OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **HAZEM YOUSSEF AFIFI, M.D.** **Respondent.**	**Case No. 22-19887-1**

FIRST AMENDED COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Donald K. White, Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Hazem Youssef Afifi, 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 First Amended Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this First Amended Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 9677). Respondent was originally licensed by the Board on January 3, 2001.

2. Patient A[2] was a fifty-three (53) year-old male at the time of the events at issue.

3. On June 27, 2018 at approximately 6:30 p.m. Patient A was admitted to Western Arizona Regional Medical Center (WARMC) with chest pain, and acute myocardial infarction, which was later determined to be severe 3-vessel disease. At or about 7:19 p.m., Patient A presented to the cath lab where a balloon angioplasty was performed. The cardiologist attempted to place a stent without success and terminated the procedure. The cardiologist spoke with the

[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 Bret W. Frey, M.D. and Col. Eric D. Wade (Ret.).

[2] Patient A's true identity is not disclosed herein to protect his privacy, but was disclosed in the Patient Designation served upon Respondent along with a copy of the original Complaint filed on October 25, 2022.

patient's family and they agreed Patient A should undergo a myocardial revascularization, though this procedure would have to be performed at Summerlin Hospital in Las Vegas, Nevada.

4. Patient A was transferred to Summerlin Hospital and admitted on June 28, 2018 and remained stable through Friday, June 29, 2018. Respondent first saw the patient on June 29, 2018 and reviewed an ECG taken at approximately 8:00 a.m. The medications Patient A was prescribed were noted as heparin, nitrogycerine (5 mcg), norepinephrine (4 mcg), fentanyl and morphine as needed. Patient A was scheduled for a coronary artery bypass grafting (CABG) surgery for the morning of Monday, July 2, 2018.

5. On Saturday, June 30, 2018, Patient A encountered a recurrence of chest pain on or about 8:00 a.m. which began at 1/10 on the pain scale, but by 10:42 a.m. the pain had escalated to 5/10. Shortness of breath with pain radiation to the shoulder and jaw were also reported. A second ECG was performed and compared with the prior ECG taken Friday morning. The report indicated *Serial changes of evolving Anterior Infarct Present, Serial changes of evolving Anterolateral Infarct Present,* and *Serial changes of evolving Inferior Infarct Present.* (emphasis added).

6. An EKG was performed and an additional 2 mg of morphine was administered. Respondent was notified at 1:30 p.m. of the EKG, increased chest pain, and increased nitroglycerine drip rate. Respondent came to patient's bedside and issued orders for sublingual nitroglycerine and to discontinue the vancomycin dose.

7. At approximately 3:00 p.m. Respondent returned and was notified of continued chest pain at 5/10 and radiation despite the new medication doses. The nursing staff clarified with Respondent if the patient would be receiving surgery this day. Respondent said no and that his surgery is scheduled for Monday. Orders were issued by Respondent for .5 mcg of metoprolol IV and to titrate down the nitro drip.

8. Respondent believed that Patient A had been administered Plavix while in the hospital at WARMC, and information that is new to the IC appears to confirm that Patient A had been administered Plavix and Respondent's concern that there could be dire consequences if

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Patient A was to undergo a CABG procedure after having been administered Plavix just two (2) or three (3) days prior.

9. At or around 4:30 p.m. the on-call cardiologist was notified that there was no relief of Patient A's symptoms of chest pain with radiation to the shoulder and jaw with the dosage of medications provided. Orders were issued for an increase in the cardiac medications to be given over time to prevent hypotension. At approximately 5:00 p.m. the patient's blood pressure was trending down and by 6:00 p.m. Patient A reported he was feeling better with a pain level of 2/10 with no radiation.

10. At approximately 8:30 p.m. the nurses attended to Patient A finding him in extreme anxiety, face dusky in appearance and bearing down. A heart monitor showed a pause then a decline. Patient A was awake, but agitated. The nurses started emergency procedures while the charge nurse paced calls to the on-call cardiologist and Respondent. A photo of the stat EKG results were sent to the on-call cardiologist's phone at approximately 8:52 p.m. A stat ABG was done at 8:55 p.m. Patient A's condition deteriorated quickly after the ABG and he died on June 30, 2018.

COUNT I

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

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

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

13. 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.

14. Respondent failed to timely seek consultation with regard to Patient A's medical condition on or about June 28-30, 2018, and Respondent should have consulted with an appropriate care provider to address the doubtfulness of, or difficulty in, the diagnosis of Patient

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A's medical condition. A timely consultation may have confirmed or denied such a diagnosis and may have enhanced the quality of medical care provided to Patient A.

15. By reason of the foregoing, Respondent is subject to discipline by the Nevada State Board of Medical Examiners as provided in NRS 630.352.

COUNT II

NRS 630.301(4) - Malpractice

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

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

18. 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."

19. 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 as the cardiac surgeon, did not offer emergency bypass surgery to Patient A on June 30, 2018 by properly evaluating Patient A's Class I indications for the emergency bypass surgery including five (5) hours of chest pain.

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

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;

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4. That the Board award fees and costs for 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 2nd day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

DONALD K. WHITE
Senior Deputy General Counsel
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Reno, NV 89521
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Attorney for the Investigative Committee

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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., 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 2nd day of June, 2023.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 5th day of June, 2023, I served a file-stamped copy of the foregoing FIRST AMENDED COMPLAINT, via USPS Certified Mail, postage pre-paid, to the following parties:

HAZEM AFIFI, M.D.
c/o Jill Chase, Esq.
Hall Prangle & Schoonveld, LLC
1140 North Town Center Drive, Suite 350
Las Vegas, NV 89144

Tracking No.: 9171 9690 0935 0255 6990 25

With courtesy copy by email to:

Jill Chase, Esq., at [jchase@hpslaw.com]
Patricia Halstead, Esq. at [phalstead@halsteadlawoffices.com]

DATED this 5th day of June, 2023.

MEG BYRD
Legal Assistant
Nevada State Board of Medical Examiners