorbidities, such as R.C., who is submitted to a period of hypoventilation, inadequate ventilation of three or four minutes. Respondent stated that

the record did not include that and everything was okay and all of a sudden it happened. The Board noted that since R.C. had significant respiratory compromise in the setting of a dependent lung that was not being ventilated by a double lumen tube, to attribute what happened to R.C. to a pulmonary embolism without other evidence of pulmonary embolism was naïve on Respondent's part. The Board did note that the cause of death was not determined with certainty.

13. Respondent was asked if double lumen tube technology has been around for long time and he answered that it had been. Respondent testified that in his training he had inserted a double lumen tube only a very few times. Respondent was asked if the standard of care requires use of a double lumen tube when the patient has one lung that is severely comprised, aerating poorly, and the other lung is depending on the operating table. Respondent stated that in reading the literature for video-assisted thoracostomy the use of a double lumen tube is noted as mandatory. Respondent noted that with other indications you could use an endo blocker and if there are tumors obstructing the area and other contraindications, a surgeon might be comfortable using a single lumen tube.

14. Respondent was asked that since R.C. had a difficult airway should he have used an arterial line to help monitor blood pressure and have easy access for arterial blood gases. Respondent stated that it would have been a good idea to do so with R.C. Respondent was asked if R.C.'s case occurred after he had taken a mini-residency as ordered by the Board. Respondent stated that it had and noted that the mini-residency had helped him to refresh his anesthesia practice, but the course did not discuss double lumen tube intubation. Respondent noted that recent continuing medical education ("CME") courses he had taken were more helpful in the use of double lumen tubes and he had worked with volunteers and cadavers in using the technique.

15. Respondent also noted that at the time of R.C.'s surgery the standard at Medical Center was to use the single lumen tube and, since he was not comfortable with using a double lumen tube, he chose to use the single lumen tube. Respondent stated that the outcome might not have been different even if the double lumen tube was used.

16. The standard of care required appropriate protection of both of the main stem bronchi through the use of a double lumen endotracheal tube.

17. Respondent fell below the standard of care because he used a single lumen endotracheal tube and, as a result, R.C. was harmed because her airway was not protected and there was a potential for lack of oxygen during the surgical procedure.

18. Respondent also failed to accurately document his preoperative physical findings when he indicated that R.C.'s lungs were clear.

19. Based on Respondent's testimony the Board raised concerns regarding his competence and issued an Interim Order for Respondent to undergo an evaluation by the Physician Assessment Clinical Education Program.

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 constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(e) ("[f]ailing or refusing to maintain adequate records on a patient;") 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 public;") and 32-1401(24)(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 Decree of Censure for failure to protect the patient's airway by failing to place a double lumen endotracheal tube, which was required based on the patient's current medical condition and pulmonary status, and for an improper preoperative evaluation and documentation of a potentially high risk patient.

2. Within one year of the effective date of this Order Respondent shall pay a civil penalty of $1,000.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within 30 days after service of this Order. A.R.S. § 41-1092.09. The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective 5 days after date of mailing. If a motion for rehearing or review is not filed, the Board's Order becomes effective 35 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 10th day of July, 2003.

ARIZONA MEDICAL BOARD

BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 10th day of July, 2003 with:

The Arizona Medical Board
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Executed copy of the foregoing mailed by U.S. Certified Mail this 10th day of July, 2003, to:

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Copy of the foregoing hand-delivered this 10th day of July, 2003, to:

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