July 2018 Public Board Actions List

Georgia Composite Medical Board
Attn: **Ms. Latisha Bias**, Public Records Unit
2 Peachtree Street, N.W., 36th Floor
Atlanta, Georgia 30303-3465
PH: (404) 657-3194
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The Board issued **two** public orders in July 2018. To view each Board order, click on the licensee's name below.

1. **Carlos A. Levy-Eliceiri, MD**
019967
Physician
Board Order Terminating Public Consent Order

2. **Kevin McCowan, MD**
053781
Physician
Public Consent Order

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD

STATE OF GEORGIA

IN THE MATTER OF:	*
	*
CARLOS A. LEVY-ELICEIRI, M.D.,	*
License No. 019967,	*
Respondent.	*

BOARD ORDER TERMINATING PUBLIC CONSENT ORDER

1.

The Georgia Composite Medical Board ("Board") entered a Public Consent Order ("Order") in the above-styled matter on or about July 11, 2013, Docket No. 20130037, which placed Respondent's license to practice medicine in the State of Georgia on probation.

2.

On or about May 22, 2018, the Board received a petition from the Respondent to terminate the Public Consent Order. The Board reviewed the petition and Respondent's compliance with the terms of the Order and determined Respondent has complied with the terms and conditions of probation.

Based on the foregoing, the Board hereby terminates the probation of Respondent's license**.** Respondent's license is returned to unrestricted status and is in good standing.

SO ORDERED, this 12th day of July, 2018.

GEORGIA COMPOSITE MEDICAL BOARD

(BOARD SEAL)

BY: _____

J. Jeffrey Marshall, M.D.
Chairperson

ATTEST: _____

LaSharn Hughes, MBA
Executive Director

BEFORE THE GEORGIA COMPOSITE MEDICAL BOARD
STATE OF GEORGIA

IN THE MATTER OF:	*
	*
KEVIN MCCOWAN, M.D.	*
License Number 53781	*
	*
Respondent	*

PUBLIC CONSENT ORDER

By agreement of the Georgia Composite Medical Board ("Board") and Kevin McCowan, M.D. ("Respondent"), the following disposition of this matter is entered pursuant to O.C.G.A. § 50-13-13(a)(4), *as amended*.

FINDINGS OF FACT

1.

Respondent is licensed to practice medicine in the State of Georgia and was licensed at all times relevant to the matters stated herein.

2.

The Respondent together with another physician provided cosmetic surgical treatment to patient E.B. on or about June 20, 2013, involving liposuction and removal of silicone from her buttocks and fat transfers to the thighs.

3.

Records of the treatment show that early in the surgery E.B. had a pulse of 125 and BP of 89/44. She improved with a liter of fluid, but from the end of the surgery through the time of her cardiac arrest, she had consistently low blood pressure and a rapid pulse.

4.

After completion of the surgical treatment, the Respondent was assisting with the patient E.B. in the recovery area when she went into distress requiring immediate medical care. The Respondent noticed a change in the patient's EKG and checked the leads and changed the lead on the monitor. The records show there was an acute EKG change. E. B. went into cardiac arrest and became pulseless and coded. Records of the treatment do not indicate that E.B.'s vital signs were measured or that any action was taken for ten minutes after E.B. coded. The records indicate that CPR was not initiated for ten minutes after E.B. became pulseless. No call was made to 911 for emergency care for approximately twenty-five minutes after E.B. coded.

5.

Paramedics from Metro Ambulance arrived at 19:21. Metro Atlanta records state, in part, patient was in cardiac arrest upon arrival with no CPR although facility states they had initiated CPR earlier and ceased due to a rhythm change. Their records also state, in part, there was approximately 500 cc of blood noted underneath the patient and the physician on the scene advised the blood was from the procedure site.

6.

After the patient expired, the Cobb County Medical Examiner observed the pads beneath the patient's arms to be saturated with blood; and the bedding, gown, compression stockings, and floor around the gurney all showed blood and blood tinged fluid. Of the nine trocar sites, only two were closed, each with a single suture.

7.

The Cobb County Medical Examiner's finding as to cause of death was: "Cardiac Dysrhythmia associated with hypovolemia secondary to liposuction procedure."

8.

Respondent's treatment of E.B. was evaluated by a Board-appointed consultant who concluded that Respondent's diagnosis and treatment departed from and failed to conform to the minimal standards of acceptable and prevailing medical practice in the following ways:

(a) The Respondent's operative care failed to meet the minimum standards.

(b) The Respondent's post-operative care of the patient failed to meet minimum standards.

(c) The Respondent's post-operative care of the patient in distress failed to meet minimum standards.

9.

The Respondent together with another physician provided cosmetic surgical treatment to patient A.J. on or about February 19, 2013, involving liposuction and fat injections to the buttocks.

10.

The surgery began about 18:15 on February 19, 2013. Respondent infused the tumescent fluid and performed the liposuction while standing on one side of the patient. C. B., a certified surgical technician, also performed the liposuction while standing on the other side of the patient.

11.

The patient, A.J., required a lot of sedation though there was no anesthesiologist or nurse anesthetist involved in the procedure. There was no EKG or other advanced monitoring during the treatment. The records show that the patient moaned and complained of pain during the procedure.

12.

The patient records contain scant operative notes; there is no operative narrative; estimated blood loss is omitted; and there is no documentation of EKG readings during surgery.

13.

Upon completion of the liposuction, A.J. was turned prone for fat injections into her buttocks area. After the fat injections had been completed, at 19:45, A.J. made a loud snore and flexed her legs backward into the air, then dropped her legs, and became incontinent.

14.

Records show emergency services were not contacted for aid or transport until 20:17.

15.

A.J. was subsequently transported to the emergency room at Wellstar Kennestone Hospital where, according to hospital records, A.J. was dead on arrival, and pronounced dead at 21:45.

16.

The Cobb County Medical Examiner's finding as to cause of death was "Sequelae of fat emboli secondary to liposuction/fat transfer."

17.

The Cobb County Medical Examiner's report also stated: "The postmortem examination and autopsy showed [the patient A.J.] had defects within her liver, diaphragm, and intercostal spaces (7^{th} and 8^{th} ribs) of the right mid-back associated with the liposuction/fat transfer procedure. There was approximately 250 cc of blood within the abdomen."

18.

Respondent's treatment of A.J. was evaluated by a Board-appointed consultant who concluded that Respondent's diagnosis and treatment departed from and failed to conform to the minimal standards of acceptable and prevailing medical practice in the following ways:

(a) The Respondent's operative care failed to meet minimum standards.

(b) The Respondent's post-operative care of the patient failed to meet minimum standards.

(c) The Respondent's post-operative care of the patient in distress failed to meet the minimum standards.

19.

Respondent hereby waives any further findings of fact with respect to the above-styled matter.

CONCLUSIONS OF LAW

Respondent's conduct constitutes sufficient grounds for the imposition of discipline upon his license to practice as a physician in the State of Georgia under O.C.G.A. Title 43, Chapters 1 and 34, *as amended*. Respondent hereby waives any further conclusions of law with respect to the above-styled matter.

ORDER

The Board having considered all the facts and circumstances of this case hereby orders, and Respondent hereby agrees, to the following terms:

1.

The Respondent's license to practice medicine in the State of Georgia shall be indefinitely limited and restricted so that Respondent may not perform any surgery or surgical

procedure of any nature or assist with any surgery or surgical procedure of any nature until and unless such limitation and restriction is lifted by the Board, in its discretion, in writing. Any decision whether to lift or modify such limitation and restriction shall be in the Board's sole discretion and shall be considered as a non-contested matter. If the Board in its sole discretion determines to lift or modify such limitation and restriction then the Board may do so by another public consent order including appropriate limitations or restrictions upon such license or other terms and conditions as the Board, in its discretion, shall determine appropriate. If any request to lift or modify such limitation and restriction is denied by the Board, in its discretion, then no additional request for lifting or modifying shall be considered for a period of six months following such denial.

2.

Respondent shall pay a fine in the amount of five thousand dollars ($5,000.00) to the Board. Said fine shall be payable by certified check or money order to the Georgia Composite Medical Board and shall be paid in full within three (3) months of the docketing of this Consent Order. Failure to pay as required shall result in further disciplinary action, including revocation, of Respondent's license.

3.

Respondent shall pay administrative fees in the amount of one thousand five hundred dollars ($1,500.00) as partial reimbursement to the Board of expenses incurred in the investigation of this matter, which expenses do not include time spent by the investigative division of the Board. Said fees shall be payable by certified check or money order to the Georgia Composite Medical Board and shall be paid in full within three (3) months of docketing of this Consent Order. Failure to pay as required herein shall result in further disciplinary action,

including revocation, of Respondent's license.

4.

This Consent Order and dissemination thereof shall be considered a PUBLIC REPRIMAND of Respondent by the Board. The Respondent also understands that pursuant to O.C.G.A. Title 43, Chapter 34A, the contents of this order shall be placed on Respondent's Physician Profile. Furthermore, by executing this Consent Order, Respondent hereby agrees to permit the Board to update the Physician's Profile reflecting this Consent Order.

5.

Respondent acknowledges that he has read this Consent Order and understands its contents. Respondent understands that he has the right to a hearing in this matter and freely, knowingly, and voluntarily waives that right by entering into this Consent Order. Respondent understands and agrees that a representative of the Department of Law may be present during the Board's consideration of this Consent Order and that the Board shall have the authority to review the investigative file and all relevant evidence in considering this Consent Order. Respondent further understands that this Consent Order will not become effective until approved and docketed by the Board. Respondent understands that this Consent Order, once approved and docketed, shall constitute a public record, evidencing disciplinary action by the Board that may be disseminated as such. However, if this Consent Order is not approved, it shall not constitute an admission against interest in this proceeding, or prejudice the right of the Board to adjudicate this matter. Respondent hereby consents to the terms and sanctions contained herein.

SIGNATURES ON FOLLOWING PAGE

Approved this 24 day of July, 2018.

GEORGIA COMPOSITE MEDICAL BOARD

(BOARD SEAL)

BY: _____
E. DANIEL DELOACH, M.D.
President

ATTEST: _____
LASHARN HUGHES
Interim Executive Director

CONSENTED TO: _____
KEVIN MCCOWAN, M.D.
Respondent

AS TO KEVIN MCCOWAN, M.D.,
Sworn to and subscribed before
me this 3rd day of July, 2018.

_____
NOTARY PUBLIC
My Commission Expires:

(NOTARY SEAL)

#1039052