BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

JASON J. COOL, M.D.

Case No. MD-16-0688A

Holder of License No. 31030

ORDER FOR LETTER OF REPRIMAND; AND
CONSENT TO THE SAME

For the Practice of Allopathic Medicine
in the State of Arizona.

Jason J. Cool, M.D. ("Respondent"), elects to permanently waive any right to a
hearing and appeal with respect to this Order for a Letter of Reprimand; admits the
jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order
by the Board.

FINDINGS OF FACT

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

2. Respondent is the holder of license number 31030 for the practice of
allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-16-0688A after receiving notification of
a malpractice settlement regarding Respondent's care and treatment of a 39 year-old male
patient ("SP") alleging delayed referral for implantable cardioverter defibrillator ("ICD") with
subsequent patient death.

4. SP was treated at a Hospital Emergency Room ("ER") on September 6, 2010
for complaints of palpitations and recurrent episodes of lightheadedness causing near
syncope, accompanied by tinnitus and visual disturbances, not related with exertion and
lasting several minutes. SP was also noted to have multiple premature ventricular
contractions ("PVCs"). At discharge, the ER referred SP to Respondent.

5. On September 7, 2010, SP was seen by Respondent. The review of systems
at that visit noted that SP was positive for the presence of chest pain. SP had a family
history of premature coronary artery disease and sudden cardiac death at least in three of his family members. Respondent ordered an echocardiogram ("ECG") and myocardial perfusion imaging ("MPI").

6. On September 28, 2010, SP underwent an ECG and MPI. Based on the results, the physician who performed the testing recommended cardiac catheterization.

7. On November 17, 2010, SP was seen by the same covering cardiologist, who mentioned in his note that SP complained of fatigue, the ejection fraction was 35 or less, and that SP met the criteria for primary prevention ICD. SP was also seen by an electrophysiologist that same month who recommended that SP continue the same medications and return after the repeat ECG planned for March of 2011. The electrophysiologist stated that he would consider ICD if the ejection fraction was equal or less than 35%.

8. On December 15, 2010, SP complained of fatigue and had an ejection fraction of equal or less than 35%. Respondent documented that SP met the criteria for primary prevention ICD and that SP was unlikely to tolerate any large increase in medications. Respondent also documented that SP had recurrent episodes of non-sustained ventricular tachycardia ("NSVT"). The ECG was scheduled to be repeated on March 17, 2011 with follow up on March 31. Respondent also stated that he would recommend ICD placement if the ejection fraction was equal or below 30%. He recommended that SP continue to wear the life vest.

9. At the March 31, 2011 follow-up visit, it was noted that SP elected to not wear the life vest since he wanted to return to work and he had already discontinued its use. The ECG showed an increased ejection fraction of 35-45%. SP did not want to see the covering cardiologist in follow up again to re-discuss the case. SP mentioned that an ICD would end his truck driving career.
10. On October 27, 2011, it was noted that a recent ECG performed on September 19, 2011 showed a decrease in the ejection fraction to 30-40%. SP elected to continue on his same medications with some adjustments. There were three more follow up visits in the office in 2012, namely January 9th, February 6th and April 9th. Those visits involved medications adjustments.

11. The standard of care required Respondent to timely recommend the implantation of an ICD. Respondent deviated from this standard of care by failing to timely recommend the implantation of an ICD for Patient SP.

12. The standard of care required Respondent to discuss with the patient the gravity of his condition and the importance of the recommended treatment. Respondent deviated from this standard of care by failing to discuss with the patient the gravity of his condition and the importance of the recommended treatment.

13. SP experienced sudden cardiac arrest and died on June 29, 2012.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e)("Failing or refusing to maintain adequate records on a patient.").

c. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q)("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").
ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 3rd day of August, 2017.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

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

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

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

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

8. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejuidgment or other similar defense.

9. Respondent has read and understands the terms of this agreement.

JASON J. COOL, M.D.

DATED: 6/11/2017

EXECUTED COPY of the foregoing mailed this 3rd day of August, 2017 to:

Neal Alden
Jardine Baker Hickman Houston
3300 N Central Ave, Suite 2600
Phoenix, AZ 85012
Attorney for Respondent

ORIGINAL of the foregoing filed this 3rd day of August, 2017 with:

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

Mary Garcia
Board staff