



1 express or implied, of the Board's statutory authority or jurisdiction regarding any other  
2 pending or future investigation, action or proceeding. The acceptance of this Consent  
3 Agreement does not preclude any other agency, subdivision or officer of this State from  
4 instituting other civil or criminal proceedings with respect to the conduct that is the subject  
5 of this Consent Agreement.

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

12 7. Upon signing this agreement, and returning this document (or a copy thereof) to  
13 the Board's Executive Director, Respondent may not revoke the acceptance of the  
14 Consent Agreement. Respondent may not make any modifications to the document. Any  
15 modifications to this original document are ineffective and void unless mutually approved  
16 by the parties.

17 8. If the Board does not adopt this Consent Agreement, Respondent will not  
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes  
19 bias, prejudice, prejudgment or other similar defense.

20 9. This Consent Agreement, once approved and signed, is a public record that will  
21 be publicly disseminated as a formal action of the Board and will be reported to the  
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

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



1 no evidence of a nodule, but noted top-normal prominence of central pulmonary arteries.  
2 Respondent indicated that JS would be discharged with primary care physician follow up.

3 5. JS was subsequently discharged on April 13, 2005, and on that same date,  
4 Respondent dictated a discharge summary that included the results of the negative stress  
5 test and noted that her dyspnea was probably secondary to allergic rhinitis. The  
6 echocardiogram ordered earlier by the cardiologist was not performed prior to JS's  
7 discharge. The following day, JS was transported to the hospital with severe SOB, rapid  
8 respiratory rate and diaphoresis where she became extremely cyanotic, suffered cardiac  
9 arrest, and died. An autopsy showed non-fully obstructing saddle type pulmonary  
10 embolism (PE) and layers of fresh thromboembolism.

11 6. The standard of care requires a physician to evaluate a patient presenting  
12 with symptoms of SOB associated with tachypnea and relative tachycardia, DOE, and  
13 EKG T-wave inversions and to include PE in the differential diagnosis and perform  
14 appropriate non-invasive testing to evaluate for this process.

15 7. Respondent deviated from the standard of care because he did not include  
16 PE in his differential diagnosis or performed appropriate non-invasive testing to evaluate  
17 JS for this process.

18 8. The diagnosis of a non-fully obstructing saddle type pulmonary embolism  
19 was missed during JS's hospitalization. JS died of saddle pulmonary embolism and the  
20 layers of fresh thromboembolism associated with the acute terminal shortness of breath  
21 and events surrounding her death.

#### 22 CONCLUSIONS OF LAW

23 1. The Board possesses jurisdiction over the subject matter hereof and over  
24 Respondent.

