

1 6. JT was admitted to the hospital and the admitting physician noted an
2 elevated WBC and anemia. Baseline lab results were discussed in the admitting
3 physicians note, but were not mentioned in Respondent's note. Upon admission, JT was
4 reported to have a large bowel movement which was tested and guaiac positive.
5 Resuscitation measures were initiated, JT was transfused with two units of PRBCs, and he
6 received Protonix. JT was later transferred to higher level of care for the massive GI bleed.

7 7. Patient KC presented to the ED with complaints of a cough that radiated to
8 his neck. He had a history of myocardial infarction and seizures. An EKG showed a normal
9 sinus with no ectopy or ischemic changes. He also had a normal chest x-ray and was
10 discharged.

11 8. Three days later, KC returned to the ED with complaints of vomiting,
12 diarrhea, and epigastric pain. An EKG showed findings consistent with lateral
13 subendocardial ischemia that were not present on the previous tracing. The physician
14 assistant (PA) signed the tracing and documented that the case was discussed with
15 Respondent. There were no cardiac enzymes and no further cardiac work up was
16 performed. KC was admitted to the hospital for gastroenteritis. The patient subsequently
17 coded the next day in the hospital and expired.

18 9. The MC found that in the case of patient JT, Respondent did not meet the
19 standard of care for emergent presentation of this patient and failed to identify a life
20 threatening situation. The MC opined that JT was placed at very real risk due to the
21 practitioner's actions or inactions. In the matter involving patient KC, the MC found that
22 there was a failure to diagnose and treat an acute ischemic cardiac event that should be
23 well within the realm of a physician practicing in an ED setting.

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

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

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

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

17 8. If any part of the Order is later declared void or otherwise unenforceable, the
18 remainder of the Order in its entirety shall remain in force and effect.

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

22 10. Any violation of this Order constitutes unprofessional conduct and may result
23 in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,
24 consent agreement or stipulation issued or entered into by the board or its executive
25 director under this chapter") and 32-1451.

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Jules F. Levey, MD
Jules F. Levey, M.D.

DATED: 10-10-12

EXECUTED COPY of the foregoing mailed
this 10th day of December, 2012 to:

Jules F. Levey, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 10th day of December, 2012 with:

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

[Signature]
Arizona Medical Board Staff