

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.

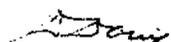
17 8. If the Board does not adopt this Consent Agreement, Respondent will not
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes
19 bias, prejudice, prejudgment or other similar defense.

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 11. Any violation of this Consent Agreement constitutes unprofessional conduct
2 and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) (“[v]iolating a formal order,
3 probation, consent agreement or stipulation issued or entered into by the board or its
4 executive director under this chapter”) and 32-1451.

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DAMON C. DAVIS, M.D.

DATED: 4/16/08

1 **FINDINGS OF FACT**

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

4 2. Respondent is the holder of license number 27240 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-07-0839A after receiving a complaint
7 regarding Respondent's care and treatment of a seventy year-old male patient ("CJ").

8 4. Respondent was contacted regarding CJ's abnormal computed tomography
9 (CT) scan and chest x-ray following CJ's transfer to the hospital. Respondent was notified
10 of CJ's prior CT scan findings regarding the original size of CJ's lung lesion and pulmonary
11 emboli and his chest x-ray findings of an increased streaky opacity in the right mid-lung
12 laterally. Respondent ordered anticoagulation treatment.

13 5. CJ continued to have right sided pleuritic chest pain with increased heart
14 rate (HR), decreased blood pressure (BP) and severe abdominal pain. The nursing staff
15 notified Respondent and he ordered a normal saline bolus and a subsequent stat CT scan.
16 Respondent did not present to the hospital to personally evaluate CJ. The nursing staff
17 also informed another physician ("Physician") of CJ's status.

18 6. Approximately five hours later, CJ complained of severe abdominal pain. The
19 nursing staff noted that CJ's BP was low and his HR had increased. It was also noted that
20 CJ was diaphoretic, cold and clammy. The stat CT scan showed opacity of the right
21 hemithorax. The nursing staff again notified Respondent of CJ's status and the abnormal
22 CT findings. Respondent did not present to the hospital to personally evaluate CJ even
23 though CJ was having continued abdominal pain and was anticoagulated. Rather,
24 Respondent ordered intravenous (IV) morphine for CJ's pain. Respondent also did not
25 address the abnormal CT findings.

1 7. Approximately three hours later, CJ again complained of abdominal pain.
2 Physician was notified and he ordered IV Lopressor. Following administration of
3 Lopressor, CJ became unresponsive, required intubation and was transferred to the
4 intensive care unit. Respondent was notified after CJ experienced cardiac arrest and he
5 gave verbal orders for vent settings with continuation of a heparin drip. CJ's BP remained
6 low and he continued to do poorly requiring multiple transfusions, pressor support and
7 bicarbonate. CJ became asystolic and subsequently died.

8 8. The standard of care requires a physician ordering an imaging procedure to
9 follow up on the results and, if the results are abnormal, to clarify whether this is a new
10 finding and make appropriate arrangements regarding intervention and treatment.

11 9. Respondent deviated from the standard of care because he did not follow up
12 on the results of CJ's abnormal CT scan findings.

13 10. The standard of care requires a physician to personally evaluate a patient in
14 the cross cover setting of severe abdominal pain in an anticoagulated patient with unstable
15 vital signs and abnormal CT scan findings.

16 11. Respondent deviated from the standard of care because he did not
17 personally evaluate CJ when he developed new abdominal pain and had unstable vital
18 signs and was found to have worsened findings on the CT scan.

19 12. Respondent continued the heparin drip after CJ developed a new finding of a
20 pulmonary hemorrhage on his chest x-ray and the subsequent stat CT scan. The
21 anticoagulation may have contributed to his continued blood loss, hypotension, cardiac
22 arrest and subsequent death. Respondent's failure to personally evaluate CJ while he was
23 anticoagulated with unstable vital signs and severe abdominal pain led to his death.

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25

1 **CONCLUSIONS OF LAW**

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

4 2. The conduct and circumstances described above constitute unprofessional
5 conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might be
6 harmful or dangerous to the health of the patient or the public.”) and A.R.S. § 32-1401
7 (27)(II) (“[c]onduct that the board determines is gross negligence, repeated negligence or
8 negligence resulting in harm to or the death of a patient.”).

9 **ORDER**

10 IT IS HEREBY ORDERED THAT:

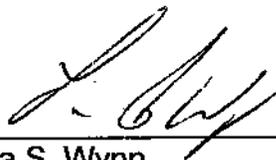
11 1. Respondent is issued a Letter of Reprimand for failure to personally evaluate
12 a patient despite being notified twice by nursing staff that the patient was not doing well
13 and for failure to followup on abnormal computed tomography scan results that he
14 ordered.

15 2. This Order is the final disposition of case number MD-07-0839A.

16 DATED AND EFFECTIVE this 5TH day of JUNE, 2008.



ARIZONA MEDICAL BOARD

19
20 By 
21 Lisa S. Wynn
22 Executive Director

23 ORIGINAL ~~copy~~ going filed
24 this 5th day of June, 2008 with:

25
Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

1 EXECUTED COPY of the foregoing mailed
2 this 5th day of August, 2008 to:

3 Damon C. Davis, M.D.
4 Address of Record

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Investigational Review