BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: JOSE HIRAM ALVAREZ, M.D., Respondent.	**Case No. 21-28177-1**

FILED
MAR - 9 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., General Counsel and attorney for the IC, having a reasonable basis to believe that Jose Hiram Alvarez, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a Medical Doctor holding an active license to practice medicine in the State of Nevada (License No. 10765). Respondent was originally licensed by the Board on December 5, 2003.

2. Patient A's true identity is not disclosed herein to protect his privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

3. On July 7, 2014, Patient A presented to Respondent for an initial consultation.

4. On June 23, 2016, Patient A undergoes surgery, including liposuction, abdominoplasty and a fat transfer to her buttocks, as performed by Respondent.

5. On June 27, 2016, Patient A attended a follow-up evaluation conducted by Respondent, who treats her with the beginning of laser treatments to her healing areas.

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Wayne Hardwick, M.D., Aury Nagy, M.D., and Mr. M. Neil Duxbury, Chairman.

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Respondent's medical records do not document the laser settings used upon Patient A. Improper laser settings (too high) have been clinically shown to cause the laser to penetrate into the tissue, getting absorbed into the lipids which creates a thermal effect. Patient A's damaged areas were due to her having full-thickness burns and tissue necrosis following Respondent's care.

6. From June 29, 2016 through July 18, 2016, Patient A received oral antibiotics and Respondent treated Patient A with his staff (Medical Assistant/Receptionist) and a licensed Esthetician[2] for a total of ten (10) laser skin treatments. Respondent's medical records do not include any treatments or diagnoses for the aforementioned Patient A's lesions, which were likely caused by the burns and necrosis.

7. On August 10, 2016, Patient A presents to the UMC burn unit and begins treatments including debridement and wound care through September 28, 2016 after receiving a second opinion from a different plastic surgeon who referred her to a burn unit. Respondent's medical records for Patient A do not include any documentation regarding wound care, including debridement and wound cleaning.

COUNT I

NRS 630.301(4) (Malpractice)

8. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

9. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

10. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

11. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he provided medical services to Patient A.

12. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

[2] Estheticians are licensed by the Nevada State Board of Cosmetology.

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COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Complete Medical Records)

13. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

14. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating disciplinary action against a licensee.

15. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete.

16. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT III

NRS 630.306(1)(b)(2) (Violation of Standards of Practice Established by Regulation)

17. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

18. Violation of a standard of practice adopted by the Board is grounds for initiating disciplinary action against a licensee pursuant to NRS 630.306(1)(b)(2).

19. NAC 630.210 requires a physician to seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services.

20. Respondent failed to timely seek consultation with regard to Patient A's post-operative medical condition. Respondent should have consulted with an appropriate care provider to address the aforementioned worsening conditions. This consultation could have enhanced Patient A's declining medical condition.

21. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

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WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs associated with the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 5 day of March, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Robert G. Kilroy, Esq., General Counsel

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

M. Neil Duxbury, having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 5th day of March, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: M. Neil Duxbury
Mr. M. Neil Duxbury, Chairman

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