

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **JEAN MOON, M.D.**

4 Holder of License No. **20256**  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Board Case No. MD-07-1066A

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on  
8 October 9, 2008. Jean Moon, M.D., ("Respondent") appeared before the Board with legal counsel  
9 Jeffrey J. Campbell for a formal interview pursuant to the authority vested in the Board by A.R.S.  
10 § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due  
11 consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

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

15 2. Respondent is the holder of License No. 20256 for the practice of allopathic  
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-07-1066A after receiving notification of a  
18 malpractice settlement involving Respondent's care and treatment of a 32 year-old female patient  
19 ("CJ") alleging Respondent failed to properly treat pre-eclampsia; failed to perform a cesarean  
20 section (C-section); and failed to communicate the plan of treatment to CJ's subsequent treating  
21 physician contributing to her cardiac arrest and permanent maternal brain damage.

22 4. CJ was experiencing elevated blood pressure along with a headache and nausea  
23 while at 33 ½ weeks gestation. On November 5, 2005, CJ was admitted to Scottsdale Healthcare  
24 Osborn by another member of Respondent's practice. This physician ordered 24-hour urine and  
25 lab studies to evaluate CJ for pre-eclampsia.

1           5.     The admitting physician then passed the patient on to another physician, who  
2 evaluated the patient, ordered laboratory studies as well as a cardiac consultation. After these  
3 instructions were carried out, the second physician, after evaluation, elected to induce the patient.

4           6.     A third physician later became involved and treated the patient for her blood  
5 pressure as well as for headache and the nausea.

6           7.     Respondent became involved with patient CJ on November 8, 2005 after the  
7 patient had been started on the induction process with Pitocin. Respondent acknowledged that  
8 she was responsible for patient CJ during her coverage at the hospital that day.

9           8.     While at Scottsdale Healthcare Osborn on November 8, 2005, Respondent took  
10 phone calls from the nursing staff about CJ's medications, blood pressure and respiration.

11          9.     Respondent ordered Labetalol to be given for systolic blood pressures greater  
12 than 170. She also ordered an albuterol inhaler for CJ and changed Vicodin to Percocet for CJ's  
13 persistent headaches. In the early evening, Respondent discontinued the Pitocin and ordered  
14 Cytotec.

15          10.    Although she was on call for ten hours, at no time during her coverage did  
16 Respondent ever personally evaluate CJ.

17          11.    Subsequent to Respondent's coverage, another physician came on call. During  
18 this physician's coverage, CJ went into cardiac arrest and a Cesarian section was performed.  
19 Although CJ survived the operation, she suffered permanent brain damage.

20          12.    The standard of care for severe pre-eclampsia with ongoing symptoms requires a  
21 physician to personally evaluate the patient.

22          13.    Respondent deviated from the standard of care by failing to personally evaluate CJ  
23 during her coverage period of ten hours.

24          14.    CJ was potentially harmed because she had a cardiac arrest and could have died  
25 from the event.

1 **CONCLUSIONS OF LAW**

2 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof  
3 and over Respondent.

4 2. The Board has received substantial evidence supporting the Findings of Fact  
5 described above and said findings constitute unprofessional conduct or other grounds for the  
6 Board to take disciplinary action.

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

10 **ORDER**

11 Based upon the foregoing Findings of Fact and Conclusions of Law,

12 **IT IS HEREBY ORDERED:**

13 1. Respondent is issued a Letter of Reprimand for failing to personally evaluate a  
14 patient with severe preeclampsia in a timely manner.

15 2. The Board retains jurisdiction and may initiate new action based upon any  
16 violation of this Order.

17 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

18 Respondent is hereby notified that he has the right to petition for a rehearing or review.  
19 The petition for rehearing or review must be filed with the Board’s Executive Director within thirty  
20 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review  
21 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.  
22 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a  
23 petition for rehearing or review is not filed, the Board’s Order becomes effective thirty-five (35)  
24 days after it is mailed to Respondent.  
25

1 Respondent is further notified that the filing of a motion for rehearing or review is required  
2 to preserve any rights of appeal to the Superior Court.

3 DATED this 11<sup>th</sup> day of December, 2008.



THE ARIZONA MEDICAL BOARD

8 By   
9 Lisa S. Wynn  
10 Executive Director

11 ORIGINAL of the foregoing filed this  
12 11<sup>th</sup> day of December, 2008 with:

13 Arizona Medical Board  
14 9545 East Doubletree Ranch Road  
15 Scottsdale, Arizona 85258

16 Executed copy of the foregoing  
17 mailed by U.S. Mail this  
18 11<sup>th</sup> day of December, 2008, to:

19 Jeff Campbell  
20 Campbell Yost Clare & Norell PC  
21 101 North 1st Avenue, Suite 2500  
22 Phoenix, Arizona 85003-1904

23 Jean Moon, M.D.  
24 Address of Record

25 

#236920