

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **HILARIO JUAREZ, M.D.**

4 Holder of License No. 12148  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Case No. MD-14-0327A

**ORDER FOR DECREE  
OF CENSURE; AND  
CONSENT TO THE SAME**

7 Hilario Juarez, M.D. ("Respondent"), elects to permanently waive any right to a  
8 hearing and appeal with respect to this Order for a Decree of Censure; admits the  
9 jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order  
10 by the Board.

11 **FINDINGS OF FACT**

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

14 2. Respondent is the holder of license number 12148 for the practice of  
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-14-0327A after receiving a complaint  
17 regarding Respondent's care and treatment of a 26 year-old female patient ("SO") alleging  
18 failure to diagnose signs of a leak post-duodenal switch.

19 4. On August 9, 2011, Respondent evaluated SO regarding a conversion from  
20 her lap band to a different bariatric surgery. On August 11, 2011, Respondent performed  
21 a duodenal switch on SO. According to the operative report, Respondent performed a  
22 laparoscopic removal of SO's adjustable gastric band and converted the band to a  
23 duodenal switch using a hand assisted technique, which included making a larger incision  
24 in the upper midline of the abdomen. A methylene dye leak test showed no evidence of a  
25 leak at the duodenal ileal anastomosis.

1           5.     SO subsequently became tachycardic and Respondent called in an order for  
2 a comprehensive blood count ("CBC") and metabolic panel at 1800 hours. At 0300 on  
3 August 12, 2011, Respondent's physician assistant ("PA") also called in an order for a  
4 CBC and a 12 lead electrocardiogram ("EKG"). The EKG showed a heart rate of 158, and  
5 the CBC showed a white blood cell count of 19,000. SO was given a bolus of fluid and  
6 seen by the PA's student at 0730. Respondent signed that note at 0800 and noted that SO  
7 had tachycardia and abdominal pain. He ordered an upper gastrointestinal series, which  
8 did not show a leak. Respondent wrote a second note at 1100 and documented that the  
9 persistent tachycardia could be secondary to pain or SO could be "dry." Pancreatic  
10 enzymes test results showed a significant increase in SO's amylase and lipase levels.  
11 These results were reported at 1412 on August 12, 2011. SO was bolused with IV fluids  
12 and checked out to Respondent's covering physician ("Covering Physician") around 1500  
13 hours.

14           6.     The Covering Physician called in an order at 1600 hours for more fluid and  
15 metoprolol. Hospital nurses called the Covering Physician at 0300 on August 13, 2011, to  
16 inform him of SO's condition. The Covering Physician ordered Lasix, more fluid and  
17 transferred SO to the intensive care unit ("ICU"). The Covering Physician saw SO at 0730  
18 and determined that he could not conclude that the tachycardia and obvious sepsis was  
19 completely due to pancreatitis and decided to take the patient to the operating room. SO's  
20 heart rate at the time was 166 and she had also had a worsening of her kidney function,  
21 continued low urine output, an increase in her white blood cell count, and mental status  
22 changes.

23           7.     SO was nonresponsive by the time the operating room team was ready at  
24 1000 hours, with a heart rate of 175 beats per minute. Patient SO coded and was  
25 intubated. CPR was performed for approximately 40 minutes, but SO ultimately expired.  
Time of death was recorded at 1034. Subsequent autopsy showed a leak at the duodenal

1 anastomosis with adjacent abscess formation involving the pancreas. The pathologist who  
2 performed the autopsy commented that the persistent tachycardia, pain and elevated  
3 white blood cell count should have prompted Respondent and the Covering Physician to  
4 check the amylase and lipase sooner and consider more timely exploration of the  
5 abdomen.

6 8. The standard of care requires a physician to make a timely diagnosis of  
7 abdominal sepsis and anastomotic leak. Respondent deviated from the standard of care  
8 by failing to timely diagnose abdominal sepsis from an anastomotic leak.

9 9. The standard of care requires a physician to provide clear communication  
10 about a patient's medical condition during transfer of care. Respondent deviated from the  
11 standard of care by failing to provide clear communication about the patient's medical  
12 condition during transfer of care.

13 10. Respondent's failure to recognize abdominal sepsis from an anastomotic  
14 leak lead to the patient's death.

15 **CONCLUSIONS OF LAW**

16 a. The Board possesses jurisdiction over the subject matter hereof and over  
17 Respondent.

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

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1 **ORDER**

2 IT IS HEREBY ORDERED THAT:

3 1. Respondent is issued a Decree of Censure.

4 DATED AND EFFECTIVE this 8<sup>th</sup> day of February, 2016.

5 ARIZONA MEDICAL BOARD

6 By Patricia E. McSorley  
7 Patricia E. McSorley  
8 Executive Director

9 **CONSENT TO ENTRY OF ORDER**

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

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

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

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

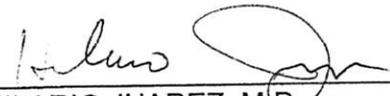
21 5. All admissions made by Respondent are solely for final disposition of this  
22 matter and any subsequent related administrative proceedings or civil litigation involving  
23 the Board and Respondent. Therefore, said admissions by Respondent are not intended  
24 or made for any other use, such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

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

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

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

12           9.     *Respondent has read and understands the terms of this agreement.*

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HILARIO JUAREZ, M.D.

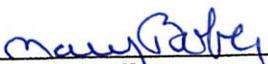
DATED: 12/24/15

15  
16 EXECUTED COPY of the foregoing mailed  
this 8<sup>th</sup> day of February, 2016 to:

17 Mandi Karvis  
18 Sanders & Parks  
19 303 N 3<sup>rd</sup> Street Suite 1300  
20 Phoenix, AZ 85012-3099  
Attorney for Respondent

21 ORIGINAL of the foregoing filed  
this 8<sup>th</sup> day of February, 2016 with:

22 Arizona Medical Board  
23 9545 E. Doubletree Ranch Road  
24 Scottsdale, AZ 85258

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