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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
PAUL L. UNDERWOOD, M.D.
Holder of License No. 22416
For the Practice of Allopathic Medicine
in the State of Arizona

Case No. MD-09-1584A
**ORDER FOR LETTER OF REPRIMAND
AND CONSENT TO THE SAME**

Paul L. Underwood, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

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 number 22416 for the practice of allopathic medicine in the State of Arizona.
3. The Board initiated case number MD-09-1584A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a 63 year-old female patient ("NH") alleging that Respondent failed to diagnose and treat an iliac artery bleed following cardiac catheterization with subsequent patient death.
4. On May 18, 2005, NH was admitted to the hospital with eight hours of chest pain and inferior ST elevation myocardial infarction. NH's blood pressure was 172/87 and her heart rate was 71. NH was started on aspirin, an intravenous ("IV") bolus of heparin and then infusion of heparin, Integrilin, nitroglycerin IV, and a beta blocker. NH's chest pain resolved, she was transferred to the intensive care unit ("ICU"), and she was free of

1 chest pain by the following day. NH's troponin peaked at 55 and no gross abnormalities
2 were identified on her echocardiogram.

3 5. On May 20, 2005, NH underwent heart catheterization and percutaneous
4 coronary intervention ("PCI") of the right coronary artery. NH received 7,000 units of IV
5 bolus heparin. A femoral angiogram showed the sheath tip within the femoral artery and
6 there was some extravasation of contrast to the groin. The sheath was immediately
7 removed. The Integrilin was discontinued and NH was transferred to the ICU. Respondent
8 saw NH at her bedside and noted that she was pale and restless. Zofran was given to NH.
9 Respondent left the hospital and was paged shortly thereafter with reports that NH's heart
10 rate was 110. A surgeon was consulted for surgery.

11 6. A code was subsequently called, NH was intubated, and ST segments were
12 elevated on the monitor. Hesperan was given and CPR was initiated. Attempts were made to
13 place a right subclavian line and a sheath was placed in the right femoral vein. NH
14 received blood and platelet transfusion, fresh frozen plasma, bicarb, epinephrine,
15 Levophed, and dopamine. NH underwent emergency right iliac artery and femoral vein
16 repair by the surgeon. She arrested shortly after an incision was made and resuscitation
17 efforts were unsuccessful.

18 7. The standard of care for an acute retroperitoneal hemorrhage as the result of
19 a high arterial puncture requires a physician to appropriately assess the patient's
20 anticoagulation status, reverse the heparin, prepare for blood transfusion, and treat the
21 retroperitoneal hemorrhage; the standard of care also requires a physician to avoid
22 administering an excessive dose of heparin in the setting of Integrilin as it increases the
23 patient's risk of bleeding.

24 8. Respondent deviated from the standard of care by failing to appropriately
25 assess NH's anticoagulation status, reverse heparin, prepare for blood transfusion, and

1 treat the retroperitoneal bleed; and by administering an excessive dose of heparin in the
2 setting of Integrilin.

3 9. NH died on May 20, 2005 during an emergency operation to repair the right
4 iliac artery and femoral vein.

5 **CONCLUSIONS OF LAW**

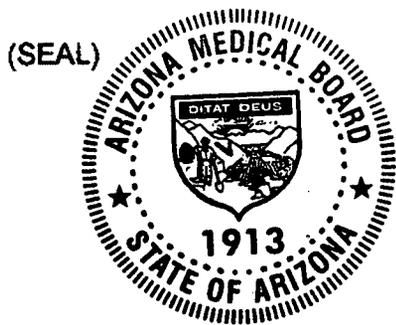
6 1. The Board possesses jurisdiction over the subject matter hereof and over
7 Respondent.

8 2. The conduct and circumstances described above constitute unprofessional
9 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be
10 harmful or dangerous to the health of the patient or the public.").

11 **ORDER**

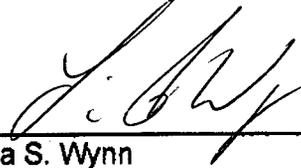
12 IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

13
14 DATED AND EFFECTIVE this 11TH day of AUGUST, 2010.



ARIZONA MEDICAL BOARD

By



Lisa S. Wynn
Executive Director

22 **CONSENT TO ENTRY OF ORDER**

23 1. Respondent has read and understands this Consent Agreement and the
24 stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent
25 acknowledges he has the right to consult with legal counsel regarding this matter.

1 2. Respondent acknowledges and agrees that this Order is entered into freely
2 and voluntarily and that no promise was made or coercion used to induce such entry.

3 3. By consenting to this Order, Respondent voluntarily relinquishes any rights to
4 a hearing or judicial review in state or federal court on the matters alleged, or to challenge
5 this Order in its entirety as issued by the Board, and waives any other cause of action
6 related thereto or arising from said Order.

7 4. The Order is not effective until approved by the Board and signed by its
8 Executive Director.

9 5. All admissions made by Respondent are solely for final disposition of this
10 matter and any subsequent related administrative proceedings or civil litigation involving
11 the Board and Respondent. Therefore, said admissions by Respondent are not intended
12 or made for any other use, such as in the context of another state or federal government
13 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
14 any other state or federal court.

15 6. Upon signing this agreement, and returning this document (or a copy thereof)
16 to the Board's Executive Director, Respondent may not revoke the consent to the entry of
17 the Order. Respondent may not make any modifications to the document. Any
18 modifications to this original document are ineffective and void unless mutually approved
19 by the parties.

20 7. This Order is a public record that will be publicly disseminated as a formal
21 disciplinary action of the Board and will be reported to the National Practitioner's Data
22 Bank and on the Board's web site as a disciplinary action.

23 8. If any part of the Order is later declared void or otherwise unenforceable, the
24 remainder of the Order in its entirety shall remain in force and effect.

25

1 9. If the Board does not adopt this Order, Respondent will not assert as a
2 defense that the Board's consideration of the Order constitutes bias, prejudice,
3 prejudgment or other similar defense.

4 10. Any violation of this Order constitutes unprofessional conduct and may result
5 in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,
6 consent agreement or stipulation issued or entered into by the board or its executive
7 director under this chapter") and 32-1451.

8
9 
10 _____
PAUL L. UNDERWOOD, M.D.

DATED: 12 JUL 2010

11 EXECUTED COPY of the foregoing mailed
12 this 12 day of August, 2010 to:

13 Paul L. Underwood, M.D.
14 Address of Record

15 ORIGINAL of the foregoing filed
16 this 12 day of August, 2010 with:

17 Arizona Medical Board
18 9545 E. Doubletree Ranch Road
19 Scottsdale, AZ 85258

20 
21 _____
22 Arizona Medical Board Staff
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