



State Medical Board of Ohio

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May 10, 2006

Stephen David Waite, M.D.
12116 Craven Avenue
Cleveland, OH 44105

Dear Doctor Waite:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Sharon W. Murphy, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 10, 2006, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage MD
Lance A. Talmage, M.D. *RAW*
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 7003 0500 0002 4329 9477
RETURN RECEIPT REQUESTED

Cc: Kevin P. Byers, Esq.
CERTIFIED MAIL NO. 7003 0500 0002 4329 9453
RETURN RECEIPT REQUESTED

Mailed 6-7-06

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on May 10, 2006, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Stephen David Waite, M.D., as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.

Lance A. Talmage MD
Lance A. Talmage, M.D. RAW
Secretary

(SEAL)

May 10, 2006
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

STEPHEN DAVID WAITE, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on May 10, 2006.

Upon the Report and Recommendation of Sharon W. Murphy, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that:

The certificate of Stephen David Waite, M.D., to practice medicine and surgery in the State of Ohio is REVOKED.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.

(SEAL)

Lance A. Talmage MD
Lance A. Talmage, M.D. RAW
Secretary

May 10, 2006
Date

2006 APR 10 P 12: 20

**REPORT AND RECOMMENDATION
IN THE MATTER OF STEPHEN DAVID WAITE, M.D.**

The Matter of Stephen David Waite, M.D., was heard by Sharon W. Murphy, Esq., Hearing Examiner for the State Medical Board of Ohio, on June 1, 2, and 3; September 23; and November 2, 2005.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated October 13, 2004, the State Medical Board of Ohio [Board] notified Stephen David Waite, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on allegations that, in the routine course of his practice as an emergency room physician, Dr. Waite had undertaken the treatment of Patients 1 through 8. The Board further alleged that Dr. Waite's care and treatment of those patients constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code." Accordingly, the Board advised Dr. Waite of his right to request a hearing in this matter. (State's Exhibit 11A)
- B. On November 10, 2004, the Board received a written hearing request submitted by Kevin P. Byers, Esq., on behalf of Dr. Waite. (State's Exhibit 11B)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Tara L. Berrien, Assistant Attorney General.
- B. On behalf of the Respondent: Kevin P. Byers, Esq.

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EVIDENCE EXAMINED

I. Testimony Heard

A. Presented by the State

1. Stephen David Waite, M.D., as upon cross-examination
2. Michael C. Choo, M.D.
3. Kenneth D. Masters

B. Presented by the Respondent

1. Jonathan Glauser, M.D.
2. Stephen David Waite, M.D.

II. Exhibits Examined

A. Presented by the State

1. State’s Exhibits 1, 2A, 2B, 3, 4, 5A, 5B, 6, 7, and 8: Certified copies of patient medical records for Patients 1 through 8, respectively. (Note: these exhibits are sealed to protect patient confidentiality).
2. State’s Exhibit 9: Curriculum vitae for Michael C. Choo, M.D.

3. State's Exhibit 10: Dr. Choo's report regarding Patients 1 through 8. (Note: This exhibit is sealed to protect patient confidentiality.)
 4. State's Exhibits 11A through 11S: Procedural exhibits.
 5. State's Exhibit 12: Patient key. (Note: This exhibit is sealed to protect patient confidentiality.)
 6. State's Exhibit 13: State's Closing Argument.
- B. Presented by the Respondent
1. Respondent's Exhibit B: Curriculum vitae for Jonathan Glauser, M.D.
 2. Respondent's Exhibit C: Copy of a record of Patient 3's April 20, 1998, visit to the Ashtabula County Medical Center Emergency Department. (Note: This exhibit is sealed to protect patient confidentiality.)
 3. Respondent's Exhibit D: Dr. Glauser's report regarding Patients 1 through 8. (Note: This exhibit is sealed to protect patient confidentiality.)
 4. Respondent's Exhibit E: A March 9, 2005, letter to the Board from Charles A. Blakely, M.D., F.A.C.S., Chief of Emergency Medicine, Department of Health and Human Services, Public Health Service, National Area Indian Health Service, Fort Defiance, Arizona.
 5. Respondent's Exhibit F: Respondent's Closing Argument.
- C. The following procedural exhibits were admitted by the Hearing Examiner, *sua sponte*
1. Board Exhibit A: Copy of the State's Third Request for a Scheduling Order filed June 27, 2005.¹
 2. Board Exhibit B: An August 24, 2005, Entry scheduling an additional day of hearing.
 3. Board Exhibit C: Copy of the State's Motion to Present the Testimony of Ken Masters by Telephone filed September 19, 2005.

¹Prior to the hearing, the parties informally resolved the issues presented in the request for a scheduling order, apparently rendering moot the need for scheduling order. Therefore, a scheduling order was not issued. See the Hearing Transcript, Volume 1, at 8-10.

4. Board Exhibit D: Copy of the State's List of Rebuttal Witness, filed September 19, 2005.
5. Board Exhibit E: Copy of the Respondent's Objection to the State's Motion for Telephonic Testimony, filed September 21, 2005.
6. Board Exhibit F: Copy of the State's Response to Respondent's Objection to State's Motion for Telephone Testimony, filed September 22, 2005.
7. Board Exhibit G: Copy of the Respondent's Response to the State's Response Regarding the Motion for Telephonic Testimony, filed September 21, 2005.
8. Board Exhibit H: A November 1, 2005, Entry scheduling an additional day of hearing.

PROCEDURAL MATTERS

At the close of the hearing, the parties agreed to submit written closing arguments. Pursuant to a schedule set forth by the Hearing Examiner and agreed to by the parties, the parties' written closing arguments were filed on January 13, 2006. The hearing record closed at that time. (See the Hearing Transcript, Volume V, at 13-14)

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

BACKGROUND OF PHYSICIAN WITNESSES

Stephen David Waite, M.D.

1. Stephen David Waite, M.D., testified that he had obtained his medical degree from Howard University Medical School. In 1997, he completed a residency in emergency medicine at Mt. Sinai Hospital, which was affiliated with the Case Western Reserve University in Cleveland, Ohio. Dr. Waite testified that he is board certified in emergency medicine. (Hearing Transcript, Volume I [Tr. I] at 12-14)

Upon finishing his residency, Dr. Waite accepted a position in the emergency department at the Ashtabula County Medical Center in Ashtabula, Ohio. In 1998, Dr. Waite was asked to resign due to problems with patient care and personality conflicts. Dr. Waite refused, and his privileges were terminated. For some months thereafter, Dr. Waite practiced at Brown Memorial Hospital in Conneaut, Ohio. From 1998 through 1999, he practiced

at Meridia Hospital, which is currently called Cleveland Clinic Huron Hospital. In 1999, he practiced at St. Francis West Medical Center, but left there in 2000. From 2000 until 2003, Dr. Waite practiced at Grant Medical Center in Columbus, Ohio. Dr. Waite testified that he had left Grant Medical Center because he had been accepted into the Case Western Reserve University Law School and needed to move to Cleveland. For several months thereafter, Dr. Waite practiced at St. Vincent Charity Hospital. Since 2004, Dr. Waite has practiced intermittently through the United States Public Health Service, while on breaks from law school. At some point in 2005, Dr. Waite left the Case Western Reserve University Law School and transferred to a law school in Arizona. At the time of hearing, Dr. Waite was practicing in the emergency department at Fort Defiance Hospital in Fort Defiance, Arizona. (Tr. I at 12-17; Tr. IV at 201-202, 231)

Michael C. Choo, M.D.

2. Michael C. Choo, M.D., testified on behalf of the State. Dr. Choo testified that, in 1987, he had completed an accelerated six-year program at Boston University and the Boston University School of Medicine. In 1990, Dr. Choo completed a residency in emergency medicine and a one-year fellowship in administrative emergency medicine at St. Vincent Medical Center, Toledo Hospital, in Toledo, Ohio. Thereafter, Dr. Choo taught at the residency program there for three years. Dr. Choo testified that he was certified by the American Board of Emergency Medicine in 1991, and recertified in 2001. (Hearing Transcript, Volume II [Tr. II] at 5-12, 169-172; State's Exhibit [St. Ex.] 9)

In 1992, Dr. Choo joined Professional Emergency Specialists of Southern Ohio, Inc., an emergency medicine group in Wilmington, Ohio. He currently practices with that group, staffing the emergency department at Clinton Memorial Hospital in Wilmington and the Dayton Heart Hospital, in Dayton, Ohio. Dr. Choo also serves as the Chief of Emergency and Outpatient Services for Clinton Memorial Hospital, and as the Medical Director for the Clinton County, Ohio, Sheriff's Department and the Highland County, Ohio, Sheriff's Department. In addition, he serves as a volunteer faculty member for the emergency medicine residency programs at the University of Cincinnati and Wright State University. Finally, Dr. Choo has been an Oral Board Examiner for the American Board of Emergency Medicine since 2002. (Tr. II at 5-12, 169-172; St. Ex. 9)

Jonathan Glauser, M.D.

3. Jonathan Glauser, M.D., testified on behalf of Dr. Waite. Dr. Glauser testified that, in 1976, he had graduated from the Temple University Medical School in Philadelphia, Pennsylvania. In 1979, he completed a residency in emergency medicine at Hennepin County Medical Center in Minneapolis, Minnesota. In 1991, he obtained an MBA Degree at Case Western Reserve University in Cleveland, Ohio. Dr. Glauser testified that he was certified by the American Board of Emergency Medicine in 1981, and recertified in 1991 and 2001. He stated that he was also certified by the American Board of Pediatric

Emergency Medicine in 1996. (Hearing Transcript, Volume III [Tr. III] at 11-14; Respondent's Exhibit [Resp. Ex.] B)

Dr. Glauser further testified that, since completing his residency, he has practiced in Cleveland. He stated that, since 1999, he has been a full-time employee at the Cleveland Clinic Foundation, and serves as the Associate Chair of Operations in the Department of Emergency Medicine. He is also an affiliate staff member at MetroHealth Medical Center. Finally, Dr. Glauser serves as an Assistant Clinical Professor of Medicine at Case Western Reserve University. In the past, Dr. Glauser served as the Clinical Director of the Adult Emergency Department at University Hospitals of Cleveland, and as the Director of the Department of Emergency Medical Services at the Mt. Sinai Medical Center. In addition, from 1982 through 1997, he was Co-Director of the residency program in emergency medicine at the Mt. Sinai Medical Center. Dr. Glauser has published numerous textbook chapters and peer-reviewed academic papers, and serves or has served on numerous committees. (Tr. III at 14-16; Tr. IV at 46-47; Resp. Ex. B)

Dr. Glauser testified that, during the time that he had served as a Co-Director of the residency program in emergency medicine at Mt. Sinai Medical Center, Dr. Waite had been a resident in that program. (Tr. IV at 46-47)

THE PATIENTS

Patient 1

Medical Records for Patient 1

4. On August 23, 1997, Patient 1, a 40 year-old female, was transported fully immobilized on a backboard via life squad to the Emergency Department at Ashtabula County Medical Center in Ashtabula, Ohio. The nursing triage note written at 5:15 p.m. provides as follows:

Arrived by squad involved in [motorcycle accident] -- passenger [without] helmet. Hit large hole in road and motorcycle went out of control. Unsure if she lost consciousness. [Alert and oriented to person, place, and time]
Four movement extremities -- maintained full immobilization. [Complains] of [right] wrist, [left] knee, [left] shoulder and arm pain. Laceration to face and both hands -- soft tissue edema [right] eye.

(St. Ex. 1 at 5) The triage nurse also noted that Patient 1 had denied being pregnant, and had stated that her last menstrual period had been two weeks earlier. (St. Ex. 1 at 5)

5. Another page of random, handwritten notes included the following: motorcycle accident, "no helmets"; "airborne," "roll over," "thrown off"; unsure whether she lost consciousness;

no loss of consciousness; back and neck pain, nausea; lacerations on the face and hands, and abrasions on the knees. (St. Ex. 1 at 11)

6. A preliminary report of a CT scan of the brain, without contrast, noted, in part, as follows:

The ventricular system is normal in size and configuration. No evidence for mass effect, lesions, intracranial hemorrhage or acute cerebral infarction is seen. The sulci are all well visualized with no evidence for midline shift.

Examination of the skull demonstrates a sharp lucency involving the left occipital bone extending towards the basilar region of the left skull adjacent to the foramen magnum. This finding is consistent with an acute nondisplaced fracture. No evidence for hemorrhage in the area is identified. No compression occipital/basilar skull fracture is described.

(St. Ex. 1 at 13)

7. Radiologic studies included the following:

- a. Cervical spine: Vertebral bodies and intervertebral disc spaces were intact. There was no prevertebral soft tissue swelling. However, there was “straightening of the normal lordotic curvature which may be related to muscle spasm. This appears to be most notable at the C5-6 interspace.” (St. Ex. 1 at 25)
- b. Right wrist: Slight dislocation of the distal ulna with soft tissue swelling. No evidence of fracture. (St. Ex. 1 at 23)
- c. Left knee: Lucencies within the soft tissues suggestive of an error which may have been introduced by a laceration. No definite bony abnormality or joint effusion. (St. Ex. 1 at 23)

8. In his emergency department note, Dr. Waite documented, in part, the following:

- **“CHIEF COMPLAINT(S):** Fall.”
- **“HISTORY OF PRESENT ILLNESS:** “The patient is a 40-year-old female who was a rider on a motorcycle who fell off the motorcycle as it crashed. The patient was not wearing a helmet. She sustained an injury to her left leg, left arm, left shoulder, and face. There was no loss of consciousness. No complaints of chest pain or shortness of breath.”
- **“SOCIAL HISTORY:** Significant for alcohol use.”

- **“PHYSICAL EXAMINATION:**” Vital signs were normal, with a blood pressure of 100/60. “The patient has multiple facial abrasions, none requiring sutures. Pupils are equal, round and reactive to light.” “Full range of motion.” “Neck is supple without tenderness.” “Pelvis is stable.” “Upper extremity demonstrates swelling and ecchymotic changes on the left side. There is no bony crepitus on palpation. The patient’s radial, ulnar, and median nerves are intact to motor and sensory.”
- **“ASSESSMENT:** The differential on this patient would include multiple trauma with bony fracture versus simple abrasion and contusions. Clinically the patient has contusions and abrasions and skin loss on the posterior knee, left side, will require suturing.”
- **“TREATMENT AND CARE GIVEN IN THE EMERGENCY DEPARTMENT:** Nonsteroidal anti-inflammatory and follow up with surgeon[.]. The patient will return if vomiting or severe headache.”
- **“DISPOSITION OF PATIENT:** The patient will receive Toradol in the emergency department and get a prescription for Percocet for pain at home.”
- **“DISCHARGE DIAGNOSIS(ES):**
 1. Multiple trauma.
 2. Multiple abrasions face.
 3. Contusion to the left shoulder, left hand, left knee, right wrist.
 4. Tissue loss to the posterior left leg, popliteal fossa.”
- **“CONDITION ON DISCHARGE:** Stable.”
- **“PROCEDURE PERFORMED:** Suture of laceration. * * *”

(St. Ex. 1 at 19, 21)

9. A nursing discharge sheet contained the following instructions:

1. Follow up with [a named physician] Monday.
2. Use Percocet for pain.
3. Return if vomiting or change in character of headache.
4. Keep wounds clean and dry.
5. Knee immobilizer until seen by [the physician noted above].

(St. Ex. 1 at 7)

Testimony of Dr. Choo regarding Patient 1

10. Choo testified that, in his care and treatment of Patient 1, Dr. Waite had failed to conform to the minimal standards of care of similar practitioners under the same or similar circumstances. (Tr. II at 20; St. Ex. 10 at 1-2)

Dr. Choo testified that Patient 1 was an unhelmeted motorcycle passenger who had been thrown from the motorcycle. Dr. Choo noted that, in a trauma such as this, the circumstances of the accident need to be discerned. Dr. Choo testified that the Advanced Trauma Life Support [ATLS] guidelines stipulate that, when assessing a trauma patient, history is extremely important, and that the trauma is an important part of that history. In this case, Dr. Waite should have documented such things as the speed of the motorcycle at the time of the accident and how far the patient was thrown. (Tr. II at 20-25, 172-173)

Moreover, Dr. Choo testified that, when accessing a victim of trauma, there are certain standards the physician must follow. He stated that all emergency medicine physicians are aware of the ABCDs of trauma evaluation, with “A” representing awareness, “B” representing breathing, “C” representing circulation, and “D” representing disability. Moreover, there must be a complete head-to-toe examination. Dr. Choo testified that there were a number of critical elements that Dr. Waite did not address in his assessment of Patient 1. (Tr. II at 23, 31)

Dr. Choo stated that, in notes taken from the report of the rescue squad, there was inconsistent information regarding whether Patient 1 had lost consciousness after the accident, although Dr. Waite did not address it. Dr. Choo explained that, if the patient does not know if he or she had lost consciousness, it is important for the practitioner to determine why the patient cannot remember: because they were under the influence of alcohol or drugs, because there is a head injury, or because events took place so quickly. Dr. Choo testified that Dr. Waite’s simply recording “no loss of consciousness” was not sufficient to address the inconsistency in the medical record. (Tr. II at 24-25, 173-175, 232-233)

Dr. Choo testified that trauma assessment has become “sort of cookbook.” He stated that, when assessing trauma, a physician is expected to run specific tests to assess specific problems, including alcohol levels and pregnancy tests. Dr. Choo testified that it is important to assess for impairment due to alcohol intake in order to properly evaluate the patient’s cognition. Documenting that the patient’s history is “significant for alcohol use” is not sufficient to assess the potential for the influence of alcohol at the time of treatment. (Tr. II at 26-27, 179-182, 233)

Moreover, Dr. Choo stated that pregnancy tests should be run in all women of childbearing age. He stated that studies have shown that many women are not aware that they are pregnant when they are, in fact, pregnant. Nevertheless, Dr. Choo acknowledged that if the patient states that her last menstrual period had been two weeks earlier, the clinician can use his or her judgment to determine the necessity of the pregnancy test. Still, he insisted that, if there is any doubt, a pregnancy test must be obtained. (Tr. II at 26-27)

Dr. Choo further testified that Dr. Waite did not fully assess the possibility of head trauma. Dr. Waite focused on facial injuries, but did not document his assessment of the head and skull. Nevertheless, because there was facial trauma Dr. Waite should have evaluated for head trauma. Documentation should have included a mental status evaluation completed by Dr. Waite himself; a neurological examination, including an assessment of spinal cord injury or impairment of sensation; and a physical examination of the skull with a description of any pain or tenderness in that area. Moreover, Dr. Choo concluded, a CT and cervical spine x-ray scan should have been obtained or at least considered. (Tr. II at 28-30, 31-32, 36-39, 178-179)

Dr. Choo testified that, because Patient 1 had suffered injury to her arm and shoulder, it would have been very prudent to document a chest wall examination and a chest x-ray. Dr. Choo noted that when someone is thrown from a vehicle there can be injuries of impact as well as velocity deceleration. He explained that internal organs may be traumatized or jolted due to the change in velocity. He testified that the chest x-ray would have been appropriate for evaluation of the visceral organs, including the aorta, the heart, and the mediastinum. (Tr. II at 34-35, 39-40)

Dr. Choo further testified that Dr. Waite had not evaluated the pelvis properly. He stated that simply palpating the pelvis and noting that there is no movement of the bony structure is not sufficient. He explained that a pelvis can be stable, yet have a fracture. Dr. Waite should have documented whether there was any pain before dismissing problems with the pelvis. In addition, Dr. Waite failed to assess for renal and bladder injuries. (Tr. II at 28-29, 34-35)

Dr. Choo testified that prescribing Percocet to Patient 1 had also been inappropriate in light of the potential head injury and Patient 1's complaints of nausea. Dr. Choo explained that Percocet is a sedative which decreases mentation and may mask the symptoms of serious injury. Dr. Choo further explained that head injury and concussion can result in symptoms of headache and nausea. Dr. Choo noted that, since Dr. Waite instructed Patient 1 to return if she experienced any change in headache, it is apparent that he had considered the possibility of head injury. (Tr. II at 41-42)

In addition, Dr. Choo testified that Dr. Waite should have documented his assessment of Patient 1's condition upon discharge. This would ensure that there was nothing catastrophic occurring. (Tr. II at 35-36)

Finally, Dr. Choo testified that Dr. Waite's approach in treating Patient 1 had been "disjointed." Dr. Choo stated that Dr. Waite had ordered a cervical spine x-ray and had expressed concern about head injury "here and there" throughout the record which indicates that he was thinking about the possibility of head and neck injuries. Nevertheless, his clinical evaluation did not reflect it and his testing was not consistent with that thinking. (Tr. II at 32, 42-43, 176-177)

Testimony of Dr. Waite regarding Patient 1

11. Dr. Waite acknowledged that there had been a discrepancy in the medical records regarding Patient 1's potential loss of consciousness. He explained that the discrepancy could be explained by the passage of time in which Patient 1's memory improved, or by Patient 1 having a better understanding of what loss of consciousness means after probing by the examiner. Dr. Waite testified that there could be no other reason for the discrepancy. (Tr. I at 34-36)

Dr. Waite acknowledged that he had not documented, and may not have investigated, how fast the motorcycle had been traveling, how far from the motorcycle Patient 1 had been thrown, or how she had landed. Dr. Waite testified that he cannot remember at this point why he had not documented this information. He admitted, however, that this information might have been useful in assessing the extent of the trauma to Patient 1, especially since Patient 1 had not been wearing a helmet. Dr. Waite suggested, however, that this information may not have been available to him. (Tr. I at 36-40)

Dr. Waite acknowledged that the medical records contained no information regarding whether Patient 1 had been drinking alcohol before the accident. Dr. Waite agreed that it may have been useful to have had this information to be sure that Patient 1 was recalling the accident accurately. Nevertheless, Dr. Waite testified that Patient 1 had been talking to him "in a very intelligent manner" and he had seen no signs of intoxication. Moreover, he stated that he had known the victim before the accident which was beneficial in evaluating her mental status. Dr. Waite admitted that he had noted her social history was "significant for alcohol use." He added, however, that, simply because someone is an alcoholic, it is not necessarily "medically relevant." Dr. Waite concluded that his notation had been sufficient documentation regarding her use of alcohol or other substances of abuse prior to or during the accident. (Tr. I at 40-42; Tr. IV at 160-162, 208-209)

Dr. Waite testified that he had examined Patient 1 for head injury. He stated that his examination was documented by his assessment of her vital signs, facial abrasions, pupils, extraocular muscles, range of motion, tympanic membranes and neck. He also stated that he had assessed for pain and documented it by saying "neck is supple and without tenderness." He noted that there was no mention of a headache. (Tr. I at 42-44)

Dr. Waite testified that he examined her scalp and skull for injury, although he had not documented it. He stated that, when there is no significant injury, he does not always document the lack of findings. (Tr. I at 44)

Dr. Waite testified that he had not discussed the skull fracture in the record because the CT scan report came back after the patient had been discharged. Dr. Waite explained in detail that he had reviewed the film himself and had not seen any evidence of bleeding around the brain, which is what he had been looking for. He further stated that he had not seen the skull fracture which was described in the CT scan report. Finally, he stated that he had not

commented on the CT scan in the medical record because he had known the report would be added to the chart at a later time. (Tr. I at 45-49) Dr. Waite explained,

My job is to make sure that there's not an obvious life threatening process that needs to be acted on right now. And, in fact, a nondisplaced fracture is not a life threatening process that needs to be addressed right now. If you have a depressed skull fracture, that is something that needs to be identified. That is something that I can see and appreciate. But, in fact, I'm not a radiologist and do not always see nondisplaced skull fractures.

(Tr. I at 49) Dr. Waite added that, although he did not document it, he remembers that the patient had been contacted, after her discharge, to advise her of the skull fracture. (Tr. I at 50)

Later, however, Dr. Waite was directed to the CT report, which indicated that the CT scan had been ordered two days after Patient 1's visit to the emergency department and had been ordered by a physician other than Dr. Waite. At that point, Dr. Waite acknowledged that he had neither ordered the CT scan nor reviewed the film. (Tr. I at 50-52, 72-73)

Dr. Waite acknowledged that he had not documented an examination of the chest wall. Nevertheless, Dr. Waite testified that he knows he did the examination because it is part of his routine examination. Dr. Waite also acknowledged that he had not ordered a chest x-ray. He stated that he had not done so "[b]ecause she didn't have chest pain on palpation of the chest, crepitus, ecchymosis or asymmetric breathing." (Tr. I at 55-57)

Dr. Waite testified that his examination of the spine was indicated by his documentation that "the neck is supple and without tenderness." Dr. Waite was then directed to the cervical spine radiology report which stated, "There is straightening of the normal lordotic curvature which may be related to muscle spasm. This appears to be most notable at the C5-6 interspace". Nevertheless, Dr. Waite opined that the radiologic findings were not inconsistent with a physical finding of "no tenderness." (Tr. I at 57-61)

Dr. Waite acknowledged that he had not ordered a pelvic x-ray. He explained that he had not done so because, on physical examination, he had not felt any bones moving. (Tr. I at 61-62) Dr. Waite further acknowledged that he should have ordered a pregnancy test and a urine test for hematuria. (Tr. I at 67)

Finally, Dr. Waite acknowledged that, in light of Patient 1's complaints of headache, nausea, facial trauma, neck muscle spasms, and questionable loss of consciousness, he should have ordered a CT scan of the brain and admitted Patient 1 for observation. (Tr. I at 71-72)

Testimony of Dr. Glauser regarding Patient 1

12. Initially, Dr. Glauser testified that he had not found deficiencies in Dr. Waite's treatment of Patient 1. He stated that, "The important circumstances of the motorcycle accident were performed as far as I can tell. A patient was injured in a motorcycle accident, not helmeted and thrown from a motorcycle. That's pretty much all that I think anybody could reasonably expect." Dr. Glauser testified that it was not necessary to document use of alcohol during or prior to the accident. He stated that having that information would not have affected treatment decisions. Dr. Glauser also initially testified that Patient 1's level of consciousness had been "well documented." Finally, Dr. Glauser opined that, even though a skull fracture had been found later in the CT scan, knowing that information at the time of Dr. Waite's evaluation would not have affected his treatment of Patient 1. (Tr. III at 18-22; Resp. Ex. D at 1-2)

Dr. Glauser further testified that the decision to not get a CT scan was justifiable. He stated that Patient 1 was alert and had no neurologic deficit. Moreover, he stated that, even if she had a loss of consciousness at the time of the accident, her level of consciousness upon presentation to the emergency department was the definitive factor. Dr. Glauser acknowledged that neurologic deficits may appear after a period of time but "not that often." Moreover, Dr. Glauser opined that, even though a skull fracture had been found later in the CT scan, knowing that information at the time of Dr. Waite's evaluation would not have affected his treatment of Patient 1. Dr. Glauser concluded that the decision to obtain a CT scan is a matter of judgment. (Tr. III at 18-22, 24-28)

Dr. Glauser noted also that Dr. Waite had not obtained a cervical spine x-ray. Nevertheless, Dr. Glauser concluded that Patient 1 had not demonstrated any criteria which would have justified obtaining one. (Tr. III at 28-32)

Later, Dr. Glauser admitted that he had not been aware in his review of the medical record that Patient 1 had been airborne at the time of the accident. Nevertheless, he stated that he is not sure it would have changed his opinion as to whether she needed a cervical spine x-ray, a head scan, or any other testing. He stated that he would still ask the same questions, such as, is there any neck pain, is there a neurologic deficit, is there evidence of substance abuse, or is there an injury which might distract the patient's attention from neck pain. Dr. Glauser concluded that a physician does not need to order an x-ray based on the mechanism of injury. (Tr. IV at 60-62, 63)

Nevertheless, when asked how he knows that Patient 1 was not intoxicated, Dr. Glauser testified that you have to rely on the judgment of the physician as to whether you are getting an accurate history. Dr. Glauser concluded that Dr. Waite should have asked the question and documented the answer. (Tr. IV at 62-68, 151-153)

Dr. Glauser testified that he would have liked to see better documentation regarding loss of consciousness and level of consciousness. (Tr. IV at 64-65) Moreover, Dr. Glauser

acknowledged that he could not find documentation of a chest x-ray or a chest wall examination which would have been appropriate. (Tr. III at 28)

Dr. Glauser testified that it would have been appropriate for Dr. Waite to obtain a pregnancy test in his management of Patient 1. He also testified that it would have been appropriate to test for blood in the urine. Nevertheless, when asked if Dr. Waite had conformed to the standards of care in his treatment of Patient 1, Dr. Glauser answered,

I don't know how to answer legalese like that. Because if I just told you I would have done things a little different * * * I am not going to say it violated a standard of care, but I wanted to see a urine. I would have wanted to see a pregnancy test.

(Tr. III at 35-38)

Dr. Glauser testified that it would have been appropriate for Dr. Waite to assess and document findings regarding Patient 1's headache. He stated that such findings determine the treatment. Nevertheless, Dr. Glauser testified that it is difficult to characterize a headache after an injury; therefore the physician relies more on the neurological exam than the specific details of the headache. However, Dr. Glauser testified that Dr. Waite should have mentioned it. (Tr. IV at 71-77)

Finally, Dr. Glauser testified that he would have liked to see additional documentation regarding Patient 1's condition upon discharge. He stated that Dr. Waite should have documented whether or not she was ambulatory. (Tr. III at 39)

Patient 2

Medical Records for Patient 2

13. On July 3, 2001, at 4:11 p.m., Patient 2, a 61-year-old female, presented to the emergency department at Grant Medical Center in Columbus, Ohio. Patient 2 complained of having had nausea, vomiting, and a headache over the past five days. Several days earlier, she had seen her primary care physician who had diagnosed her as having a sinus infection. The primary care physician gave her an antibiotic injection and prescriptions. In the emergency department, Patient 2 stated that she was continuing to feel ill and that her headache was only slightly improved. Nevertheless, only eight minutes after her arrival in the emergency department, Patient 2 reportedly rated her headache pain as "0/10." (St. Ex. 2A at 23)

At 5:40 p.m., Patient 2 reported her headache pain to be 8/10. She also complained of nausea. Benadryl and Compazine were administered intravenously. At 6:34 p.m.,

Patient 2 reported that she had had no relief from the pain medication. Toradol was given intravenously. (St. Ex. 2A at 25)

14. A CT scan of the brain [without contrast] revealed the following:

FINDINGS: Axial images of the brain were obtained without the use of IV contrast. Some of the images are degraded by patient motion. There is effacement of the sulci in the posterior aspect of the right parietal cortex near the vertex. No other sulci throughout the remainder of the brain are better appreciated. No intracranial mass or mass effect is seen. No intracranial hemorrhage is appreciated. No extra-axial fluid collections are present. The ventricles are normal and symmetric bilaterally. The visualized paranasal sinuses are clear.

IMPRESSION: Subtle effacement of the sulci involving the right parietal lobe near the vertex. Otherwise the examination is normal. A follow up examination such as MRI may be helpful to further evaluate for the possibility of a subtle abnormality at that site.

(St. Ex. 2A at 29)

15. In an emergency department note dictated by a physician assistant but signed by Dr. Waite, the following was documented, in part:

- **“CHIEF COMPLAINT(S):** Headache.”
- **“HISTORY OF PRESENT ILLNESS:”** The information recorded paralleled that recorded by the triage nurse.
- **“REVIEW OF SYSTEMS:** Review of systems is consistent with history of present illness. Patient admits to nausea and vomiting. She denies diarrhea. She denies abdominal pain. She denies fevers, sweats or chills. She denies chest pain. She denies neck stiffness. She denies shortness of breath.”
- **“PHYSICAL EXAMINATION:”** Patient 2’s blood pressure was 140/84, her heart rate was 102, and her respirations were 18. Her temperature was 97.5. Pupils were equal and reactive to light. Her nose was without erythema, without edema, without discharge in the interior vault. Throat was normal, pink tissue, with no cervical lymphadenopathy present. There was no meningismus.
- **“EMERGENCY DEPARTMENT COURSE:** Patient was seen and evaluated and disposition made by Dr. Waite. Medical decision making-Patient did receive while here in the emergency department Compazine 10, 50 of Benadryl and IV bolus of fluids. Following that she did receive 30 of Toradol. She states she is feeling much

better. She is being discharged to home. Dr. Waite is evaluating the patient as to whether or not the need for a CT. He will add an addendum to this report.”

(St. Ex. 2A at 9, 11)

In his addendum, Dr. Waite noted: “Patient complains of headache for several days but clinically has no evidence to support nuchal rigidity. She is not febrile, and has had no lateralizing signs. There is good motor strength in the upper and lower extremities. CT of the brain is pending and will be dictated as an addendum.” Dr. Waite’s preliminary diagnosis was cephalgia. (St. Ex. 2A at 15)

16. Patient 2 continued to complain of headache in the frontal lobe, but stated that she had had some relief. Dr. Waite discharged Patient 2. His discharge diagnosis was “tension, headache.” Patient 2 was given a prescription for Vicodin to be taken as needed. She was also instructed to follow up with “the clinic” as her primary care physician in seven days. (St. Ex. 2A at 27, 31)
17. On July 8, 2001, the physician assistant noted that she had spoken with the daughter of Patient 2. The daughter had informed the physician assistant that Patient 2 was then in another hospital recovering from surgery to repair a brain aneurysm. The brain aneurysm had been discovered after another physician ordered an MRI. The daughter noted that family members were “pressing for legal action.” (St. Ex. 2A at 19)
18. Patient 2 died on July 11, 2001, while a patient at Mount Carmel East Medical Center in Columbus, Ohio. Her Certificate of Death cites subarachnoid hemorrhage/intracranial hemorrhage as the immediate cause of death. It also lists intracranial aneurysm as an underlying cause. (St. Ex. 2B)

Testimony of Dr. Choo regarding Patient 2

19. Dr. Choo testified that Dr. Waite’s treatment and care of Patient No. 2 had deviated from standards of care. (Tr. II at 44-45; St. Ex. 10 at 11-12) Dr. Choo stated that a physician in an emergency department is responsible to “screen patients for catastrophic conditions, and appropriately triage and stabilize them.” Dr. Choo explained that, in this case, Dr. Waite’s workup and documentation had not met the standards necessary to screen for those catastrophic events. (Tr. II at 44-45)

First, Dr. Choo testified that, even though this proved not to be the source of Patient 2’s problems, Dr. Waite should have ruled out partially-treated meningitis. He explained that, when someone presents with Patient 2’s symptoms, the patient has not had a history of headaches, and the patient has been partially treated with antibiotic therapy for a suspected infection, partially-treated meningitis should be a concern. Dr. Choo testified that sinusitis can lead to meningitis especially when the sphenoid sinuses are involved. Dr. Choo acknowledged that Dr. Waite had documented “no meningismus.” Nevertheless, Dr. Choo

testified that, in a patient treated with antibiotics, a lack of meningismus does not preclude a finding of meningitis. Dr. Choo concluded that, in this circumstance, the only definitive test would have been a lumbar puncture or spinal tap. (Tr. II at 45-48)

Dr. Choo added that this is another example of Dr. Waite's disjointedness. He stated that Dr. Waite had been concerned enough about meningitis to document that there was no meningismus, an indication of nuchal rigidity or stiffness in the neck that would indicate a meningeal irritation. Nevertheless, Dr. Waite did not follow through to rule out meningitis in a satisfactory manner. (Tr. II at 42)

Similarly, Dr. Waite reviewed Patient 2's CT scan results, and indicated that there were no life-threatening reasons for her headache, such as a subarachnoid hemorrhage. Dr. Choo testified that, if Dr. Waite's concern had been a subarachnoid hemorrhage, he should have known that a CT scan was not the appropriate test to order. Dr. Choo explained that, after 24 hours, a CT scan will not rule out a subarachnoid hemorrhage because the blood would likely have been reabsorbed. Therefore, a spinal tap is necessary to rule out a subarachnoid hemorrhage in that situation. Dr. Choo concluded that Dr. Waite's failure to perform a spinal tap had fallen below the minimal standards of care because, once the suspicion of hemorrhage had been raised, he should have followed through with the appropriate evaluation. (Tr. II at 48-56, 61-63, 185-186, 192-194)

Dr. Choo testified that the classic presentation of a subarachnoid hemorrhage is sudden onset of "the worst headache in [the patient's] life." He acknowledged that Patient 2 had not had a classic presentation. Nevertheless, he noted that there were inconsistencies in the medical record regarding the degree of her pain. Dr. Choo further testified that the changing degree of Patient 2's headache pain might have resulted from treatment with pain medication. Dr. Choo explained that relief of symptoms with treatment does not preclude the underlying condition. (Tr. II at 57, 188, 234-235)

Dr. Choo further testified that Dr. Waite's documentation of "no lateralizing signs," an indication that there were no central neurological deficits, was not sufficient to rule out a subarachnoid hemorrhage. Dr. Choo explained that, in many cases of subarachnoid hemorrhage, there are no lateralizing signs. (Tr. II at 60-61)

Finally, Dr. Choo testified Dr. Waite should not have discharged Patient 2, but should have admitted her to the hospital for further evaluation. He noted that the problems which led to Patient 2's death could have been discovered in the emergency department or during the admission following the emergency department visit. (Tr. II at 58-59)

Testimony of Dr. Waite regarding Patient 2

20. Dr. Waite testified that, after being given medications for her headache, Patient 2 had felt better and "asked for the opportunity to be discharged." He stated that, because there had

been no worrisome findings on the CT scan or examination, he had believed it safe to discharge her. (Tr. I at 83-84, 87)

Dr. Waite testified that he had ordered the CT scan because Patient 2 had been diagnosed with sinusitis and had presented with an atypical headache. He stated that the CT scan had been indicated to determine if her sinus infection had worsened. He added that he had also been concerned about intracranial pathology. (Tr. I at 86-87, 90)

Dr. Waite disagreed with Dr. Choo's testimony that Dr. Waite had not been concerned that Patient 2 may have been partially treated for meningitis. Dr. Waite testified that his concern is reflected in his documentation that there was "no meningismus." Dr. Waite further explained that he had ruled out partially treated meningitis because Patient 2 had not had a fever or meningismus. Moreover, she had been taking appropriate antibiotics for a sinus infection. He acknowledged that Patient 2 had complained that the antibiotics were not effective, but he added that it is not atypical that a patient would not have total relief before the full course of antibiotics had been completed. (Tr. I at 90-93, 144-145)

Dr. Waite further testified that he had been less concerned that Patient 2 had had a subarachnoid hemorrhage. He explained that her symptoms were not the typical presentation for a subarachnoid hemorrhage. Nevertheless, he stated that, with a headache, a physician is always concerned about subarachnoid hemorrhage. Nevertheless, Dr. Waite testified that a physician is able to rule out a subarachnoid hemorrhage without performing a lumbar puncture or spinal tap. He stated that Patient 2 had not presented with the type of headache which would suggest a subarachnoid hemorrhage, and the physical examination argued against it. In addition, the CT scan did not reveal a subarachnoid hemorrhage. Dr. Waite acknowledged that a CT scan is not necessarily reliable with the passage of time, but stated that a lumbar puncture is similarly unreliable. (Tr. I at 93-94, 98-100, 144-145)

Dr. Waite testified that he had not considered hospitalizing Patient 2 for further evaluation of her headache because he had ruled out any life-threatening processes, such as "an infectious process with the history and physical; a bleeding event with CT scan; [or] a tumor with CT scan." (Tr. I at 144-145)

Testimony of Dr. Glauser regarding Patient 2

21. Dr. Glauser testified that there had been no indication that Patient 2 had had meningitis. He stated that her neck had been supple and she had not had a fever. Therefore, he concluded that Dr. Waite had not needed to perform a lumbar puncture to assess Patient 2 for partially treated meningitis. (Tr. III at 46-49; Tr. IV at 6-7, 11-12; Resp. Ex. D at 2-3)

Dr. Glauser also testified that Dr. Waite had appropriately assessed intracranial pathologies because he had ordered the CT scan. When asked if Dr. Waite should have performed a lumbar puncture to rule out intracranial pathologies other than partially-treated meningitis,

Dr. Glauser testified that a physician cannot perform a lumbar puncture on every patient who comes to the emergency department with a headache. He stated that a lumbar puncture is appropriate to evaluation for an intracranial hemorrhage when the patient presents with a “thunderclap headache,” which is an excruciating headache of sudden onset. Dr. Glauser concluded that Patient 2 had not done so; therefore, a lumbar puncture had not been indicated. (Tr. III at 47; Tr. IV at 7-11, 90-91, 150-151)

Dr. Glauser also testified that a headache that is caused by a subarachnoid hemorrhage does not “wax and wane” as did Patient 2’s headache. He acknowledged, however, that Patient 2 had been treated with medication for pain which may have had some effect on the consistency of her headache. (Tr. IV at 92)

Nevertheless, Dr. Glauser testified that he would have liked to have seen a more detailed history including a description of the onset of the headache. He stated that, had Dr. Waite more clearly defined the onset of the headache as having had a gradual onset, there would have been no question about the need for a lumbar puncture. (Tr. IV at 6, 7-8, 11-12, 93)

When asked if Dr. Waite’s care of Patient 2 had complied with the standards of care, Dr. Glauser testified that he would have to “waffle” on his answer due to the lack of appropriate documentation. (Tr. IV at 12-13)

Patient 3

Medical Records for Patient 3

22. On April 20, 1998, Patient 3, a 54-year-old male, presented to the Emergency Department at the Ashtabula County Medical Center. Patient 3 complained of right-sided flank pain after falling to the floor three days earlier. The triage nurse noted ecchymosis in the right rib area. Breath sounds were clear with no shortness of breath. He was moving all extremities and was alert and oriented. There was an odor of alcohol noted, and Patient 3 stated that he had had two beers that day. Blood pressure was 84/60 on the right and 98/70 on the left. (St. Ex. 3 at 3)
23. A PA and lateral chest x-ray revealed acute fractures of the right sixth through eighth ribs and subcutaneous emphysema in the soft tissues. The right lung field also demonstrated a small pleural effusion, most likely consistent with a hemothorax. No definite pneumothorax was noted and there was no shift of the mediastinum. (St. Ex. 3 at 11)
24. Patient 3’s medical record as certified by the hospital does not contain an emergency department note prepared by Dr. Waite. The certified record does contain, however, at the bottom of the Emergency Department Record, Dr. Waite’s instructions that Patient 3 should follow-up at a clinic or return to the Emergency Department if he experienced chest pain or shortness of breath, and that he should take Percocet for pain. Dr. Waite also recorded diagnoses of multiple rib fractures and hemothorax. (St. Ex. 3 at 3)

25. Shortly before hearing, Dr. Waite presented an emergency department note for Patient 3.² In that note, Dr. Waite documented, in part, the following:

- **“CHIEF COMPLAINT(S):** Back pain.”
- **“HISTORY OF PRESENT ILLNESS:** This 53-year-old male states he fell 3 days ago striking the floor injuring the right side of his chest. Has noticed purple discoloration to the chest and has traveled to the emergency department for evaluation. He is denying shortness of breath or other constitutional symptoms with the exception of pain at the chest.”
- **“REVIEW OF SYMPTOMS:** Negative for cardiovascular, respiratory, GI, GU, neurological, ENT, eye, hemopoietic, endocrine, psych or dermatologic symptoms. There are musculoskeletal symptoms of pain, right chest, as stated.”
- **“SOCIAL HISTORY:** Significant for alcohol use.”
- **“PHYSICAL EXAMINATION:”** Afebrile. Not tachypneic or tachycardic. Heart rhythm regular without rubs or gallops. Bilateral breath sounds, rales at the right base. No wheezes or rhonchi. No flailing or free moving segment of the chest. Abdomen soft and nontender. Extremities show no deformity or swelling. No sensory deficits.
- **“MEDICAL DECISION-MAKING:** Differentiate hemothorax, pneumothorax, rib fracture, rib contusion, chest wall contusion. This patient had evidence to support rib fracture on exam with crepitus palpable. Chest x-ray demonstrates multiple rib fractures with a hemothorax. No pneumothorax is appreciated. The patient is not hypoxic with a pulse ox of 95% on room air. It is felt that he will benefit from surgical follow-up as he may require aspiration of the hemothorax. At the time of emergency department exam, the patient has an expanded lung and is oxygenating well, is complaining only of pain. It is felt that he will benefit from analgesics and follow. Dr. Hearn on call for surgery contacted and agrees with this plan.”

(Resp. Ex. C)

Testimony of Dr. Choo regarding Patient 3

26. Dr. Choo testified that Dr. Waite’s care and treatment of Patient 3 had failed to conform to the minimal standards of care. (Tr. II at 65-70; St. Ex. 10 at 3-4) For example, Dr. Choo testified that Patient 3 had presented with abnormal vital signs including hypotension.

² See the following pages in the hearing transcript for a discussion of how Dr. Waite obtained that document: Volume I at 8-10, 17-22, 104-105, 120-131; Volume IV at 171-172, 227-229)

Despite this, Patient 3 was discharged without any repeat vital signs. Moreover, nothing was done in an attempt to identify the reason for the vital sign abnormality. In addition, Dr. Choo noted that it was interesting that Dr. Waite, in his dictated note, had mentioned only the blood pressure of 90/70 and had failed to mention the blood pressure of 84/60. (Tr. II at 65-70, 75, 83, 196-197, 196-200)

Dr. Choo further testified that there was no description of the fall or the cause of the fall. More specifically, Dr. Choo testified that the velocity and distance of the fall could affect treatment decisions. He further testified that both the standards of care and ATLS guidelines require that the physician document the events surrounding a trauma. (Tr. II at 67, 73, 200-202, 236)

Dr. Choo testified that Dr. Waite did not do anything to address the hemothorax, such as checking the hemoglobin. Dr. Choo testified that:

[H]emothorax, by definition, is blood in the thorax, caused by trauma of various sorts, either penetrating or blunt trauma, and to have a hemothorax be visible on a chest x-ray, you have to have at least 200 CCs of blood in the chest cavity. So, you know, that's a pretty significant amount of blood, and it happened a few days ago. The question is did his hemoglobin drop? Was he bleeding internally, or did he have loss of a significant amount of blood? And I thought that would be a main point to address.

(Tr. II at 71, 76-77, 79-81, 202-203)

In addition, Dr. Choo testified that Dr. Waite had failed to address the odor of alcohol. Dr. Choo testified that, even though Patient 3 stated that he had only consumed two beers, it is important to evaluate the degree of intoxication. Dr. Choo stated that this is important because, if the patient is intoxicated, the physician cannot trust the reported history. Moreover, Dr. Choo explained that patients do not always admit the truth when discussing alcohol consumption. At the same time, because Patient 3's history is significant for alcohol, it may be an indication that he functions well with a high blood alcohol level. Dr. Choo concluded that Dr. Waite's failure to address the odor of alcohol had fallen below the minimal standards of care. (Tr. II at 71-75, 204)

Dr. Choo testified that that, at the time he wrote his report, he had opined that Dr. Waite had failed to consider Patient 3's subcutaneous emphysema and had failed to refer Patient 3 for surgical evaluation. He further testified, however, that, after reviewing the dictated note Dr. Waite had provided shortly before hearing, it appeared that Dr. Waite had done these things. (Tr. II at 76, 78)

Testimony of Dr. Waite regarding Patient 3

27. Dr. Waite testified that Patient 3's first blood pressure had been low but that the second blood pressure was not "worrisome." (Tr. I at 115-116) Moreover, Dr. Waite opined that nurses had taken orthostatic blood pressures: one while Patient 3 was lying down, and the second when Patient 3 was sitting. Dr. Waite explained,

To appreciate a fall in the blood pressure, were there evidence of low blood pressure, blood pressures will go from said number to a lower number when you go from a lying down to sitting up position, when there's concern for a blood loss or a low blood pressure. In fact, in his case it went up, suggestive against that. And in fact, the fact that a blood pressure was done immediately after is really attempting to assess is this really a low blood pressure or, you know, is my cuff just not on right.

(Tr. I at 115-116) Dr. Waite did not discuss the possibility the blood pressures had been taken in different arms rather than in different positions. Dr. Waite further testified that a physician can assess perfusion by "examining capillary refill, by feeling pulse, by listening to a patient talk, and by [assessing] his color." (Tr. I at 115-116)

Dr. Waite testified that he cannot remember if he had smelled an odor of alcohol about Patient 3. He does remember telling him not to drive while taking Percocet or drinking alcohol. (Tr. I at 116-117) Regarding alcohol, Dr. Waite explained:

The big issue in emergency medicine is whether or not a patient can protect themselves, because people drink alcohol every day. We're concerned in a medical standpoint -- or in a medical situation with whether or not they are able to take care of themselves away from the emergency department, not so much what everybody coming into the emergency department's level is. If you're demonstrating the ability to protect yourself, if you're not stumbling and slurring speech and just unable to really function, it's not as important what your number is, because this patient had actually already admitted to drinking alcohol. So there was no confusion. If you're confused and lethargic and I can't get a history that you drank alcohol, and I'm concerned about what your mental state is and why you're like that, then an alcohol [test] would be important. In this case he's already admitted to drinking alcohol.

(Tr. I at 117-118)

Dr. Waite testified that, in the dictated note not found in the certified record, he had documented that he had contacted Dr. Hearn who was the surgeon on call and that Dr. Hearn had agreed with his plan. (Tr. IV at 169; Resp. Ex. C)

Testimony of Dr. Glauser regarding Patient 3

28. Dr. Glauser testified that he had first assumed that the two blood pressures had been taken in different positions rather than in different arms. Nevertheless, he testified that even if the two blood pressures had been taken in different arms, he maintained that there had been no reason to be concerned about Patient 3's "borderline hypotension." As basis for his opinion, Dr. Glauser explained that alcohol is a vasodilator which can cause hypotension. (Tr. IV at 14-17, 99-100)

On cross-examination, Dr. Glauser admitted that it would have been appropriate to recheck Patient 3's blood pressure before discharge. (Tr. IV at 102-103)

Dr. Glauser further testified that, since Patient 3 had presented in stable condition on the third day following his injury, there really had not been much that needed to be done. Dr. Glauser concluded that Dr. Waite's treatment of Patient 3 had complied with the standards of care. (Tr. IV at 18 Resp. Ex. D at 3)

Patient 4

Medical Records for Patient 4

29. On September 7, 1997, Patient 4, a ten-day-old female, presented to the Emergency Department at Ashtabula County Medical Center with a rectal temperature of 103.3 and "grunting." The triage nurse documented that the baby had been held by a five-year-old who had fallen while holding the baby; the baby had hit her head on the floor. She had also had streaks of blood in her stool. (St. Ex. 4 at 3)
30. In his emergency department note, Dr. Waite documented, in part, the following:
- **"CHIEF COMPLAINT(S):** Fever."
 - **"PHYSICAL EXAMINATION:** Temperature 103.3, pulse 70, respiratory rate 40 and no blood pressure taken on this patient. Mentating well. Brisk capillary refill. Child awake and alert. Looks well hydrated. Moist conjunctivae. Moist oropharynx. No evidence to support bulging fontanel. Neck is supple. CVS: Regular. LUNGS: Clear. ABDOMEN: Soft and nontender. Stool is seen in the diaper firm. There is some bloody mucus seen in the stool, however, abdomen is soft and nontender. EXTREMITIES: No deformity or swelling.

"The differential in this patient would include meningitis, pneumonia, sepsis and it is not felt that the patient is septic. The patient looks well and feeds well in the emergency department. Able to take 4 oz. in a rapid amount of time in the emergency department. No vomiting. Again, looks well to examiner. There was

incidental history of child being dropped by older sibling at roughly five, some 10 hours prior to this emergency department visit. Again, patient does not demonstrate a depressed skull fracture, unlikely intracranial hemorrhage in this patient who is sucking well in the emergency department and has had no vomiting. Likely viral syndrome. Mother gives history of being sick this week and questions whether or not child may have the same thing she has.”

- “**MEDICAL DECISION-MAKING:** High complexity.”
- “**PROCEDURE PERFORMED:** None.”

(St. Ex. 4 at 15)

31. Dr. Waite diagnosed “viral syndrome.” He recommended that Patient 4 follow-up with a family physician, return if vomiting, and use infant Tylenol for fever. (St. Ex. 4 at 3, 15)

Testimony of Dr. Choo regarding Patient 4

32. Dr. Choo testified that Dr. Waite had failed to conform to the minimal standards of care in his treatment of Patient 4. (Tr. II at 89-90; St. Ex. 10 at 7-8) Dr. Choo testified that a fever workup in a child less than thirty days old requires a full septic workup because physical examination is deemed to be unreliable. Dr. Choo emphasized that there is no clinical judgment involved; a full septic workup is required. The septic workup should include blood cultures, urine cultures, chest x-ray and spinal tap. Moreover, the infant is always admitted for further evaluation. Dr. Choo testified that Dr. Waite had done none of these things. Dr. Choo testified that missing a diagnosis of sepsis could result in an infant’s death. (Tr. II at 89-90, 91, 93)

Dr. Choo added that a septic workup had also been warranted by the fact that there was blood in the child’s stool. He stated that the concern would be necrotizing enterocolitis [NEC] which required septic workup and abdominal x-rays. Moreover, because NEC is often the result of trauma and hypoxia to the abdomen during delivery, Dr. Waite should have documented an extensive history regarding the pregnancy and delivery. Finally, as in sepsis, Dr. Choo testified that missing a diagnosis of NEC could result in an infant’s death. (Tr. II at 92-93)

Noting that the mother had been ill earlier in the week, Dr. Choo further testified that Dr. Waite should have documented information regarding the mother’s illness. Nevertheless, Dr. Choo maintained that, despite the fact that the mother had been ill, a septic workup had been required on this infant. (Tr. II at 90)

Dr. Choo testified that he had also had concerns regarding Patient 4’s grunting. He further explained that grunting is often an indication that the lungs are filled with fluid, which

could result from pneumonia or congenital deformity. He stated that grunting is an attempt to force air into the lung to increase positive end expiratory pressure [PEEP] to help keep the alveoli open. With grunting, the physician should assess for nasal flaring and cyanosis of the fingertips. In addition, a chest x-ray is indicated. Dr. Choo noted that Dr. Waite had done none of these things. (Tr. II at 94-95)

Testimony of Dr. Waite regarding Patient 4

33. Dr. Waite testified that it would have been appropriate to order a complete septic workup for Patient 4, and acknowledged that he had not done so. Dr. Waite testified that he had believed that the child's mother and her siblings had been suffering from a viral syndrome, and that the infant had acquired the family's illness. Nevertheless, Dr. Waite could not explain why the record only noted that the mother had been ill. Moreover, he could not explain why he had not documented family members' symptoms or other facts regarding their illnesses. Dr. Waite acknowledged that he had "assumed that the mother had a flu, a viral syndrome" and then "further assumed that the child had the same viral syndrome." He further acknowledged, however, that he had not documented his assumptions. (Tr. I at 147-150, 172-175)

Dr. Waite conceded that his care and treatment of Patient 4 had fallen below the minimal standards of care. (Tr. I at 149-153, 175-176) Dr. Waite explained:

I missed this. I missed this. Looking at this, it screams to me that I messed up. * * * I think that I lost in -- you know, in -- I lost in the history from mom, you know, that, you know, we're all -- we all got the same thing. I lost the fact that this was a ten-day-old baby. I lost that and said it doesn't matter; you still have to do all these things. The gross majority of these patients don't have sepsis, and I lost that. I didn't do everything because the baby looked so good, and there was a decent enough history that I said, you know, we probably are okay. But it didn't matter. I needed to do the septic workup. Admittedly, I dropped the ball on this case.

(Tr. I at 154-153)

Testimony of Dr. Glauser regarding Patient 4

34. Dr. Glauser testified that Dr. Waite's care and treatment of Patient 4 had been completely unacceptable. He further stated that he could not "defend the care in this case." Finally, Dr. Glauser testified that he would not expect that a physician who had recently completed a residency would "make such a clinical mistake." (Tr. IV at 21, 49-50, 107; Resp. Ex. D at 3)

Patient 5

Medical Records for Patient 5

35. On March 17, 1998, at 3:30 a.m., Patient 5, a 52-year-old female, presented to the Emergency Department at Ashtabula County Medical Center. The nursing triage note indicates that Patient 5 complained of having had dull pain under the left breast since approximately 2 a.m. She also complained of shortness of breath, nausea, headache, and hot flashes. Her skin was warm and dry, and she denied diaphoresis. She was alert and oriented. Her blood pressure was 166/72, pulse 92, and respirations 20. Patient 5 had a history of cerebral vascular accidents, non-insulin dependent diabetes mellitus, and depression. Among other medications, Patient 5 was taking Coumadin 5 mg daily. (St. Ex. 5A at 3)
36. Patient 5's CK-MB was 1.4 [normal value 0.0-3.8], and her Troponin I level was less than 0.35, suggesting a "healthy individual." Hematology studies revealed a hemoglobin of 10.9 [normal value: 12.0-16.0] and a hematocrit of 33.2 [normal value 36.0-46.0]. (St. Ex. 5A at 15, 19, 21)

An electrocardiogram [EKG] taken at 3:41 a.m. revealed normal sinus rhythm, rate 96, with nonspecific inferior T-wave abnormalities. A chest x-ray was normal. (St. Ex. 5A at 25, 29)

37. In his emergency department note, Dr. Waite documented, in part, the following:
- **"CHIEF COMPLAINT(S):** Chest Pain."
 - **"HISTORY OF PRESENT ILLNESS:"** Chest pain began approximately two hours prior to the emergency department visit. Patient complained of difficulty breathing with chest discomfort, but denies diaphoresis. She also complained of nausea and headache. She has chronic medical problems including diabetes, depression, and cerebrovascular accident.
 - **"CURRENT MEDICATIONS:** Glucophage, Zolofit and Coumadin."
 - **"REVIEW OF SYSTEMS:** Negative for GU, ENT, eye, hematopoietic, endocrine, musculoskeletal, psych, or dermatologic symptoms. There are cardiopulmonary, GI, neuro symptoms as stated in the HPI."
 - **"PHYSICAL EXAMINATION:** Afebrile, hemodynamically stable not tachypneic. Atraumatic. Normocephalic head. Moist conjunctiva. Moist oropharynx. No evidence of otorrhea or rhinorrhea. No evidence of epistaxis. EOMs: Full range of motion. CVS: Regular without rubs, gallop or murmurs. Lungs: Clear without wheezes, rales, or rhonchi. Abdomen: Abdomen soft and nontender. Active bowel

sounds. Extremities: Extremities show no deformity or swelling. Skin: warm and dry. Neurological: the patient is appropriate. No motor or sensory deficits of the upper or lower extremities.”

- **“TREATMENT AND CARE GIVEN IN THE EMERGENCY DEPARTMENT:** The chest x-ray shows no evidence of infiltrate or effusion. Cardiac enzymes are not elevated. The EKG demonstrates a normal sinus rhythm with narrow complex, good R-wave progression. There are nonspecific T-wave changes in the inferior leads which will be compared to an old EKG if available.”
- **“MEDICAL DECISION-MAKING:** This patient evaluated for myocardial chest pain, evaluate for pneumonic chest pain, evaluate headache for neuro compromise. This patient has no evidence to support pneumonia or congestive failure.”
- **“DISPOSITION OF PATIENT:** During the patient’s ER visit, she had resolution of her chest discomfort. No drugs were instituted. This patient complains primarily of headache after arrival in the emergency department. She receives Toradol for her headache and had improvement of her head pain. She states no further chest pain or shortness of breath. It is felt that in light of negative enzymes and resolution of her symptoms, that she can be safely discharged with instructions to follow up with her private medical doctor. She will be discharged and encouraged to return if chest pain reoccurs or shortness of breath. The patient is stable at the time of discharge.”
- **“DISCHARGE DIAGNOSIS(ES):** Atypical chest pain.”

(St. Ex. 5A at 9, 11)

38. Dr. Waite did not report any findings of bruising on Patient 5’s body. (St. Ex. 5A)
39. At 6:35 a.m., a nurse documented that Patient 5 was free from chest pain and shortness of breath. She also stated that Patient 5’s headache was “much improved.” (St. Ex. 5A at 23) Dr. Waite prescribed Toradol to be taken at home. (St. Ex. 5A at 33)
40. Patient 5 returned to the emergency room approximately seven hours later complaining of blurred vision, nausea and vomiting, frontal headache, numbness and tingling in her left hand, and “new bruising” in her neck and jaw. “Old bruising” was noted on her arms, legs and abdomen. A CT scan revealed bilateral subdural hematomas, cerebral swelling, and a small midline shift. Her INR was 7.4. She was transferred to the Cleveland Clinic via Life Flight. (St. Ex. 5A at 35, 41, 43)

Patient 5 was discharged from the Cleveland Clinic on April 1, 1998, to a facility for “acute rehabilitation.” (St. Ex. 5B at 63, 65)

Testimony of Dr. Choo regarding Patient 5

41. Dr. Choo testified that Dr. Waite had failed to conform to the standards of care in his treatment of Patient 5. (Tr. II at 97; St. Ex. 10 at 5-7) Dr. Choo testified that Patient 5's presenting complaints of chest pain, shortness of breath, and nausea should have raised concerns about acute coronary syndrome. He noted that Patient 5 was a diabetic with a history of vascular disease as evidenced by strokes in the past, and opined that Patient 5 should have been admitted to the hospital for continued evaluation of her cardiac status. (Tr. II at 97-98)

Dr. Choo added that Dr. Waite's work up of Patient 5 had been disjointed. He explained that Patient 5's chest pain had started only ninety minutes prior to her emergency department visit, which was not enough time to allow an elevation of cardiac enzymes. Therefore, even if cardiac enzymes were normal, they could not have been relied upon to rule out a cardiac event. In that case, serial enzymes would have been appropriate prior to discharge. Dr. Choo concluded that Dr. Waite had failed to follow through with the cardiac work up. He again stated that Patient 5 should have been admitted to the hospital. (Tr. II at 101-102)

Dr. Choo further testified that Dr. Waite had inappropriately treated Patient 5's complaint of headache. First, Dr. Choo testified that Dr. Waite should have documented his assessment of Patient 5's headache, including the type, duration, quality, and location of the headache as well as associated pertinent symptoms. Dr. Choo also testified that Dr. Waite should have performed a fundoscopic examination because, in diabetics, papilledema must be considered. The fundoscopic examination is often the first indication of increased intracranial pressure. Failure to do a fundoscopic examination was inconsistent with the standards of care. (Tr. II at 102-106)

Dr. Choo further explained that Dr. Waite had treated the headache without giving consideration to the potential adverse or catastrophic effects of Coumadin which Patient 5 had been taking. Dr. Choo stated that Coumadin is a blood thinner used to prevent coagulation. Dr. Choo testified that anyone who is taking Coumadin and who presents with headache must be assessed for potential intracranial bleeding. This is done by ordering coagulation studies, specifically the international normalized ratio [INR], and obtaining a CT scan to be sure that there is no insidious bleeding within the head. He stated that these things are especially important to do before administering Toradol which can also decrease coagulation. (Tr. II at 98-100, 102-104, 106-108, 207-209, 238-239)

Dr. Choo noted that, in a subsequent admission, Patient 5 was found to have bilateral subdural hematomas and an INR of 11. He stated that the desired level for the INR is 2, and that an INR of 11 is extremely high and that spontaneous bleeding may result. (Tr. II at 111)

42. Dr. Choo did not address the “old bruising” that had been found on Patient 5’s body when she returned to the emergency department seven hours after she had been treated by Dr. Waite.

Testimony of Dr. Waite regarding Patient 5

43. Dr. Waite testified that cardiac enzymes are not always elevated within two hours of the onset of a cardiac incident. Nevertheless, Dr. Waite testified that he had not obtained serial enzymes because her chest pain had resolved in the emergency department. Dr. Waite explained that, when a patient comes to the emergency department with a complaint, the physician must evaluate various organ systems. With complaints of chest pain, he considers cardiac, gastrointestinal, and pulmonary etiologies. Dr. Waite stated that he had ruled out a cardiac etiology of Patient 5’s complaints based on the resolution of her pain and the negative cardiac enzymes. (Tr. I at 160-161, 179-180)

Dr. Waite further testified that he recognizes now that she would have benefited from serial enzymes, especially in light of her diabetes. He stated that eight years of medical practice have helped him to better manage his patients. He admitted that he had made some mistakes shortly after finishing his residency. (Tr. I at 161-162)

Dr. Waite testified that he had failed to evaluate an anticoagulation profile because he had been focused on Patient 5’s chief complaint of chest pain. Moreover, Dr. Waite acknowledged that Toradol should be used with caution in patients who have a high risk of bleeding. He admitted that he had not weighed the risks and benefits of using Toradol in this patient. (Tr. I at 162-164, 170-174)

Dr. Waite further acknowledged that he had “not done much” regarding Patient 5’s complaint of headaches. He reiterated that it was a secondary complaint, and that he had been focused on the chest pain. He acknowledged that he should have focused more on the headache. Dr. Waite testified that he would manage this patient differently today. (Tr. I at 164, 168-170)

In addition, Dr. Waite acknowledged that he had not evaluated Patient 5 for temporal arteritis, which can lead to blindness, or for nuchal rigidity. Moreover, he had not performed a fundoscopic examination to evaluate for papilledema. Dr. Waite explained that different types of headaches present with different symptomatology, and it is not necessary to screen for every type of headache on every patient. (Tr. I at 166-170, 177-178)

Finally, Dr. Waite acknowledged that his failure to check Patient 5’s INR had been a deviation from the standards of care. He further testified that it would have been appropriate to document the thought process that led to his decision-making. (Tr. I at 180-181)

Testimony of Dr. Glauser regarding Patient 5

44. Dr. Glauser testified that the decision to order serial enzymes or not is a matter of judgment. Similarly, he stated that it is not necessary to admit every patient who complains of chest pain, and that decision is also a matter of judgment. Nevertheless, Dr. Glauser testified that Patient 5 should have been observed or hospitalized for her complaints of chest pain in light of her many risk factors. (Tr. IV at 23-24, 25, 27, 108-109, 118-121, 146-148, 156; Resp. Ex. D at 3-4)

Dr. Glauser testified that “it would have been nice to know the INR,” but that it is not routinely checked in a patient with complaints of chest pain. Nevertheless, he stated that one of the differential diagnoses in this case would have been a pulmonary embolus, and that the INR may have been helpful to rule out a pulmonary embolus. (Tr. IV at 24)

Dr. Glauser testified that it had not been necessary to evaluate her sedimentation rate to rule out temporal arteritis, especially in a patient whose main complaint was chest pain. (Tr. IV at 25-26)

Finally, Dr. Glauser testified that Patient 5’s chief complaint was chest pain, and that is where Dr. Waite should have devoted the most attention. Nevertheless Dr. Glauser concluded that Dr. Waite should have checked the INR. Had it been high, Dr. Waite would have had the option of ordering a head CT scan to evaluate the headache. Dr. Glauser surmised that, had he done so, we would not be discussing this case today. Dr. Glauser concluded that Dr. Waite’s failure to check INR had been a failure to comply with the standards of care. (Tr. IV at 26-31, 110-113)

Patient 6

Medical Records for Patient 6

45. On October 29, 1997, at approximately 10:00 p.m., Patient 6, a 13-month-old male, presented to the Emergency Department at Ashtabula County Medical Center. The nursing triage note revealed that the child had been congested with difficult breathing and a barking cough. He also had stridor and was using his accessory muscles to breathe. He was seen by Dr. Waite, who ordered one liter of oxygen through a nasal cannula and 0.1 mg of racemic epinephrine aerosol. Dr. Waite diagnosed Patient 6 with laryngotracheitis/croup. Dr. Waite noted that Patient 6 would be admitted to the pediatric unit under the care of Dr. Wnek. (St. Ex. 6 at 23)
46. In his emergency department note, Dr. Waite documented, in part, the following:

- **“CHIEF COMPLAINT(S): Difficulty Breathing.”**

- **“PHYSICAL EXAMINATION:”** There was evidence of posterior larynx swelling. No wheezes were heard.
- **“ASSESSMENT:** Would include laryngotracheitis versus pneumonia versus reactive airway disease. Clinically patient is suffering from laryngotracheitis. It is felt that he will benefit from racemic epinephrine. Patient is hypoxic at 80% on room air. It is felt that he will benefit from oxygen and will be admitted to the floor for further management.”
- **“MEDICAL DECISION-MAKING:** High complexity.”
- **“ADDENDUM:** The patient required placement in a papoose in an attempt to have oxygen placed as a nasal cannula. The child was very irritable and hypoxic and required placement of nasal cannula oxygen. The patient was very uncomfortable with placement of nasal cannula and continued to pull the cannula from his nose. At that time it was felt that the patient warranted placement in the papoose in order to limit his ability to remove the nasal cannula. After placement of nasal cannula oxygen, the saturation improved to 99% on 2 liters and it was felt at the patient would benefit from continued oxygen therapy as well as continued aerosols. The respiratory service was contacted and alerted to the need for urgent aerosols once arriving on the floor and were ready to administer it when the patient arrived on the floor.”

(St. Ex. 6 at 27, 29, 31)

47. In a nurse’s note, the following is documented:

22:05. Crying. HR 174. Exam by Dr. Waite. Pulse ox 87%. Aerosol treatment. O₂ per 2L NC. Child irritable-Mom holding. O₂ sat 89%. Crying. Papoose applied per order Dr. Waite. O₂ NC↑. O₂ sat 99%. O₂ at 2L NC. Report called to 4N.

(St. Ex. 6 at 33) On the same document, the nurse noted that she had called the report to the floor at 11:00 p.m. (St. Ex. 6 at 33)

In the respiratory care sheet, however, it is noted that, at 10:18 p.m., Patient 6 received one dose of racemic epinephrine via aerosol. At that point, he had a harsh croupy cough and wheezing. His oxygen saturation on room air was 87%. (St. Ex. 6 at 21)

In a nursing care plan, it was noted that, at 11:30 p.m., Patient 6 had been transferred from the emergency department on a cart, “strapped in papoose, crying. Mother extremely upset. Child released from papoose, placed in mom’s arms. Assurance given.” (St. Ex. 6 at 59)

48. Patient 6 received a second dose of racemic epinephrine via aerosol at 11:40 p.m. At 12:10 a.m., Dr. Wnek provided telephone orders to the nurses on the floor. Racemic epinephrine was ordered as needed for stridor. However, no additional doses were necessary. (St. Ex. 6 at 21, 35)

Patient 6 was discharged the following afternoon. At that time, he had no stridor and his lungs were clear. Oxygen saturation on room air was normal. (St. Ex. 6 at 15, 17 37, 39)

Testimony of Dr. Choo regarding Patient 6

49. Dr. Choo testified that Dr. Waite had failed to comply with the minimal standards of care in his treatment of Patient 6. (Tr. II at 112-113; St. Ex. 10 at 4-5) Dr. Choo testified that Dr. Waite had diagnosed Patient 6 as suffering from croup, or laryngotracheitis. Dr. Choo explained that croup generally falls into two categories: one results from a bowel infection and follows like a viral syndrome; the other is spasmodic croup, which is likely allergy related. He stated that spasmodic croup comes on suddenly and then sometimes resolves. Dr. Choo testified that Dr. Waite did not document sufficient history to make that distinction. (Tr. II at 113-114)

In addition, Dr. Choo testified that, once a physician diagnoses croup, it is important to determine that there are no other problems occurring. Dr. Choo testified that Dr. Waite had failed to document his consideration of other causes for Patient 6's stridor and hypoxia, which fell below the minimal standards of care. In that vein, it would have been appropriate to obtain a chest or neck x-ray to evaluate for foreign body aspiration or pneumonia. Dr. Choo stated that simply because the patient's temperature was not elevated does not rule out pneumonia. Nevertheless, Dr. Choo testified that, because Dr. Waite had been so convinced that the problem was laryngotracheitis, failure to consider other diagnoses in this case did not fall below the minimal standards of care. (Tr. II at 114-115, 129-133, 136-137)

Dr. Choo testified that, while ruling out other problems, it is important to treat the patient's symptoms, initially with humidified air or a vaporizer, to soothe the airway. If that is not effective, then racemic epinephrine is appropriate. If racemic epinephrine is not effective, or if the child is hypoxic, then treatment with steroids should be considered and that consideration documented. It is important then to observe the child for several hours in the emergency department after which, depending on how the child responds to the treatment, the child is either admitted to the hospital or discharged. (Tr. II at 114-115, 134, 134, 210-211)

Dr. Choo testified that, if the patient presents with laryngotracheitis which is severe enough to cause hypoxia, it is appropriate to administer steroids. Dr. Waite's failure to do so had been a violation of the standards of care. (Tr. II at 134-135, 137)

Dr. Choo also testified that it is very important in treating a child in respiratory distress to do nothing to agitate the child. Agitation only increases the respiratory distress. He explained that treatment providers tend to stay away from the child as much as possible and leave them in the comforting arms of the parent or caregiver. Therefore, Dr. Choo testified, Dr. Waite's ordering the child to be wrapped in a papoose was very inappropriate, not only because it agitated the child but also because it restricted chest wall movement which further compromised oxygenation. Moreover, he testified that it is generally more effective to have the parent or caretaker hold the child's arms to prevent the child from removing the oxygen cannula from his or her nose, rather than to place the child in a papoose. Dr. Choo concluded that placing this child, who was in respiratory distress, in a papoose had been highly inappropriate. (Tr. II at 115-118, 125, 211-213)

Dr. Choo further testified that oxygenation for this child should have been by humidified air rather than by a cannula. Therefore, it would have been more appropriate to use a handheld vaporizer, or "blow-by," rather than a nasal cannula. Dr. Choo explained that it generally works well to have the parent or caretaker hold the child while the respiratory therapist walks around the child holding the blow-by as close as possible to the child. The child is then comforted by the parent, the airway opens up, and the child can breathe better. Dr. Choo concluded that use of a papoose in this case was contraindicated and fell below the minimal standards of care. (Tr. II at 119, 135-136, 213-214)

Finally, Dr. Choo testified that Dr. Waite should have observed and documented the child's response to the racemic epinephrine, which he did not do. Dr. Choo noted that, even if the patient's oxygen level had improved before admission to the floor, that does not mean that the underlying inflammation or other condition had resolved. He added that Dr. Waite had been concerned enough about this child to order that the respiratory therapist be present upon admission to the hospital ward. Dr. Choo concluded that Dr. Waite's failure to document his reevaluation of Patient 6 after administration of racemic epinephrine and additional aerosol treatments had been below the minimal standards of care. (Tr. II at 119-129, 137-139)

Testimony of Dr. Waite regarding Patient 6

50. Dr. Waite testified that Patient 6 had not tolerated the blow-by aerosol treatment. When asked where this was documented in the medical record, Dr. Waite referred to the nursing care plan which stated, "Child irritable. Mom holding."³ Dr. Waite testified that he had also tried a mask which the patient had not tolerated. Dr. Waite acknowledged that the child's intolerance of either the blow by or the mask was not documented in the medical record. (Tr. I at 181-184)

³ That note actually states, "Crying. HR 174. Exam by Dr. Waite. Pulse ox 87%. Aerosol treatment. O₂ per 2L NC. Child irritable-mom holding. O₂ sat 89%. Crying. Papoose applied per order Dr. Waite. O₂ NC↑. O₂ sat 99%. O₂ at 2L NC. Report called to 4N." (St. Ex. 6 of 33)

Dr. Waite further testified that he had decided to put Patient 6 in a papoose because Patient 6 had been pulling the cannula from his nose. When he did so, his oxygen saturation decreased. Dr. Waite testified that application of the papoose had been the only effective means of improving the child's oxygenation. Dr. Waite added that the child had already been agitated and unhappy, and application of the papoose had not made the situation any worse. Moreover, Dr. Waite testified that, had the papoose not worked, the only alternative would have been to intubate the child, which would have been a more extreme means of improving his oxygenation. (Tr. I at 184-189; Tr. IV at 184-186)

Dr. Waite acknowledged that he had not been able to assess Patient 6 after he was transferred to the floor. Nevertheless, he stated that the pediatrician who accepted Patient 6 had been responsible for the child after admission. (Tr. I at 192-193)

Dr. Waite testified that he had not completed all of Patient 6's treatment in the emergency department. He stated that "the goal of the emergency department is to stabilize and then get to the appropriate place. In fact, that's what was done. He received aerosol treatment here and improved drastically from 87 percent to 99 percent out of a hundred, and was admitted to the floor for further therapy." (Tr. I at 193)

Dr. Waite testified that he had considered other causes of the stridor and hypoxia. He stated that, in his physical exam, he had noted no evidence of posterior pharyngeal swelling and no wheezing, which was his assessment for a possible aspiration of a foreign body. He stated that he had also assessed for reactive airway disease. In addition, he stated that his documentation that there were no rhonchi or fever indicated that he had assessed the patient for pneumonia. (Tr. I at 194-196)

Dr. Waite further testified that he had not considered radiologic tests to rule out other causes because "it is pretty well established, children with barky coughs have croup." He stated radiologic tests are used to determine whether a patient should be admitted to the hospital. In this case, he reasoned, a chest x-ray had not been necessary because the child was hypoxic; therefore, there had been no question that he would be admitted to the hospital. (Tr. I at 197)

Finally, Dr. Waite testified that he had considered administering steroids, but had decided against it because Patient 6 had not needed steroids. Dr. Waite acknowledged that he had not documented his consideration of steroids. He added that he disagreed with the opinion of his expert, Dr. Glauser, who opined that children in this condition require steroid treatment. Dr. Waite also explained that there are contraindications to the administration of steroids to a patient who may have a bacterial infection because steroids may interfere with antibiotic treatment. Dr. Waite concluded that his failure to administer steroids had been consistent with the standards of care, despite the opinions of Dr. Glauser and Dr. Choo. (Tr. I at 197-201; Tr. IV at 182-184, 216-218)

Testimony of Dr. Glauser regarding Patient 6

51. Dr. Glauser testified that, for the past twenty-five years, it has been well accepted that patients should be treated with steroids. Dr. Glauser concluded that failure to do so had been a failure to conform to the standards of care. (Tr. IV at 31-33, 35, 121-123 Resp. Ex. D at 4-5)

In addition, Dr. Glauser testified that the decision to use a papoose with a child who is fighting her nasal cannula can only be made by the practitioner who is present. Dr. Glauser testified that it is important to administer oxygen and using the papoose may have been necessary. Dr. Glauser testified that he did not have as much problem with Dr. Waite's use of the papoose as with his failure to administer steroids. (Tr. IV at 33-35)

Patient 7

Medical Records for Patient 7

52. On September 30, 1997, at 5:35 a.m., Patient 7, a 66-year-old female, presented to the Emergency Department at Ashtabula County Medical Center. The nursing assessment reported that Patient 7 complained of having had mid-sternal chest pain intermittently over the prior two weeks. Patient 7 described the pain as worsening with inspiration. She also complained of diaphoresis with the chest pain, but denied radiation of pain, nausea, vomiting, and shortness of breath. (St. Ex. 7 at 5, 23)

In handwriting other than the nurse's handwriting, it also states: "epigastric pain [without] radiation [for two weeks]." (St. Ex. 7 at 5, 23)

53. Dr. Waite ordered a cardiac profile. On a specimen drawn at 6:32 a.m., CPK was 191 [normal values: 20 to 232]; SGOT or AST was 35 [normal values: 15 to 46]; and LDH was 751 [normal values: 313 to 618]. (St. Ex. 7 at 5, 15) An EKG showed sinus tachycardia with a rate of 103, and nonspecific lateral T-wave abnormalities. It was read as a "borderline EKG," and noted to be a preliminary report which "must be reviewed by the physician." (St. Ex. 7 at 19) Finally, a chest x-ray showed left ventricular prominence and tortuosity of the thoracic aorta. The lungs were clear. (Tr. I at 7 at 21)

54. In his emergency department note, Dr. Waite documented, in part, the following:
- **"CHIEF COMPLAINT(S):** Epigastric discomfort."
 - **"HISTORY OF PRESENT ILLNESS:** The patient is a 66-year-old female who states that she has had some epigastric discomfort on and off for the past two weeks. She states it has been really bad since midnight, some six hours prior to emergency department presentation. She has no history of dyspepsia, has had no vomiting, but states she has had a lot of burping and feels a lot of gas in her epigastrium. She is

denying shortness of breath or frank chest pain. She has no other constitutional symptoms.”

- “**REVIEW OF SYSTEMS:** Negative for cardiovascular, respiratory, * * * symptoms.”
- “**PAST MEDICAL HISTORY:** Chronic medical problems include hypertension.”
- “**PHYSICAL EXAMINATION:**” Findings included no jugular vein distention; cardiac rhythm regular, without rubs, gallops or murmurs; and lungs clear bilaterally without wheezes, rales, or rhonchi.
- “**ASSESSMENT:** Would include dyspepsia in this patient who complains of epigastric pain and has focal reproducible pain on palpation of the epigastrium versus a myocardial event which the patient does not seem to demonstrate. She has a normal sinus rhythm and no elevation of the CPK. The patient has minimal relief with GI cocktail in the emergency department and it is felt that the patient will benefit from an H2 blocker.”

(St. Ex. 7 at 11, 13)

55. Dr. Waite ordered a GI cocktail. Upon discharge, he diagnosed dyspepsia and prescribed Axid. (St. Ex. 7 at 5, 25)

Testimony of Dr. Choo regarding Patient 7

56. Dr. Choo testified that Dr. Waite’s care and treatment of Patient 7 had not complied with the standards of care. (Tr. II at 141; St. Ex. 10 at 8-9) Dr. Choo testified that Patient 7 had presented with classic cardiac symptoms, which may have been an indication of myocardial infarction. Dr. Choo further testified that, as in other cases, Dr. Waite initiated appropriate investigation and then failed to complete the workup, despite the fact that there were abnormalities in the EKG and cardiac enzymes. Moreover, Dr. Waite failed to discuss the abnormalities, and discharged Patient 7 with a gastrointestinal diagnosis which was not well supported by the patient’s presentation. (Tr. II at 142-146, 219-221)

Dr. Choo noted that there were changes on the EKG in the lateral leads, which should have raised Dr. Waite’s suspicion that her problems were of cardiac etiology. Moreover, the LDH was elevated. Dr. Choo explained that LDH is not used any more to rule out cardiac events because it is very nonspecific. Today, troponin is used; but it was not available at the time of Patient 7s emergency department visit. Nevertheless, when LDH is used, it should be monitored serially as it tends to rise over time during a cardiac event. Moreover, Dr. Choo testified that Dr. Waite should have obtained LDH isoenzymes which are more specific for cardiac injury than a simple LDH. Dr. Choo testified that if, for some reason,

isoenzymes had not been available at that time, Patient 7 should have been admitted to the hospital for observation. (Tr. II at 146-149, 222-223)

In addition, Dr. Choo testified that Dr. Waite had ordered a GI cocktail to treat the GI symptoms. However, the GI cocktail did not provide relief. Therefore Dr. Waite should have reconsidered a cardiac etiology and administered nitroglycerin to see if Patient 7's symptoms would be relieved. Dr. Choo concluded that failure to do so had been inconsistent with the standards of care. (Tr. II at 150)

Dr. Choo further testified that, if Dr. Waite had been convinced that the etiology of her symptoms was gastrointestinal, Dr. Waite should have explored other possibilities when the GI cocktail was not effective. Dr. Choo explained that Dr. Waite should have considered and tested for other etiologies, such as pancreatitis and gallbladder dysfunction, both of which could present with atypical chest pain and abdominal pain. (Tr. II at 149-150, 151)

Finally, Dr. Choo concluded that it had been below the standards of care to not admit Patient 7 to the hospital for further workup to identify the reason for her persistent symptoms. (Tr. II at 151-152, 154-155)

Testimony of Dr. Waite regarding Patient 7

57. Dr. Waite testified that the results of the EKG and the cardiac enzymes, in addition to the history and physical and the condition of the patient, had convinced him that Patient 7 was not experiencing a cardiac event. (Tr. I at 216-217; Tr. IV at 223-225)

Dr. Waite testified that Patient 7's EKG had shown lateral T-wave flattening, "but certainly no evidence of an acute cardiac event." Nevertheless, Dr. Waite testified that Patient 7 would have benefited from serial EKGs. (Tr. I at 206-208, 214)

Dr. Waite acknowledged that Patient 7 would have benefited from serial cardiac enzymes and admission to the hospital for observation. Nevertheless, Dr. Waite testified that an isolated elevated LDH does not mean that there is an acute cardiac event. Dr. Waite acknowledged that he had not ordered LDH isoenzymes, but testified that isoenzymes had probably not been available at that hospital at that time. He stated that, had they been available, they would have been done as part of the cardiac panel. (Tr. I at 209-212, 214, 216; Tr. IV at 187-188, 191-194)

Dr. Waite testified that he had diagnosed dyspepsia, which is upper abdominal discomfort or stomach or intestinal pain caused by acid. He stated that he had made the diagnosis based upon the laboratory data, history, and physical examination which had included a tender epigastrium. Dr. Waite testified that he had ordered a GI cocktail of lidocaine, an anesthetic; Donnatal, an anti-spasmodic; and Maalox or Mylanta, a gastric base coat. Dr. Waite acknowledged that the GI cocktail had not been effective, and that he should have considered a trial of sublingual Nitroglycerin, which he had not. (Tr. I at 217-220)

Dr. Waite testified that he had not considered a diagnosis of gallbladder or pancreatic dysfunction because Patient 7 had not complained of upper right quadrant pain. He acknowledged that, retrospectively, gallbladder disease should have been considered. (Tr. I at 220-221; Tr. IV at 189-190)

Dr. Waite testified that, after discharge from the emergency department, Patient 7 had been seen by her family physician. The family physician admitted Patient 7 to the hospital later that day. Dr. Waite acknowledged that she would have benefited from admission to the hospital directly from the emergency department. He denied, however, that failure to do so had constituted a violation of the standards of care. He stated that he had not been unreasonable to discharge a patient who he believed to have dyspepsia and who had adequate follow-up. (Tr. IV at 190-191, 219-222)

Testimony of Dr. Glauser regarding Patient 7

58. Dr. Glauser testified that he had seen no reason to screen for pancreatic or gallbladder disease in the emergency setting since she was not in excruciating pain and was ambulating. He stated that obtaining amylase or lipase levels would not have provided any benefit. (Tr. IV at 35-36; Resp. Ex. D at 5-6)

Dr. Glauser further testified that failure to admit the patient had not been inappropriate. Dr. Glauser testified that, unless the emergency department has an observation area, the physician cannot order serial EKGs and serial cardiac enzymes unless the patient is admitted to the hospital. Determining whether it is appropriate to confine the patient to an inpatient stay is a clinical judgment best made by the physician treating the patient. Nevertheless, he testified that it would not have been “a mistake to keep her.” Dr. Glauser testified that he does not believe, even at this time, that Ashtabula County Medical Center has an observation area in their emergency department. (Tr. IV at 36-38)

Dr. Glauser further testified that it would have been appropriate to document the presence or absence of diabetes and hyperlipidemia. He noted that they are risk factors for cardiac disease. (Tr. IV at 123-124)

Dr. Glauser testified that he had assumed that cardiac isoenzymes were not available at that hospital at that time. He stated that if the CPK-MP had been available, there is no reason why it should not have been ordered and run. (Tr. IV at 124-128) Nevertheless, Dr. Glauser testified:

If you are going to rule out an MI, then the standard of care, the definitive test is time. It is not any single blood test. So I would either admit or discharge this lady based on my history, not based on one set of blood tests whether they are enzymes, isoenzymes, or anything like that. It should not affect your decision.

(Tr. IV at 128)

Dr. Glauser further testified that, although LDH had once been used to rule out a myocardial infarction, it had been recognized as unreliable as early as the 1970s. He stated that, by 1997, there had been absolutely no reason to order LDH to rule out cardiac injury. (Tr. IV at 129-131)

Dr. Glauser concluded that, once a physician orders a cardiac profile, the physician is committed to following through with that evaluation. Therefore, Dr. Waite should have kept Patient 7 for observation. He concluded that the standards of care would require either that Patient 7 had been admitted for observation or that the cardiac workup had not been initiated in the first place. (Tr. IV at 131-136, 141-145)

Testimony of Kenneth D. Masters regarding Patient 7

59. Kenneth D. Masters testified on behalf of the State. Mr. Masters testified that, for the past fifteen years, he has been the Administrative Laboratory Director for the Ashtabula County Medical Center. Mr. Masters further testified that, in September 1997, LDH isoenzymes had been available at Ashtabula County Medical Center through a reference laboratory. Moreover, Mr. Masters stated that the laboratory staff routinely provides a list of available tests to medical and nursing staff to update them regarding available tests. (Hearing Transcript, Volume V)

Patient 8

Medical Records for Patient 8

60. On April 10, 1998, at 5:55 p.m., Patient 8, a 63-year-old male, presented to the Emergency Department at Ashtabula County Medical Center with complaints of shortness of breath and diaphoresis after exposure to fumes from a mixture of bleach and drain cleaner. His breath sounds were diminished throughout and his oxygen saturation was 85% on room air. He denied chest pain. Patient 8 had a history of congestive heart failure, chronic obstructive pulmonary disease, and hypertension. (St. Ex. 8 at 15, 31, 35)
61. A chest x-ray revealed a normal cardiac silhouette and pulmonary vascularity. Lungs were clear. An EKG was abnormal, with tachycardia at a rate of 122, an unusual P axis, and a left bundle branch block. (St. Ex. 8 at 27, 43)

An aerosol treatment was administered at 6:07 p.m. At 6:16 p.m., arterial blood gases revealed: PaCO₂ of 46.9, PaO₂ of 59.0, and SaO₂ of 86.5. A second aerosol treatment was completed at 6:25 p.m., and a fourth at 7:05 p.m. Oxygen saturation was 92% on room air. At 7:35 p.m., a nurse reported to "Dr. Stewart" that the oxygen saturation was 90% on

room air. At 8:47 p.m., arterial blood gases revealed: PaCO₂ of 39.4, PaO₂ of 58.0, and SaO₂ of 89.9. (St. Ex. 8 at 25, 35)

62. The record does not contain an emergency department note written by a physician. (St. Ex. 8)
63. Dr. Waite diagnosed chemical pneumonitis. He wrote discharge instructions advising Patient 8 to use Albuterol as directed, to follow up with a family physician, and to return for chest pain or shortness of breath. (St. Ex. 8 of 31) Nevertheless, Patient 8 was admitted to the hospital at 11:30 p.m. with a diagnosis of bronchospasm. He improved after receiving a respiratory treatment with Solu-Medrol. (St. Ex. 8 at 7, 47)

Testimony of Dr. Choo regarding Patient 8

64. Dr. Choo noted that there had been two physicians involved in Patient 8's care in the emergency department. It appeared that Dr. Waite had treated the patient initially, and then another physician, Dr. Stewart, assumed the care of Patient 8. Dr. Choo testified that he could not tell from the record at what point the transition took place. Dr. Choo testified that it appeared that Dr. Stewart had been the physician who admitted Patient 8 to the hospital. (Tr. II at 157-158, 162-164; St. Ex. 10 at 10-11)

Dr. Choo added that his assessment of Dr. Waite's treatment of Patient 8 had been made more difficult because neither Dr. Waite nor Dr. Stewart had dictated an emergency department note. Nevertheless, Dr. Choo testified that there had been enough information available to determine that Dr. Waite's care and treatment of Patient 8 had failed to conform to the standards of care. (Tr. II at 156-157, 239-240)

Dr. Choo testified that Dr. Waite had written discharge orders, although the patient had been admitted to the hospital rather than being discharged. Dr. Choo testified that it is inconsistent with the standards of care to discharge a patient before the care has been completed and the patient has been stabilized. He noted, however, that it is possible that Dr. Waite had written discharge instructions at the end of his shift in order to assist the oncoming physician. Nevertheless, Dr. Choo testified that even considering discharging this patient who was extremely ill and who had conditions that were potentially catastrophic had been inappropriate. Dr. Choo testified that the risk in writing discharge notes under these circumstances is that someone may pick up the chart and discharge the patient thinking that the orders were written to be carried out. (Tr. II at 159-160, 162, 165-166, 229-232)

Dr. Choo testified that the standard for transferring care of a patient to a second physician is to dictate or document your care and treatment of the patient, and to discuss the case with the oncoming physician. It is important to advise the second physician of what you have done, and allow incoming physician to determine the appropriate course of treatment and

the appropriate disposition. Therefore, writing discharge orders in this situation had not complied with the standards of care. (Tr. II at 168)

Dr. Choo further testified that he was troubled by the discharge instructions themselves. He explained that, in order to write such instructions, Dr. Waite could not have appreciated the severity of the patient's condition. Dr. Choo explained that Patient 8 had presented with significant symptoms such as hypoxia and tachycardia, in addition to underlying conditions of coronary artery disease and congestive heart failure. Dr. Choo testified that the risk of cardiac strain was of great concern. Dr. Choo concluded that it was very unlikely that Patient 8 could have been sent home safely and that further evaluation had been warranted. (Tr. II at 161, 165-167)

Testimony of Dr. Waite regarding Patient 8

65. Dr. Waite testified that shift change for physicians in the emergency department at the Ashtabula County Medical Center had occurred between seven o'clock and eight o'clock in the evening. He stated that the shift ended at seven o'clock, but the outgoing physician generally stayed for a period of time thereafter. (Tr. I at 226; Tr. IV at 195-196)

Dr. Waite testified that he had not specifically planned to discharge Patient 8. Nevertheless, he stated that:

The plan is always to discharge a patient if they are improving. And it is not atypical at shift change to try to take care of as much work as possible so that the oncoming physician doesn't have to see new patients, as well as dispositioning the patients that you'll be signing out to them.

(Tr. I at 228) Dr. Waite testified that, once he had written the discharge orders, there was no way to delete them from the medical record. He explained that there was nowhere on the record to write "cancel." He acknowledged, however, that that he could have drawn a line through the orders and initialed them. (Tr. IV at 194-195)

Dr. Waite testified that it had been his decision to admit Patient 8 to the hospital and that he had made that decision because Patient 8's oxygenation levels had dropped. Nevertheless, Dr. Waite acknowledged that there is no indication that he is the physician who admitted Patient 8 to the hospital. Dr. Waite added that his history and physical is missing from the chart, therefore other parts of the chart may also be missing. Nevertheless, Dr. Waite testified that he can "glean" from the information in the chart that he had been the doctor who admitted Patient 8 to the hospital. (Tr. I at 228-233, 241-242; Tr. IV at 196-198)

Dr. Waite testified that he had observed Patient 8 for potential cardiac ischemia and cardiac strain. He noted that his evaluation would have been documented in his history and physical examination, but that document was missing from the record. (Tr. I at 233-242)

Testimony of Dr. Glauser regarding Patient 8

66. Dr. Glauser testified that deciding whether to admit Patient 8 to the hospital had been basically “a coin flip.” He explained that nothing had happened during the night and it is hard to determine whether the admission had made any difference in the outcome. Nevertheless, he testified that it is “never a bad idea” to watch someone overnight. (Tr. IV at 39-40 Resp. Ex. D at 6)

Dr. Glauser testified that it had been inappropriate for Dr. Waite to not indicate that his discharge orders were erroneous once it was determined that Patient 8 would be admitted to the hospital. (Tr. IV at 40-42, 137) Nevertheless, Dr. Glauser testified that Dr. Waite’s care of Patient 8 had been consistent with the standards of care. (Tr. IV at 42-43)

LETTERS OF SUPPORT

67. Dr. Waite presented a letter written in his support by the director of emergency medical services at Fort Defiance Hospital where Dr. Waite is currently employed. At the time the letter was written, Dr. Waite had worked at the hospital for one month. (Tr. IV at 201-202; Resp. Ex. E) Dr. Waite explained:

I interviewed with the gentleman who wrote this and had the opportunity to discuss pending issues in Ohio regarding my license. I was given the opportunity to work at this hospital under his supervision and, after some time of working there, he felt moved, obligated, I don’t know, to contact the Board himself and write a letter on my behalf to attempt to assuage some of the assault that was directed towards me.

(Tr. IV at 202)

68. Charles A. Blakely, M.D., F.A.C.S., is the Chief of Emergency Medicine, Department of Health and Human Services, Public Health Service, National Area Indian Health Service, Fort Defiance, Arizona. By letter dated March 9, 2005, Dr. Blakely wrote to the Board “a glowing letter of recommendation and attestation” on behalf of Dr. Waite. Dr. Blakely wrote, in part, as follows:

Immediately upon joining our ED rotation, it was abundantly evident that Dr. Waite was very highly motivated to get off to a good start and provide the best possible care to our patients. He quickly ingratiated himself with our Native-American patients and veteran nurses with his efficient yet thorough work-ups, his gentle, friendly demeanor, and his tireless good humor and spirits. His people skills are excellent. He carries himself with a quiet, warm and friendly manner, and numerous nurses and physicians have quietly taken me aside to suggest that we “do all we can to keep him here with us.” From a personal point of view alone, he is a joy to have around during a busy evening

in the ED. His clinical skills and judgment are excellent. He is polished in his procedures and their application, and he is facile and efficient at separating “the wheat from the chafe,” or the truly sick from the not so sick.

* * *

All new physicians here are given temporary privileges in our hospital, and are subjected to recurring scrutiny in the form of chart reviews and the careful monitoring of personal interactions with patients and staff. All of Dr. Waite’s chart work so far has reflected a good fundamental basis of medical knowledge, careful attention to detail, appropriate use of lab and x-ray studies, and sound judgment without exception. He has repeatedly demonstrated appropriate and timely interactions with his consultants. There has been no hint of complaints about his care, nor has there been any deleterious feedback from patients, nurses, or other physicians regarding this physician in the month he has been with us. Further, I am unaware of any pending problematic cases, personal issues, moral problems, substance abuse problems, or other negatives that might interfere with or threaten his future with us in this hospital.

(Resp. Ex. E)

DR. WAITE’S CLOSING REMARKS

69. Dr. Waite testified that he has benefited from the process of reviewing his care and treatment of the eight patients in this matter. (Tr. IV at 203) He explained:

Much of the criticism that I have heard regarding these patients has been focused on my documentation. I mean, there are certainly absences in what I have put on paper and what I have made as part of the record, and I think that, though a painful lesson, it’s certainly been a help to recognize the deficiency that is created without adequate documentation.

There are many things that I would do different, and we have talked about some of those. But looking at and listening to both my expert and the State’s expert, there is clear evidence that my documentation was not what it needed to be in virtually every one of these.

(Tr. IV at 203) Dr. Waite testified that there were also deficiencies in his clinical practice. Nevertheless, Dr. Waite testified that these cases took place many years ago and his practice has improved greatly since that time. He acknowledged, however, that he had continued to have problems while working at Grant Medical Center from 2000 to 2003. (Tr. IV at 203-205)

Dr. Waite concluded that he would do whatever the Board required him to do to maintain his certificate to practice medicine and surgery in this state. (Tr. IV at 204)

LEGAL ISSUES

Prior to issuing the notice of opportunity for hearing in this matter, the Board had obtained certified copies of medical records for the patients upon whom the Board's allegations were based. Thereafter, Dr. Choo, the State's expert witness, issued a report based upon his review of the certified medical records. The Board issued the notice of opportunity for hearing based, in part, upon the opinion expressed in Dr. Choo's report.

The medical records for Patient 3, as certified by the hospital, which were reviewed by Dr. Choo, did not contain a dictated Emergency Department note documenting Dr. Waite's care and treatment of that patient. Nevertheless, shortly before hearing, Dr. Waite presented to the State a copy of a typed Emergency Department note apparently dictated by Dr. Waite.⁴ Dr. Waite explained he had obtained a copy of that document because, as his relationship with Ashtabula County Medical Center deteriorated, he had begun copying his patient records. He stated that he had obtained the dictated Emergency Department note for Patient 3 in this manner.

At hearing, Dr. Choo was presented with a copy of this document. After reviewing the document, Dr. Choo changed his opinion regarding some of the deficiencies he had documented in his report. Specifically, Dr. Choo testified that, based on that note, it appeared that Dr. Waite had considered the subcutaneous emphysema and had referred Patient 3 for evaluation.

Accordingly, neither the Hearing Examiner nor the Board will find that the evidence presented at hearing supported those specific allegations. Nevertheless, there is no question that the Board had been substantially justified in raising those allegations in its notice of opportunity for hearing.⁵

FINDINGS OF FACT

The State provided sufficient evidence to support findings that Stephen David Waite, M.D., had failed to comply with the minimal standards of care in his treatment of Patients 1 through Patient 8. The following are examples:

1. Patient 1 presented to the emergency department after being thrown from a motorcycle while not wearing a helmet. Dr. Waite failed to address numerous critical elements in his evaluation of Patient 1. First, Dr. Waite failed to document details regarding the accident,

⁴ See Respondent's Exhibit C.

⁵ See the following pages in the Hearing Transcript for discussion of these issues: Volume I at 8-10, 17-22, 104-105, 120-131; Volume II at 76, 78; Volume IV at 171-172, 227-229)

such as speed of the motorcycle and the distance Patient 1 had been thrown. Documenting this information is mandated by the Advanced Trauma Life Support [ATLS] guidelines and by the standards of care. Moreover, Dr. Waite did not address inconsistencies in the record regarding whether Patient 1 had lost consciousness, and he did not address the possibility that Patient 1 was under the influence of alcohol or drugs.

In addition, Dr. Waite did not document adequate evaluation of potential injury to the head, chest, or pelvis. Dr. Waite's description of his evaluation of these areas was not sufficient. Similarly, his explanation that he had performed certain evaluations but not documented them was not persuasive, especially in light of his testimony that he remembers reviewing Patient 1's CT scan in the emergency department when, in fact, it had not been ordered until several days later. Finally, Dr. Waite inappropriately prescribed Percocet upon discharge, and failed to reevaluate Patient 1 prior to discharge.

2. Patient 2, a 61 year old female, presented to the emergency department with complaints of headache that had been partially treated with antibiotic therapy for a purported sinus infection. Dr. Waite considered the possibility of partially-treated meningitis as indicated by his documenting a lack of nuchal rigidity. Nevertheless, he failed to obtain a spinal tap, the only definitive test to rule out partially-treated meningitis.

Similarly, Dr. Waite ordered a CT scan and determined that there were no life-threatening reasons, such as a subarachnoid hemorrhage, for the headache. Nevertheless, the appropriate test for making that determination would have been a spinal tap, not a CT scan. Moreover, Dr. Waite's testimony that documentation of "no lateralizing signs" had been an indication that there was not a subarachnoid hemorrhage was not convincing because, as noted by Dr. Choo, in many cases of subarachnoid hemorrhage there are no lateralizing signs.

Finally, Dr. Waite inappropriately discharged Patient 2 who should have been admitted to the hospital for further evaluation.

3. a. Patient 3, a 54-year-old male, presented to the emergency department with complaints of right side and flank pain after falling three days prior. He was hypotensive, and a chest x-ray revealed acute fractures of the right sixth through eighth ribs and subcutaneous emphysema in the soft tissues. The right lung field also demonstrated a small pleural effusion, most likely consistent with a hemothorax. No definite pneumothorax was noted and there was no shift of the mediastinum.

Dr. Waite failed to document any information regarding the trauma, such as the velocity or distance of the fall, which, as noted in Findings of Fact 1, is required under the ATLS guidelines. Dr. Waite did not document any attempt to identify the reason for the hypotension and did not even recheck the blood pressure before discharging Patient 3 from the emergency department. Finally, Dr. Waite failed to address Patient 3's alcohol consumption and possible intoxication.

- b. The State failed to prove its allegations that Dr. Waite had failed to evaluate potential causes of the patient's subcutaneous emphysema and had failed to refer Patient 3 for immediate consultation and evaluation by as general or trauma surgeon. [See Legal Issues, above.]
4. Patient 4, a ten-day-old female, presented to the emergency department with a rectal temperature of 103.3 and "grunting." Moreover, the infant had recently been dropped and presented with blood in her stool. Dr. Waite did not evaluate the infant for sepsis. Moreover, he did not admit the infant for further evaluation and treatment, which had been absolutely required under the circumstances. Failure to do these things could have resulted in the infant's death.
5. Patient 5, a 52-year-old female, presented with dull pain under her left breast, shortness of breath, nausea, headache, and hot flashes. She had a history of cerebral vascular accidents, non-insulin dependent diabetes mellitus, and depression. Among other medications, Patient 5 was taking Coumadin, an anti-coagulant.

Dr. Waite failed to perform adequate evaluation for an acute coronary syndrome and should have admitted Patient 5 to the hospital for continued evaluation of her cardiac status. Moreover, Dr. Waite inappropriately evaluated and treated Patient 5's complaint of headache.

Most importantly, Dr. Waite failed to address the potential catastrophic effects of Coumadin which Patient 5 had been taking. It is significant that Patient 5 returned to the emergency department a few hours after Dr. Waite treated her. At that time, the examiner found both new bruising on multiple areas of Patient 5's body. Dr. Waite did not mention any bruising in his examination of Patient 5. This supports the conclusion that Dr. Waite had not even considered the potential catastrophic effects of Coumadin because, if he had, the bruising would have been a readily apparent sign of a clotting deficiency.

Finally, the standards of care required that Dr. Waite check her INR and obtain a CT scan to be sure that there was no insidious bleeding within the head. This was especially important since Dr. Waite administered Toradol which can also decrease coagulation.

6. Patient 6, a 13-month-old male, presented to the emergency department with congestion, difficulty breathing, and a barking cough. He also had stridor and was using his accessory muscles to breathe. On room air, his oxygen saturation was 87%. Although Dr. Waite diagnosed croup/laryngotracheitis, he did not obtain sufficient history or testing to determine the etiology of the syndrome. Moreover, Dr. Waite did not order appropriate treatment and did not observe the child's response to treatment. Finally, Dr. Waite inappropriately ordered that the child be restrained in a papoose when other, less stressful, means had been available to obtain the desired oxygenation. Finally, since the child

presented with laryngotracheitis severe enough to cause hypoxia, the standard of care required that steroids be administered.

7. Patient 7, a 66 year-old female, presented to the emergency department complaining of midsternal chest pain and diaphoresis for approximately six hours, and intermittent epigastric discomfort for the past two weeks. An EKG revealed changes in the lateral leads, and her LDH was elevated. Dr. Waite failed to adequately investigate cardiac etiologies. Moreover, he inappropriately failed to administer a trial of nitroglycerin; failed to order cardiac isoenzymes, serial cardiac enzymes, or serial EKGs; and failed to admit Patient 7 to the hospital for observation and continued evaluation of her cardiac status.

In addition, Dr. Waite diagnosed dyspepsia, which was not well supported by her presentation. He treated her with a G.I. cocktail, which did not provide relief. Nevertheless, Dr. Waite failed to investigate alternative reasons for her symptoms and inappropriately discharged her with the diagnosis of dyspepsia.

8. Patient 8, a 63-year-old male, presented to the emergency department with complaints of shortness of breath and diaphoresis after exposure to fumes from a mixture of bleach and drain cleaner. His breath sounds were diminished throughout and his oxygen saturation was 85% on room air. He was tachycardic and had an abnormal EKG. Patient 8 had a history of congestive heart failure, chronic obstructive pulmonary disease, and hypertension.

Dr. Waite inappropriately wrote discharge orders for Patient 8 prior to completion of treatment. Moreover, although Patient 8 was admitted to the hospital rather than discharged, Dr. Waite did not cancel the discharge orders in the medical record. Failure to do so risked the possibility that another staff member would inadvertently discharge the patient in unstable condition. Moreover, the content of the discharge orders reveals that Dr. Waite did not appreciate the severity of Patient 8's condition.

CONCLUSIONS OF LAW

The conduct of Stephen David Waite, M.D., as described in Findings of Fact 1, 2, 3a, 4, 5, 6, 7, and 8, constitutes “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

* * * * *

In his care and treatment of these patients, Dr. Waite demonstrated extremely poor judgment and careless disregard. His care and treatment of Patient 4 or Patient 5, alone, warrants permanent revocation of his certificate to practice in this State.

It is notable that most of these cases took place in 1997, shortly after Dr. Waite had completed his residency training in emergency medicine. Dr. Waite argued that these cases do not reflect his current level of practice, as his practice has improved significantly since 1997. This argument is questionable, however, since he treated Patient 2 in 2001, and his practice was below the minimal standard of care even then. This would suggest that, at least as recently as 2001, Dr. Waite's practice had not sufficiently improved. If so, the Board has no alternative but to permanently revoke Dr. Waite's certificate to practice medicine and surgery in this State.

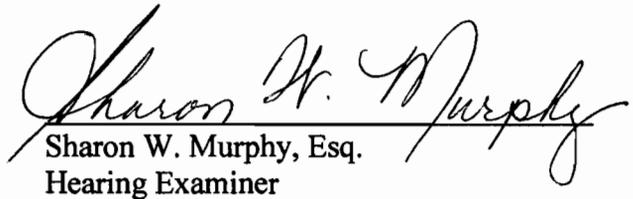
On the other hand, there are mitigating factors in this matter. First, in most of these cases, Dr. Waite did not try to defend his mistakes. Instead, he acknowledged and apologized for the deficiencies in his practice. In addition, Dr. Waite testified that he is willing to do anything the Board asks in order to prove that he is worthy of the privilege to practice medicine and surgery in Ohio. Unfortunately, the hearing record does not contain any evidence of Dr. Waite's current practice skills and/or judgment, and the Board has no means to assess whether Dr. Waite is capable of practicing safely without a significant risk of harm to the public. However, if the Board believes that there is a possibility that Dr. Waite's skills and judgment have improved since 1997 and 2001, the Board may wish to remand this matter to the Hearing Examiner to accept additional evidence regarding Dr. Waite's current fitness to practice.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Stephen David Waite, M.D., to practice medicine and surgery in the State of Ohio is PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of notification of approval by the Board.


Sharon W. Murphy, Esq.
Hearing Examiner



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF MAY 10, 2006

REPORTS AND RECOMMENDATIONS

Dr. Robbins announced that the Board would now consider the findings and orders appearing on the Board's agenda. He asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Carl Floyd Gottschling, M.D.; Donald R. Kiser, D.O.; Gary Ray Lutz, D.O.; Sonia Shetal Shah, M.D.; and Stephen David Waite, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Steinbergh	- aye
	Dr. Robbins	- aye

Dr. Robbins asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Steinbergh	- aye
	Dr. Robbins	- aye

Dr. Robbins noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

Dr. Robbins stated that, if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....
STEPHEN DAVID WAITE, M.D.

Dr. Robbins directed the Board's attention to the matter of Stephen David Waite, M.D. He advised that objections were filed to Hearing Examiner Murphy's Report and Recommendation and were previously distributed to Board members.

Dr. Robbins continued that a request to address the Board has been timely filed on behalf of Waite. Five minutes would be allowed for that address.

Dr. Waite was accompanied by his attorney, Mr. Byers.

Mr. Byers stated that there are objections on the table. He stated that these may not be in the typical form of objections because Dr. Waite has been very professional, dignified and responsible throughout the course of this proceeding. Mr. Byers advised that Dr. Waite certainly realizes the importance of his Ohio license and has done his very best to cooperate throughout the process. He noted that Dr. Waite tried to explain and not duck, weave or dodge responsibility. Mr. Byers stated that Dr. Waite's testimony at hearing was very credible about his treatment of these patients so long ago, when he was just out of residency.

Dr. Waite at this time addressed the Board. He appealed to the Board to allow him to continue to hold his license to practice medicine in this state. Dr. Waite stated that he recognizes that the Board has a duty to protect the citizens of the state, and he does recognize that he departed from the standard of care on several occasions with the cases before the Board. He advised that, although this process has been uncomfortable, he thinks that it has been instrumental in highlighting those departures. Dr. Waite stated that he is confident that similar departures would not occur.

Dr. Waite stated that Hearing Examiner would have the Board permanently revoke his license to practice in the state, based on these seven cases from the first nine months after his residency, as an attending, and the

one case from 2001. He stated that he believes that what has occurred in the interim should be considered. Since 1997 and 1998, he has become Board certified by the American Board of Emergency Medicine. He's also taken care of thousands of patients without similar departures. Dr. Waite stated that he recognizes the State's desire and need to ensure that physicians are conforming with the standards of care, but he doesn't think that it can be said that a pattern of poor medicine has ensued since these early departures.

Dr. Waite stated that, admittedly, there were errors in 1997. When questioned in the hearing, he was asked to explain his decision making. He was not trying to give an excuse, but to answer the questions. Given these same cases today, similar errors in judgment would not occur. He believes that improvement has taken place, as evidenced by the intervening years. He advised that he, like many of his colleagues, would manage cases differently if he had a second opportunity. Dr. Waite stated that the recommendation of permanent revocation, in light of the temporal nature of these cases and the lack of a similar pattern is unduly harsh. Dr. Waite asked that the Board allow him to continue to practice in this state.

Dr. Robbins asked whether the Assistant Attorney General wished to respond.

Mr. Clifford stated that he will defer to the Report and Recommendation.

DR. KUMAR MOVED TO APPROVE AND CONFIRM MS. MURPHY'S FINDINGS OF FACT, CONCLUSIONS, AND PROPOSED ORDER IN THE MATTER OF STEPHEN DAVID WAITE, M.D. MR. BROWNING SECONDED THE MOTION.

Dr. Robbins stated that he would now entertain discussion in the above matter.

Dr. Kumar stated that it is always difficult to completely evaluate what went on and what is going on in minimal standards cases. On the record there are eight cases. He would exclude case number 2, which was the subarachnoid hemorrhage, because he doesn't think that he can fault Dr. Waite significantly for what he did. He added that he believes that that was the only case that went to a malpractice trial. He was acquitted at the trial.

Dr. Kumar stated that in the other seven cases, Dr. Waite admits that he practiced below standards of care. He actually practiced way, way, way below the minimal standards of care. The question really comes down to whether this physician can be rehabilitated, retrained to be an effective physician. Dr. Kumar stated that it's easy to retrain a physician to go and look at the CT scans and what they look like. It's very hard to train a person not to lie about something missed. Dr. Kumar stated that in this case, Dr. Waite said that he ordered a CT scan, but he actually didn't order the scan.

Dr. Kumar continued that it's easy to train a person on what to do to figure out whether the patient has an MI or not; however, it is harder to train a physician to go back and realize that "you have to look at more than just one focus of chest pain issues."

Dr. Kumar stated that he thinks that it is easier to say that the issues here are those of medical documentation. Dr. Waite suggests that the error was a lack of proper documentation. Dr. Kumar stated that he disagrees with that. He added that, if you look at the documentation, it is in the newest format, which talks about the chief complaint, the history, etc. Dr. Kumar stated that pertinent things are missing from the documentation. It's not a matter that Dr. Waite doesn't know how to document; it's a matter that Dr. Waite's mindset is not looking at what is important or not important to document. That sometimes is a lot harder to educate a person to do. It's easy to educate a person that when you are looking for a person with an injury to the lungs because of inhalation of some chemicals; but it's hard to train a person that, even if the patient looks good, the patient should be kept in the hospital under observation for at least a short period of time. Dr. Kumar continued that it's easy to find a fractured rib on an x-ray, but it's harder to teach someone that he needs to consider that there may be other injuries which need to be found and given attention.

Dr. Kumar stated that he cannot comprehend Dr. Waite's care of the less-than-two-week old child with sepsis and no monitoring being done. There was no admission or exact workup done.

Dr. Kumar stated that, concerning Patient 8, Dr. Waite wrote a discharge note on the patient, but the next physician on duty admitted the patient. Dr. Kumar stated that he believes that Dr. Waite wanted to discharge the patient, but the patient got kept because the next physician on site realized that the patient needed to be admitted. Dr. Kumar stated that he thinks that Dr. Waite realizes that himself. Dr. Waite has a knowledge base, but has difficulty applying to actual effective practice. That's why he thought about changing his career and began law school. Maybe that's a better profession for Dr. Waite.

Dr. Talmage left the meeting at this time.

Dr. Kumar stated that, considering all these things, he doesn't believe that the Board can effectively rehabilitate and monitor him. Dr. Waite was terminated from one place and went to another place where he continued to have the same problems. He didn't learn in those three-four years. Dr. Kumar again stated that he doesn't believe that the Board can rehabilitate Dr. Waite, and for that reason, he will vote for permanent revocation.

Dr. Egner stated that she has a lot of the same thoughts as Dr. Kumar. She doesn't know if medicine is Dr. Waite's career. Dr. Choo, the State's expert on many cases, said that Dr. Waite's thinking was disjointed. Dr. Egner stated that it's a thought practice of how to evaluate patients, how to diagnose them, and how to treat them. Dr. Waite should have had it by then.

Dr. Egner stated that she is troubled that there are very few minimal standards cases that the Board sees where the licensee will also look at those cases on the record and say, "you're right, there are some things that I should have done differently, or could have done better." On just about every one of these cases, except for Patient 3, he saw things that he agreed with the State's expert on. Today he says the same thing.

Dr. Egner stated that her other problem is that she doesn't know what kind of physician Dr. Waite is today.

He might be okay. She does believe that physician's get better with age to a point, and so he may be a better physician today. He may be a fine physician today, but she doesn't know that. She'd like to remand this and have Dr. Waite evaluated. Dr. Egner stated that that's what Colorado's Center for Personalized Education for Physicians (CPEP) is for, and she thinks that he fits the kind of problems that they could evaluate. She stated that the Board is not looking at Dr. Waite's surgical skills, but at how he thinks and processes. Does he have the right knowledge base. Dr. Egner noted that Dr. Waite is Board certified today and wasn't at the time of these occurrences.

Dr. Egner stated that she doesn't know what to do, but she's not sure that permanent revocation is appropriate.

Dr. Egner stated that she would like to say that the Report and Recommendation is excellent. It's very clear and easy to tell what happened with the patients. It presents all sides of this case. Dr. Egner stated that Hearing Examiner Murphy did an excellent job with the Report.

Dr. Steinbergh agreed with Dr. Egner. The Report and Recommendation allowed the Board to clearly follow what happened in the number of cases that were reviewed.

Dr. Steinbergh stated that the cases were bad. She was particularly taken by the baby cases. The baby comes in under the age of 30 days and doesn't get an appropriate evaluation. That was bad. A woman came in on Coumadin, and no INR is done. There wasn't even an evaluation of the anemia that she presented with. No one seemed to be concerned about that.

Dr. Steinbergh stated that she thinks that Dr. Waite realizes the kinds of mistakes that he made. There's no question about the mistakes. The real issue is where he is today. Does the Board need to permanently revoke this license or not? Dr. Steinbergh stated that her feeling after finishing reading this case was: He's a young physician; he's made a number of very serious mistakes, without question. In 2001 he made a serious mistake in the last case reviewed. The question is whether Dr. Waite is someone who can go for remediation, and, if so, what does the Board do. Dr. Steinbergh stated that she does think that Dr. Waite meets the criteria for CPEP. Dr. Steinbergh stated that she would be willing to table this to draw up an alternative order that would include a CPEP evaluation. This would send him at his expense to be evaluated. It's a lengthy procedure but it would give the Board some reassurance and would actually tell Dr. Waite where he is; he may think he's a good physician today, but there are still some doubts about that. The alternative order would suspend Dr. Waite's license indefinitely.

Dr. Egner suggested that the Board remand this matter because the Board won't know what to do with him without the evaluation. If the Board remands the matter to the Hearing Examiner, he or she can offer a proposed order based on the results of CPEP.

Dr. Buchan stated that this is very difficult, but the pattern of Dr. Waite's behavior frightened him. Dr. Buchan added that, that having been said, he's leaning more toward the revocation direction. He stated that he's not sure that Dr. Waite's thinking and processing was encouraging enough for him to believe that

the Board should remand or send Dr. Waite for further remediation. He stated that he will continue to stay somewhat open to that idea, but these are frightening cases to review.

Dr. Varyani stated that he knows that Dr. Waite admitted to mistakes concerning Patients 6, 7, 8, and 5, but he can't imagine an emergency room doctor, knowing that a patient is on Coumadin, not ordering clotting studies. Concerning the case of the 13-month-old who came into the emergency room with breathing difficulties, no treatment was given. Dr. Varyani stated that everyone should know what to do. He added that he's not an emergency room physician, but he would know what to do and how to treat that patient.

Dr. Varyani stated that Dr. Kumar was very nice to Dr. Waite. These are cases that he cannot ignore. He might ignore one or two examples, but he cannot ignore five serious cases. Dr. Varyani stated that he knows that Dr. Waite is now board certified, but board certification means bookish knowledge. The problems were with the pure practical, clinical side of medicine. If you have bookish knowledge but don't apply it clinically, he doesn't know how a physician could improve. Dr. Varyani stated that he doesn't feel comfortable with another order.

Dr. Varyani continued that the Report and Recommendation was excellent, and he's sure that a lot of time went into it. He added that he, personally, cannot allow a license to someone who did something so egregious, who missed five very simple things.

Dr. Davidson stated that she has a little bit different point of view, but she was given pause by the fact that he's practiced, become board certified, and the Board has let him have his license for the intervening five years. There are residencies that are better than others and that give you more opportunities to experience different things. Dr. Davidson stated that Dr. Waite should have known these even if he went through a mediocre residency, and he apparently didn't. Dr. Davidson stated that she does like Ms. Murphy's suggestion that the Board might give Dr. Waite the chance to prove that his current fitness to practice is adequate. Dr. Davidson stated that she is leaning more in the direction of Dr. Egner and Dr. Steinbergh and requiring a CPEP evaluation.

Mr. Browning stated that, given the documented history of incompetence that, unfortunately, wasn't dealt with for years, why wouldn't it be reasonable to revoke the license, but not permanently. If Dr. Waite can build a case, either by going to Colorado or anything else he wants to do, the Board will then take it under advisement and, meanwhile, the public will be protected.

Mr. Browning stated that he can't ignore the history. Even if Dr. Waite fixed the problems he had, there are still the documented, serious problems in the past.

Dr. Egner agreed.

Ms. Sloan stated that she sees Mr. Browning's point, but she's also looking at the fact that there has been quite a few years between the time these egregious mistakes were made and now. What has Dr. Waite done to make any type of improvements to change what he had been doing? She stated that she doesn't

know what kind of physician he is today; she added that she would hope that he's a better physician, but she can't say that. For her, that seems to be the question now. What can the Board do? Ms. Sloan stated that the Board should find out whether or not he's improved. The Board shouldn't leave it to his own devices. It should make sure that Dr. Waite gets to an evaluation so that the Board has that information. Ms. Sloan stated that she leans toward Dr. Egner's and Dr. Steinbergh's position because she would want to have that information in front of her in order to make an intelligent decision as to whether or not he is a good doctor.

Dr. Kumar stated that time has passed, and maybe Dr. Waite has learned and improved. He pointed out that in those last four or five years Dr. Waite has been working in the emergency room as a part-time physician. He's not working in a full-time capacity. He's also going to law school and he's also working in the emergency room in an Indian reservation. Dr. Kumar stated that he's not sure that Dr. Waite has faced all the tough things that come through the emergency room doing the part-time work.

Dr. Kumar stated that he's not opposed to sending Dr. Waite to CPEP, if that's the judgment of everybody. If the Board remands it, what will the hearing examiner do without further information? Dr. Kumar stated that the Board would have to create an order to permanently revoke, stay the revocation, and then order him to go through the evaluation and abide by the evaluators' recommendations.

Mr. Browning stated that he doesn't think that that's the Board's responsibility. There is strong evidence to revoke Dr. Waite's license. The Board could impose a non-permanent revocation, and give Dr. Waite an opportunity to prove that he's a fundamentally different physician. The Board may or may not agree that that's the case. He does not offer the amendment assuming that the Board will be back here giving Dr. Waite a license.

**MR. BROWNING MOVE TO AMEND THE PROPOSED ORDER IN THE MATTER OF
STEPHEN DAVID WAITE, M.D., BY DELETING THE WORD, "PERMANENTLY."
DR. BUCHAN SECONDED THE MOTION.**

Dr. Steinbergh stated that she could support that. She added that she thinks that it is particularly important to consider the public members' input in these cases. Under the proposed amended order, Dr. Waite would have the record of this meeting and would understand what he needs to do before he applies for restoration. He would have to prove that he's an appropriate physician, and that would take some time. Dr. Steinbergh at this time asked whether she could ask Dr. Waite a question.

Ms. Pfeiffer advised that the Board must base its decision on the hearing record.

Dr. Egner stated that she likes Mr. Browning's idea. She thinks that it's a good idea to revoke. Dr. Waite now knows what the Board is looking for. If the CPEP evaluation comes back and says that he has a great knowledge base now and looks good, that's nice. If CPEP says that he has a very poor knowledge base and is not good at logical medical decision making, the Board will know what to do. Then, if it comes back being not quite the report the Board was looking for, the Board will then have to look and decide

whether these cases are serious enough to permanently revoke a physician. Dr. Egner stated that they are serious enough.

Dr. Steinbergh stated that the Board will still have the opportunity to evaluate and to make a determination as to whether or not he needs continued monitoring. Dr. Steinbergh stated that she thinks that CPEP is very thorough in its recommendations, and the Board would have to apply that into a consent agreement should the Board decide to license Dr. Waite. The amendment puts the onus on Dr. Waite and the Board will have nothing to do with it until Dr. Waite brings back information that will make the Board members feel more comfortable about licensing him.

A vote was taken on Mr. Browning's motion to amend:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Steinbergh	- aye

The motion carried.

DR. KUMAR MOVED TO APPROVE AND CONFIRM MS. MURPHY'S FINDINGS OF FACT, CONCLUSIONS, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF STEPHEN DAVID WAITE, M.D. DR. STEINBERGH SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Steinbergh	- aye

The motion carried.



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

October 13, 2004

Stephen David Waite, M.D.
12116 Craven Avenue
Cleveland, OH 44105

Dear Doctor Waite:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) In the routine course of your practice as an emergency room physician, you undertook the treatment of Patients 1 through 8 (as identified on the attached confidential Patient Key - Key confidential and not subject to public disclosure).
 - (a) On or about August 23, 1997, Patient 1, a forty-year-old female, was transported fully immobilized on a backboard via life squad to the Emergency Department [ED] after a "rollover" motorcycle accident in which Patient 1 was not wearing a helmet and was thrown "airborne" from the motorcycle. Patient 1 had a possible loss of consciousness and exhibited facial trauma. You failed to properly perform and/or order and/or investigate and/or document in the patient record:
 - the important circumstances of the motorcycle accident;
 - history of alcohol or other substance use by the patient during and prior to the accident;
 - assessment for potential head injury including scalp or skull examination;
 - chest wall examination;
 - spinal examination;
 - chest X-ray;
 - head CT scan;
 - pelvis X-ray;
 - standard trauma screening labs such as urinalysis to screen for renal or bladder injury;
 - pregnancy status; and

Mailed 10-14-04

- Patient 1's condition and physical status at the time of discharge from the ED.

(b) On or about July 3, 2001, Patient 2, a sixty-one-year-old female, presented to the ED with complaints of persistent headache and vomiting of one week duration that was refractory to the reported treatment with antibiotics for a sinus infection. The patient had no prior history of headache. You failed to properly perform and/or order and/or investigate and/or document in the patient record:

- Possible partially treated meningitis;
- adequate consideration of intracranial pathologies such as intracranial bleeding and/or tumor;
- a lumbar puncture or spinal tap; and
- consideration for hospital admission for careful monitoring and continued evaluation.

Further, you inappropriately discharged Patient 2.

(c) On or about April 20, 1998, Patient 3, a fifty-four-year-old male, presented to the ED with complaints of right side and flank pain after falling three days prior, and presented with an ecchymotic area over the right side of his chest, abnormal blood pressure of 84/60, tachycardia, and the odor of alcohol. Patient 3 was diagnosed with acute multiple rib fractures, hemothorax and subcutaneous emphysema. You failed to properly perform and/or order and/or investigate and/or document in the patient record:

- tests or evaluation to determine the etiology of the abnormal vital signs;
- efforts to determine the patient's alcohol level; and
- evaluation of the potential causes of the patient's subcutaneous emphysema.

Further, despite the above diagnoses, you discharged Patient 3 without performing and/or documenting an evaluation of the potential causes of the patient's subcutaneous emphysema. Further, you failed to refer Patient 3 for an immediate consultation and evaluation by a general or trauma surgeon in the ED.

(d) On or about September 7, 1997, Patient 4, a ten-day-old female, presented to the ED with a high fever of 103.3 rectal temperature and "grunting." You failed to properly perform and/or order and/or investigate and/or document in the patient record:

- a complete septic work-up, including an extensive history and physical examination, laboratory screening including CBC with differential, blood cultures, urinalysis with cultures, chest X-ray and lumbar puncture.

Further, you failed to admit Patient 4 for close observation and antibiotic treatment.

- (e) On or about March 17, 1998, Patient 5, a fifty-two-year-old female, presented to the ED with complaints of sudden onset of left sided chest pain, shortness of breath, nausea and headache of one and one-half hours duration. Patient 5 reported taking medication including Coumadin, Glucophage and Zoloft, and had a history of diabetes and previous cerebrovascular accidents. You failed to properly perform and/or order and/or investigate and/or document in the patient record:

- appropriate cardiac evaluation with three serial sets of cardiac enzymes;
- assessment of Patient 5's anticoagulation profile;
- Patient 5's symptom of headache, including the type, duration, quality and location of the headache as well as associated pertinent symptoms;
- assessment or screening for nuchal rigidity, as well as potential temporal arteritis;
- fundoscopic examination; and
- consideration of potential adverse events or consequences as a result of Patient 5's Coumadin therapy.

Further, you administered Toradol to Patient 5 without assessing and/or obtaining any information about Patient 5's anticoagulation profile.

- (f) On or about October 29, 1997, Patient 6, a one-year-old male, presented to the ED with a report of sudden onset of difficulty breathing, barking cough, congestion and stridor during sleep at home. On arrival, Patient 6 was noted to have a hypoxia of 87% on room air. You diagnosed Patient 6 with "laryngotracheitis (croup)" and ordered that Patient 6 be placed in physical restraints, i.e., a papoose, in order to administer oxygen via nasal cannula. You failed to properly perform and/or order and/or investigate and/or document in the patient record:

- consideration of other causes of Patient 6's stridor and significant hypoxia;
- consideration of radiological tests to rule out other causes of Patient 6's stridor and significant hypoxia;
- consideration of steroid administration; and
- assessment of Patient 6's response to the administration of racemic epinephrine aerosol.

Further, you inappropriately ordered the use of physical restraint on Patient 6 who presented with a potential airway emergency. Further, you ordered the administration of racemic epinephrine aerosol to be performed on the pediatric in-patient floor which failed to ensure physician assessment of the effectiveness of the treatment and failed to provide for potential airway protection.

(g) On or about September 30, 1997, Patient 7, a sixty-six-year-old female, presented to the ED with complaints of persistent epigastric pain with mid-sternal heavy pressure chest pain. Patient 7 reported intermittent epigastric discomfort of two-weeks duration, with more severe symptoms of chest pressure and diaphoresis noted in the six hours prior to being seen in the ED. An ECG performed in the ED showed mild S-T changes over the lateral/apical leads, leads I, AVL. You failed to properly perform and/or order and/or investigate and/or document in the patient record:

- a trial of sublingual nitroglycerin;
- a detailed history to ascertain more specific cardiovascular risks such as hyperlipidemia and diabetes;
- consideration of other potential etiologies for Patient 7's symptoms;
- evaluation to screen for gallbladder or pancreas dysfunction;
- serial ECGs in the ED given the abnormal ECG; and
- test for LDH iso-enzymes;
- in-patient admission with observation and continued evaluation of Patient 7's cardiac status.

(h) On or about April 10, 1998, Patient 8, a sixty-three-year-old male, presented to the ED with complaints of severe respiratory distress, diaphoresis and hypoxia secondary to exposure to bleach and drain cleaner fumes. Patient 8 had a history of congestive heart failure [CHF] and hypertension. You failed to properly perform and/or order and/or investigate and/or document in the patient record:

- an appreciation of the severity of the presentation of Patient 8;
- significant observation and careful monitoring for potential cardiac ischemia and strain; and
- appropriate assessment of observed tachycardia with LBBB and documented ventricular arrhythmia.

Further, you inappropriately considered discharging Patient 8 despite his severe presentation with hypoxia, tachypnea, diaphoresis and tachycardia and a history of CHF and hypertension.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

Stephen David Waite, M.D.
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CERTIFIED MAIL # 7000 0600 0024 5143 8244
RETURN RECEIPT REQUESTED