IN THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

FILED
OSAH
MAR 20 2015

Kevin Westray, Legal Assistant

GEORGIA COMPOSITE MEDICAL BOARD, Petitioner,	:	
	:	Docket No.:
v.	:	OSAH-CSBME-PHY-1511102-89-Malihi
STEPHEN WEISS, MD, Respondent.	:	

J. David Stubins, Esquire
Senior Assistant Attorney General
For Petitioner

Christopher L. Ray, Esquire
For Respondent

MICHAEL MALIHI, Judge

DECISION

I. INTRODUCTION

Petitioner, the Georgia Composite Medical Board (hereinafter "the Board"), filed this matter for the purposes of pursuing disciplinary action against Respondent, Dr. Stephen Weiss, M.D., and his license to practice as a physician. For reasons indicated herein, the Board's request to impose sanctions against Respondent's license to practice as a physician is **DENIED**.

II. FINDINGS OF FACT

1.

Respondent holds a license to practice medicine in the State of Georgia from the Board and held such license at all times referenced in this Decision. He earned his medical degree from Temple University in Philadelphia, Pennsylvania. (Dr. Weiss Test., 431:12-13).[1] He is board certified in

[1] All citations to witness testimony list the name of the witness and the page and line of the hearing transcript where the relevant testimony appears.

general surgery and currently has over thirty-five years of experience as a surgeon. (Dr. Weiss Test., 431:17–21).

2.

Respondent first became involved in A.R.'s care in June 2007 when her primary care physician asked him to evaluate her for complaints of intermittent abdominal pain. (Dr. Weiss Test., 47:12–19). In early 2008, Respondent and A.R. decided to go forward with a laparoscopic hernia repair surgery to address A.R.'s chronic pain. (Dr. Weiss Test., 50:7–10). Respondent performed this procedure on A.R. at Liberty Regional Medical Center (hereinafter "Liberty Regional")—a critical access hospital located in Hinesville, Georgia—on March 10, 2008. (Ex. R-2, p.3). A.R. was discharged from Liberty Regional on March 14, 2008, four days after the surgery. (*Id.*).

3.

On Sunday, March 16, 2008 at approximately 5:35 a.m., A.R. presented to the emergency department at Liberty Regional with complaints of abdominal pain and inability to urinate. (Exhibit R-2, p. 137; Dr. Weiss Test., 440:21–441:7). An emergency department physician at Liberty Regional evaluated A.R., prescribed medications, administered intravenous fluids, and ordered a CT scan of her abdomen. (Exhibit R-2, p.145).

4.

At approximately 11:11 am on March 16, 2008, A.R. underwent a CT scan, which revealed a well-defined 5 x 10 x 9 cm fluid collection in her abdomen. (Ex. R-3, pp. 142, 177).

5.

Respondent first learned of A.R.'s presentation to the emergency department at approximately 12:30 p.m., when Dr. Snow, one of the emergency department physicians who managed A.R.'s care, contacted him to discuss the patient's condition. (Dr. Weiss Test., 104:2–9,

441:8–13). Based upon this discussion with Dr. Snow, Respondent understood that A.R. had presented to the emergency department with complaints of sudden-onset abdominal pain, that her vital signs and white blood cell count were normal, and that the results of a CT scan suggested an early abscess.[2] (Dr. Weiss Test., 441:14–20). At that time, Respondent requested that A.R. be admitted to Liberty Regional under his care. (Dr. Weiss Test., 442: 4–13).

6.

Respondent arrived at Liberty Regional at approximately 4:00 p.m. (Dr. Weiss Test., 449:20–23). Upon arrival, Respondent spoke with the nurses who were caring for A.R., reviewed her chart and other electronic records, reviewed the images from the earlier CT scan, and physically examined A.R. (Dr. Weiss Test., 450:2–15).

7.

Upon reviewing the images from the CT Scan, Respondent observed no evidence that would lead him to conclude that A.R. had an ongoing or active bowel leak. (Dr. Weiss Test., 446:3–19). The CT scan of A.R.'s abdomen did not show any extravasation of contrast[3] or free air.[4] The radiologist who performed the CT scan did not note any evidence of an active leak in the preliminary or final reports. (Exhibit R-3, pp. 142, 177; Dr. Weiss Test., 446:3–19; Dr. Park Test., 315:13–316:7).

8.

Due to A.R.'s symptoms and physical condition, including her increased heart rate and temperature, Respondent planned to treat her for an abdominal abscess. (Dr. Weiss Test., 452:12–

[2] An abscess is a collection of fluid that has become infected with bacteria. (Testimony of Dr. Weiss, 118:16–20).
[3] Contrast material leaking from the bowel into the abdomen. (Dr. Weiss Test., 446:3–12).
[4] Air that has leaked out of the bowel. (Dr. Weiss Test., 446:13–16).

453:3). He planned to continue treating her with intravenous fluids and antibiotics, and subsequently arrange for percutaneous drainage of the suspected abscess. (Dr. Weiss Test., 452:12–453:3).

9.

Percutaneous drainage is a procedure whereby a catheter is inserted through the skin and guided into an abscess cavity using an ultrasound or CT scan, allowing the fluid to be physically drained from the cavity. (Dr. Elwood Test., 222:20–223:3; Dr. Weinreb Test., 375:19–376:13; Dr. Park Test., 311:22–312:2 and 343:4–344:1). Percutaneous drainage is the preferred method for treating an abscess because it is less invasive than surgery. (Dr. Weinreb Test., 375:19–376:13). Typically, the procedure is performed by an interventional radiologist. (Dr. Elwood Test., 222: 20–22, 223:6–7). Liberty Regional did not have an interventional radiologist on duty on March 16, 2008.

10.

Because Respondent concluded that A.R. did not have an active bowel leak, he elected not to immediately proceed with surgery, but to instead allow the antibiotics and fluids time to achieve the intended effect. (Dr. Weiss Test., 134:4–18, 151:4–152:20, and 452:12–453:3). After examining A.R. once more, Respondent completed a "History and Physical" and left the hospital at approximately 5:30 p.m. (Exhibit R-3, p. 143; Dr. Weiss Test., 455:22–25).

11.

At approximately 8:45 p.m., one of the nurses caring for A.R. contacted Respondent because A.R.'s condition had deteriorated. (Dr. Weiss Test., 454:12–15, 455:9–17). Upon learning of the change in A.R.'s condition, Respondent determined that he needed to return to the hospital to re-examine her, and issued orders over the telephone for a complete blood count, an EKG, and additional fluids. (Ex. R-3, p. 148; Dr. Weiss Test. 454:12–15 and 455:9–17).

12.

Respondent arrived at Liberty Regional at approximately 10:45 p.m., whereupon he physically examined A.R. His examination did not reveal any signs of full belly peritonitis (i.e., widespread tenderness from an inflamed and infected abdominal wall). (Dr. Weiss Test., 456:19–25). A.R.'s symptoms included: continued abdominal pain; decreased urine output; elevated pulse and temperature; and elevated hemoglobin and white blood cell count. (Exhibit R-3, p. 152; Dr. Weiss Test., 462:18–26, 463:3–8, 463:17–21).

13.

Respondent's working diagnosis was an infected abdominal abscess, probably from a GI source. (Dr. Weiss Test., 159:7–15). He attributed the deterioration in A.R.'s condition to progression of the infection and resultant profound dehydration. (Dr. Weiss Test., 157:12–20). He did not conclude, however, that A.R. had an ongoing, active bowel leak at that time. (Dr. Weiss Test., 157:21–158:4, 158:10–18, 159:7–15 and 160:8–15).

14.

After reevaluating A.R.'s condition at 10:45 p.m., Respondent ordered Gentamicin (a broad-spectrum antibiotic) and increased intravenous fluids. (Ex. R-3, p. 149; Dr. Weiss Test., 155:14–156:18). Respondent indicated in A.R.'s progress notes that he planned to ameliorate her dehydration, get a repeat set of labs the following morning, and, based on the lab results and the patient's condition, consider a laparotomy. (Ex. R-3, p. 152; Dr. Weiss Test. 463:22–464:5).

15.

Respondent elected not to transfer A.R. to Memorial Health University Medical Center (hereinafter "Memorial Health") in Savannah, Georgia because she was unstable; her condition was deteriorating, and she was sick and profoundly dehydrated. (Dr. Weiss Test., 168:16–24, 459:16–

21). Additionally, the process of transferring A.R. to Memorial Health would likely be prolonged due to the influx of tourists visiting Savannah for St. Patrick's Day. (Dr. Weiss Test., 169:16–170:5). (Dr. Weiss Test., 168:16–170:5, 459:21–24). Finally, even if a transfer of A.R. was accomplished without delay, Respondent would not likely have been able to arrange for a percutaneous drainage with an interventional radiologist at Memorial Health on a Sunday afternoon or evening. (Dr. Weiss Test., 453:18–454:11).

16.

After assessing the resources available to him at Liberty Regional, Respondent determined that performing surgery on A.R. at Liberty Regional would not be the best course of action. As a critical access hospital, Liberty Regional lacked an intensive care unit or any critical care facilities. Moreover, no physician anesthesiologist, cardiologist, critical care pulmonologist, or intensivist was on duty at Liberty Regional to assist with surgery. (Dr. Weiss Test, 457:15–25, 458:1–13; 458:16–25, 459:1–3).

17.

Respondent's decision not to operate on A.R. at Liberty Regional on the evening of March 16, 2008 was further influenced by the patient's condition. (Dr. Weiss Test., 164:14–166:25). A.R. had a Mallampati III airway, a condition that would have made intubation exceedingly difficult without the assistance of an anesthesiologist. (Dr. Weiss Test., 165:9–14). Further, the EKG results showed ischemia (i.e., not enough blood was getting through the patient's coronary arteries), and A.R. was severely dehydrated; administering the anesthesia necessary to perform surgery could have possibly resulted in a fatal drop in blood pressure. (Dr. Weiss Test., 163:10–16, 165:15–166:5).

18.

At approximately 8:20 a.m. on Monday, March 17, 2008, Respondent performed an exploratory laparotomy on A.R. at Liberty Regional. (Ex.R-3, p. 158–59, 163). Respondent's decision to proceed with surgery was motivated by (1) his conclusion that A.R. had been sufficiently hydrated to mitigate the risk of anesthesia-induced hypotension and (2) the fact that an anesthesiologist was available to assist with surgery at that time. (Dr. Weiss Test., 173:25–174:13). Respondent examined the bowel during the procedure and did not find an active leak. (Dr. Weiss Test., 148:3–8). He did, however, identify a "very small punctate wound" in A.R.'s bowel. (Ex. R-3, p. 158). Although it was not actively leaking, Respondent removed a segment of A.R.'s bowel containing the punctate wound because it was the only abnormality that he was able to identify as a potential source of the abscess. (Dr. Weiss Test., 121:6–123:7 and 447:3–448:3).

19.

A.R. remained ill after Respondent completed the exploratory laparotomy, and was transferred to Memorial Health at approximately 3:56 p.m. (Resp.'s Ex. 3, p. 157). A.R. passed away at Memorial Health on March 30, 2008.

20.

Dr. David Elwood, M.D., conducted a peer review of Respondent's treatment of A.R. on behalf of the Board. (Dr. Elwood Test., 238:3-5). Dr. Elwood is a physician licensed to practice medicine in the State of Georgia and is board certified in general surgery. (Dr. Elwood Test., 191:22-25). He earned his medical degree from University of Connecticut School of Medicine and currently practices as a general surgeon at Kennestone Hospital in Marietta, Georgia. (Dr. Elwood Test., 190:22, 192:22-23).

21.

After reviewing the documentation relevant to Respondent's treatment of A.R., Dr. Elwood concluded that Respondent's treatment of A.R. departed from or failed to conform to the minimum standards of acceptable and prevailing medical practice. (Dr. Elwood Test.; 265:10-15). The only departure from the minimum standards of acceptable and prevailing medical practice that Dr. Elwood identified was Respondent's decision to not perform an exploratory laparotomy on A.R. at 10:45 p.m. on March 16. (*Id.; see also Petitioner's Statement of Matters Asserted* ¶ 12). At that time, according to Dr. Elwood, Respondent had, or should have had, sufficient information—specifically, the results of the 8:50 p.m. blood tests—to conclude that A.R. was in septic shock and that an immediate exploratory laparotomy was necessary to abate the abscess. (Dr. Elwood Test., 264:7-265:9). Dr. Elwood did not take into account the assets available to Respondent at Liberty Regional in reaching the conclusion that Respondent's decision to not operate on A.R. fell below minimum standards of acceptable and prevailing medical practice. (Dr. Elwood Test., 278:6-13).

22.

At the evidentiary hearing, the Board introduced transcripts of testimony given by Drs. Alan Kravitz, Kenneth Hagan, James Paul Shaffer, and John Porter during discovery depositions taken in the course of medical malpractice litigation arising from the above-described facts. (Petitioner's Exhibits 6–9). The four doctors, all of whom were retained as expert witnesses by the plaintiff in the medical malpractice litigation, gave deposition testimony to the effect that Respondent's decision to not perform surgery at or before the 10:45 p.m. timeframe on March 16, 2008 deviated from the standard of care. (*Id.*). None of the doctors testified at the hearing on this matter.

23.

David Park, M.D. and Seth Weinreb, M.D. testified on behalf of Respondent at the hearing on this matter. Dr. Park and Dr. Weinreb are both experienced physicians and surgeons, and well-qualified experts in the fields of surgery, general surgery, hernia repair surgery, and the surgical management of patients with abdominal and pelvic abscesses.

24.

Dr. Park is a physician licensed to practice medicine in the State of Georgia and is board certified in general surgery. (Dr. Park Test., 298:9–16). He has over twenty years of experience as a surgeon and has instructed other surgeons in the performance of hernia repair surgery. He received his surgical training at Emory University and is on staff at St. Joseph's Hospital in Atlanta. (Dr. Park Test., 303:6–304:4). Dr. Park is familiar with the minimum standards of acceptable medical practice in caring for patients with postoperative complications after hernia repair surgery. (Dr. Park Test., 304:5–9).

25.

Dr. Park testified that, given the fact that A.R. was severely dehydrated, operating on her at 10:45 p.m. would likely have presented significant complications. (Dr. Park Test., 325:18–326:9). He opined that Respondent's course of action—administering a broad-spectrum antibiotic, ordering additional fluids, and planning for a percutaneous drainage the following day—was "very reasonable," and testified further that he "would have pursued the same course of action." (Dr. Park Test., 325:16–17). In Dr. Park's opinion, transferring A.R. on the evening of March 16 would have been unwise without first bringing her to a more stable condition. (Dr. Park Test., 326:13–20).

26.

Dr. Weinreb is a physician licensed to practice medicine in North Carolina. (Dr. Weinreb Test., 358:9–13). He earned his medical degree from Harvard Medical School and completed his surgical residency at Emory University. (Dr. Weinreb Test., 358:21–359:4). Currently, he is the chairman of the department of surgery at Rex Hospital, a community hospital that is part of the University of North Carolina Healthcare System. (Dr. Weinreb Test., 360:18–361:22). Dr. Weinreb's surgical practice is focused specifically on hernia repair surgery and the majority of the surgeries that he performs are hernia repairs. (Dr. Weinreb Test., 362:21–363:19). He is familiar with the minimum standards of acceptable medical practice in caring for patients with postoperative complications after hernia repair surgery. (Dr. Weinreb Test., 359:4–8).

27.

Dr. Weinreb testified that, in his opinion, Respondent's management of A.R.'s care on March 16, including the decision not to operate on her at 10:45 p.m., but rather to hydrate her, give her antibiotics and to wait until the following morning to perform surgery, did not fall below the minimum standard of care. (Testimony of Dr. Weinreb, 365: 21–366: 5, 382:6–7). Dr. Weinreb opined that Respondent's decision not to transfer A.R. to Memorial Health did not fall below the minimum standard of care because it would have likely taken hours to effectuate a transfer, which would have placed A.R. at "definite risk." (Dr. Weinreb Test, 387:22–388:24).

III. CONCLUSIONS OF LAW

1.

Because this matter concerns the Board's proposed imposition of sanctions on Respondent's license to practice medicine, the Board bears the burden of proof. Ga. Comp. R. & Regs. 616-1-2-.07. The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21.

2.

O.C.G.A. § 43-34-8 states, in pertinent part, that the Board has the authority to discipline a licensee upon a finding that the licensee has [e]ngaged in any unprofessional . . . conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person." O.C.G.A. § 43-34-8(a)(7) (2014); *see also* O.C.G.A. §43-1-19(a)(6). Unprofessional conduct includes "any departure from, or failure to conform to, the minimum standards of acceptable and prevailing medical practice." O.C.G.A. § 43-34-8(a)(7); *see also* Ga. Comp. R. & Regs. 360-3-.02. The sole issue in this matter is whether Respondent engaged in unprofessional conduct by departing from or failing to conform to the minimum standards of acceptable and prevailing medical practice in his treatment of patient A.R. when he decided not to proceed with surgery at 10:45 p.m. on March 16, 2008, but to instead wait until the following morning.

3.

At approximately 10:45 p.m. on March 16, 2008, Respondent determined that the appropriate course of treatment for patient A.R. was to start an additional broad spectrum antibiotic, correct her dehydration, get a repeat set of labs, and consider a laparotomy early the next morning, rather than proceed immediately with an exploratory laparotomy. Two expert witnesses, both of whom are accomplished and preeminent in the field of surgery and postoperative care, testified that Respondent's plan of care was reasonable and consistent with minimum standards of acceptable and prevailing medical practice. Dr. Park and Dr. Weinreb testified that Respondent's decision to delay surgery was reasonable, and, given the patient's condition and the resources available to Respondent at the time, did not depart from, or fail to conform to, the minimum standard of acceptable and prevailing medical practice. Further, both witnesses testified that, considering the risks associated with transferring a patient in A.R.'s condition, Respondent's decision not to transfer her to Memorial

Health was reasonable. The testimony of live sworn witnesses such as that of Respondent, Dr. Park, and Dr. Weinreb carries far greater evidentiary weight than the out-of-court testimony submitted by the Board.

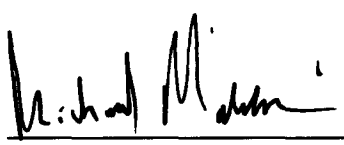
4.

Dr. Elwood's testimony to the effect that Respondent should have operated on A.R. on the night of March 16, 2008 evidences a differing opinion as to the appropriate treatment plan, but fails to demonstrate that Respondent's treatment fell below minimum standards of acceptable and prevailing medical practice. *See, e.g., Hayes v. Brown*, 108 Ga. App. 360, 366 (1963). Moreover, Dr. Elwood failed to consider the resources that were available to Respondent at Liberty Regional in reaching the determination that Respondent's decision to delay surgery fell below the applicable standard of care. Had Respondent opted to immediately proceed with surgery, he would have been operating on an unstable patient at a facility with no intensive care unit, with no physician anesthesiologist, cardiologist, pulmonary critical care specialist, or intensivist to assist him. These factors bear significantly on the propriety of Respondent's course of conduct.

IV. DECISION

For the foregoing reasons, the Board has not carried its burden of proving that Respondent departed from or failed to comply with the minimum standards of acceptable and prevailing medical practice. Therefore, the Court recommends that **NO DISCIPLINARY ACTION** be taken against Respondent and that **NO SANCTIONS** be imposed against his medical license.

SO ORDERED, this 20th day of March, 2015.



MICHAEL MALIHI, Judge