STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 99-3983
RAJESH BHAGVATIPRAS DAVE, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly-designated Administrative Law Judge, William F. Pfieffer, conducted a formal hearing in the above-styled case on December 6, 2000, in Tampa, Florida.

APPEARANCES

For Petitioner: Eric Scott, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317-4229

For Respondent: Christopher J. Schulte, Esquire
Burton, Schulte, Weekley, Hoeler, Poe and Robbins, P.A.
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STATEMENT OF THE ISSUE

The issue presented in this case is whether Respondent should be subjected to discipline for the violations of Chapter

458, Florida Statutes, alleged in the Administrative Complaint issued by Petitioner on August 17, 1999.

PRELIMINARY STATEMENT

By Administrative Complaint dated August 17, 1997, Petitioner, the Department of Health, Board of Medicine, alleged that Respondent, Rajesh Bhagvatipras Dave, M.D., a licensed physician, violated provisions of Chapter 458, Florida Statutes, governing the practice of medicine in the State of Florida. The two-count Administrative Complaint relates to the Respondent's care of Patient C.C. from March 1995 through October 1995.

Petitioner alleges in Count I of the Complaint that Respondent failed to practice medicine with the level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in violation of Subsection 458.331(1)(r), Florida Statutes, by (1) failing to do a complete history and physical examination on a new patient with significant risk factors for cardiopulmonary disease; (2) by failing to order a chest X-ray as part of a work-up on a new elderly patient with a long history of smoking; (3) by failing to follow up on the patient's abnormal chest X-ray; and (4) by failing to follow up with the patient's test results that revealed an elevated glucose level.

Petitioner alleges in Count II of the Complaint that Respondent failed to keep written medical records justifying the course of treatment for the patient, in violation of Subsection 458.331(1)(m), Florida Statutes, by failing to document a plan or evaluation for the course of treatment of Patient C.C.'s abnormal chest X-ray and elevated plasma glucose level.

Petitioner may seek permanent revocation or suspension of Respondent's license, restriction of Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of Respondent on probation, the assessment of costs related to the investigation and prosecution of the case, and/or any other relief that the Board deems appropriate. Specifically, Petitioner seeks an order requiring Respondent to pay a $5,000 administrative fine, complete the UF CARES Program, comply with the evaluation, and receive a reprimand.

Respondent contested the allegations of the Complaint and timely requested a formal administrative hearing. Petitioner forwarded the Complaint to the Division of Administrative Hearings on September 22, 1999, requesting the assignment of an Administrative Law Judge to conduct a formal hearing pursuant to Subsection 120.57(1), Florida Statutes. The matter was assigned to David Maloney, an Administrative Law Judge of the Division of Administrative Hearings, and the case was set for final hearing

on March 7-9, 2000. Four Joint Motions to Continue were granted and the hearing was ultimately scheduled to be held December 6, 2000.

Respondent filed a Motion to Dismiss Petitioner's Administrative Complaint and Memorandum of Law in Support based on Respondent's contention that the Probable Cause Panel was improperly constituted, in violation of Rule 64B8-1.001, Florida Administrative Code, which directs that determination of probable cause shall be made by a panel consisting of three members of the Board of Medicine. Respondent asserted that the Probable Cause Panel was comprised of only two members of the Board of Medicine. Respondent's Motion to Dismiss was denied.

At the final hearing, Petitioner presented the testimony of J.C. (Patient C.C.'s daughter). By Joint Stipulation, Petitioner also presented the testimony of Agency Expert H. Curtis Benson, M.D., by post-hearing deposition taken on January 5, 2001, and filed on January 29, 2001. Petitioner offered five exhibits which were admitted into evidence.

Respondent testified on his own behalf. Respondent also presented the expert testimony of Kent R. Corral, M.D. Petitioner offered 14 exhibits into evidence. All were accepted.

By stipulation, the parties agreed to file their proposed recommended orders by January 30, 2001. The Transcript was

filed on January 2, 2001. Petitioner and Respondent filed their Proposed Recommended Orders on January 30, 2001, which were duly considered.

FINDINGS OF FACT

1. Petitioner is the state agency charged with regulating the practice of medicine, pursuant to Section 20.43, Florida Statutes, Chapter 455, Florida Statutes, and Chapter 458, Florida Statutes. Pursuant to the provisions of Section 20.43, Florida Statutes, Petitioner has contracted with the Agency for Health Care Administration to provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards.

2. Respondent is a licensed physician in the State of Florida, having been issued license number ME 0063067. Respondent is board-certified in internal medicine.

3. On March 10, 1995, Patient C.C., a 68-year-old woman with a history of cigarette smoking first presented to Respondent as a new patient with a complaint of nocturia (frequent urination at night).

4. Patient C.C. completed a medical history form for Respondent indicating her past medical history and any medical complaints that she had at that time. Patient C.C.'s history was negative, with the exception of treatment for a skin disorder and arthritis of the fingers. Patient C.C. reported no

history of cardiorespiratory problems and had no complaints of cardiorespiratory problems.

5. Patient C.C. had undergone laboratory testing on March 8, 1995, that revealed an elevated glucose level of 167. While the blood glucose level was elevated, Patient C.C. did not meet the specific diagnosis criteria, as it existed in 1995, to be diagnosed as a diabetic.

6. Respondent conducted a physical examination of Patient C.C., noting his findings in Patient C.C.'s chart. Due to the elevated glucose level, Respondent directed Patient C.C. to begin a 1500 calorie diet and follow an exercise regimen. Respondent advised Patient C.C. of his evaluation, assessment, and proposed plan of treatment.

7. While in his care, Respondent regularly ordered laboratory testing to monitor Patient C.C.'s glucose levels. A report dated May 13, 1995, revealed that Patient C.C.'s glucose level had decreased to 136. A report dated September 7, 1995, revealed Patient C.C.'s glucose level to be 128. Laboratory testing performed at Community Hospital of New Port Richey on October 17 and 18, 1995, revealed glucose levels of 135 and 133, respectively. Upon receipt of the laboratory findings and pertinent diagnostic testing, Respondent advised Patient C.C. of the results, discussed his recommended course of treatment, and noted the discussion in her medical record.

8. On October 16, 1995, Patient C.C. presented to Respondent suffering from uncontrolled hypertension, anxiety, stress, and non-specific chest discomfort. Respondent immediately admitted Patient C.C. into Community Hospital of New Port Richey.

9. Patient C.C. underwent a chest X-ray during her hospitalization. The X-ray revealed a right upper lobe consolidation and the radiologist's report urged follow-up. Respondent received the radiologist's report and discussed the findings with Patient C.C.

10. On October 24, 1995, Respondent advised Patient C.C. by certified letter that he would no longer provide medical care for Patient C.C., that her condition required medical attention, and that she should seek the care of another physician without delay. Patient C.C. received the certified letter on October 27, 1995.

11. Respondent never had the opportunity to provide follow-up or additional care to Patent C.C. as related to the abnormal chest X-ray or elevated glucose level.

12. The evidence at the hearing established that the care provided to Patient C.C. by Respondent was within the standard of care. The evidence at hearing also established that the Respondent's medical records for Patient C.C. documented and justified the course and scope of his treatment of Patient C.C.

13. Respondent's expert testified that the standard of care did not require Respondent to obtain a chest X-ray when he initially saw Patient C.C. in March 1995. Petitioner's expert offered no testimony and presented no evidence on this issue. Practice guidelines did not require and, in fact, recommended against obtaining routine chest X-rays to screen for lung cancer, even for patients at risk, such as smokers.

14. Respondent and the Respondent's expert, Dr. Corral, both testified that Patient C.C. was not a diabetic, and therefore, did not require treatment for a condition from which she did not suffer. Petitioner's expert, Dr. Benson, testified that Patient C.C. was a diabetic and required definitive treatment for that specific condition. Dr. Benson's testimony is less credible on this issue, and the testimony of Respondent and Dr. Corral is found to be more persuasive and credible. Patient C.C. did not meet the 1995 criteria to be diagnosed as a diabetic. The clear and unambiguous criteria required elevation of plasma glucose greater than 200 mg/dl, or a feasting plasma glucose greater than 140 mg/dl on two consecutive occasions. Patient C.C. never met the criteria. Respondent adhered to the standard of care in diagnosing, evaluating, monitoring, and treating Patient C.C.'s elevated glucose levels.

15. In summary, Petitioner failed to establish by clear and convincing evidence that Respondent failed to meet the

standard of care with regard to his alleged failure to (1) perform a complete history and physical examination on a new patient with significant risk factors for cardiopulmonary disease; (2) to order a chest X-ray as part of a work-up on a new elderly patient with a long history of smoking; (3) follow up on the patient's abnormal chest X-ray; and (4) follow up with the patient's test results that revealed an elevated glucose level.

16. Additionally, Petitioner failed to establish by clear and convincing evidence that Respondent did not keep written medical records justifying the course of treatment of the patient by failing to document a plan or evaluation for the course of treatment of Patient C.C.'s abnormal chest X-ray and elevated plasma glucose level.

CONCLUSIONS OF LAW

17. Based on the findings of fact made above, the following conclusions of law are reached.

18. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this cause, pursuant to Sections 120.569, 120.57(1), and 455.225, Florida Statutes.

19. License revocation and discipline proceedings are penal in nature. Because Petitioner sought permanent revocation or suspension of Respondent's license to practice medicine, the

burden of proof on Petitioner in this proceeding was to demonstrate the truthfulness of the allegations in the Complaint by clear and convincing evidence. Subsection 458.331(3), Florida Statutes; Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

20. The "clear and convincing" standard requires:

> [T]hat the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983). The findings in this case were made based on the standard set forth in Osborne Stern, Ferris, and Slomowitz.

21. Subsection 458.331(2), Florida Statutes, authorizes the Board of Medicine to revoke, suspend, or otherwise discipline the license of a physician for violating the following relevant provision of Section 458.331, Florida Statutes:

> (1)(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar

> conditions and circumstances. . . . As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

22. The Complaint alleged that the Respondent practiced medicine below the standard of care by failing to do a complete history and physical examination on a new patient with significant risk factors for cardiopulmonary disease; by failing to order a chest X-ray as part of a work-up on a new elderly patient with a long history of smoking; by failing to follow upon on the patient's abnormal chest X-ray; and by failing to follow up with the patient's test results that revealed an elevated glucose level.

23. Petitioner failed to establish by clear and convincing evidence the charge of failing to do a complete history and physical examination on a new patient with significant risk factors for cardiopulmonary disease. The evidence established that the Respondent took an appropriate history from Patient C.C., adequately examined Patient C.C. based on her sole presenting complaint of frequent urination at night, and recommended the appropriate treatment. The weight of the expert

testimony established that Patient C.C. had no complaints that were cardiopulmonary in nature and that, in fact, Patient C.C. was asymptomatic of any cardiopulmonary problems. Under the circumstances, the Respondent's records adequately note the taking of a history, the performance of physical examination, an assessment of Patient C.C.'s condition, and a plan for Patient C.C.'s treatment.

24. Petitioner failed to establish by clear and convincing evidence the charge of failing to order a chest X-ray as part of a work-up on a new elderly patient with a long history of smoking. Petitioner failed to present any expert testimony or any other evidence critical of Respondent on this issue. In fact, the only evidence presented on this issue was the testimony of Respondent and Respondent's expert, Dr. Corral. Both Respondent and Dr. Corral testified that the standard of care did not require a physician to obtain a chest X-ray on an asymptomatic patient presenting for the first time to the physician's practice. Their testimony was corroborated by the clinical practice guidelines and recommendations of the United States Department of Health and Human Services, the American Cancer Society, and the National Cancer Institute. These clinical practice guidelines, in fact, recommend against the use of chest X-rays for routine screening for lung cancer in the

general public or even in people at increased risk for lung cancer, such as smokers.

25. Petitioner failed to establish by clear and convincing evidence the charge of failing to follow up on Patient C.C.'s abnormal chest X-ray. The evidence presented established that Respondent discussed the chest X-ray findings with Patient C.C. and recommended follow-up, as noted in the hospital discharge summary. Appropriate follow-up could have consisted of simple observation or a repeat X-ray, but the standard of care did not require follow-up on the chest X-ray while Patient C.C. was hospitalized. Rather, Respondent could have begun follow-up on the chest X-ray findings within the month following Patient C.C.'s discharge from the hospital. Respondent did schedule Patient C.C. for a return visit. Respondent, however, was not given the opportunity to follow up and to monitor completely on the chest X-ray because Patient C.C. was discharged from Respondent's practice.

26. Petitioner failed to establish by clear and convincing evidence the charge of failing to follow up with Patient C.C.'s test results that revealed an elevated glucose level. The evidence established that Patient C.C. presented to Respondent's practice with a elevated glucose level of 167 and that Respondent directed that Patient C.C. exercise and be placed on a 1500-calorie A.D.A. diet to control her blood sugar. On this

issue, the testimony presented by Petitioner's expert, Dr. Benson, is less credible than the testimony presented by Respondent's expert, Dr. Corral. Dr. Benson adamantly, but incorrectly, believes that Patient C.C. was a diabetic and required treatment for that condition. Dr. Benson's opinions are directly in conflict with published diagnostic criteria clearly establishing that Patient C.C. was not a diabetic as defined by the diagnostic criteria as it existed in 1995. Patient C.C. never had an unequivocal elevation of plasma glucose greater than 200 mg/dl. Patient C.C. never recorded a fasting plasma glucose level greater than 140 mg/dl on two consecutive occasions. Respondent appropriately and regularly ordered and obtained laboratory studies to monitor Patient C.C.'s blood sugar. Patient C.C.'s blood sugar was appropriately controlled by diet and exercise.

27. Respondent did not violate Subsection 458.331(1)(t), Florida Statutes, by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

28. Subsection 458.331(2), Florida Statutes, authorizes the Board of Medicine to revoke, suspend, or otherwise discipline the license of a physician for violating the

following relevant provision of Section 458.331, Florida Statutes:

> (1)(m) Failing to keep . . . medical records . . . that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

29. The Complaint alleged that Respondent failed to keep written medical records justifying the course of treatment of the patient by failing to document a plan or evaluation for the course of treatment of Patient C.C.'s abnormal chest X-ray and elevated plasma glucose level.

30. Petitioner failed to establish by clear and convincing evidence the charge of failing to keep written medical records justifying the course of treatment of the patient by failing to document a plan or evaluation for the course of treatment of Patient C.C.'s abnormal chest X-ray. The evidence presented established that Respondent could have documented a plan or an evaluation within the month after Patient C.C.'s discharge from the hospital. Respondent did schedule Patient C.C. for a return visit, which does document continued follow-up of the patient. Respondent, however, could not have followed up completely on the chest X-ray because Patient C.C. was discharged from the Respondent's practice. The more credible evidence also

established that Respondent did discuss the chest X-ray findings with Patient C.C. and recommended follow-up, as noted and documented in the hospital discharge summary, which is a part of Respondent's medical records for Patient C.C.

31. Petitioner failed to establish by clear and convincing evidence the charge of failing to keep written medical records justifying the course of treatment of the patient by failing to document a plan or evaluation for the course of treatment of Patient C.C.'s elevated blood sugar. The evidence presented established that Respondent's medical records include routine and regular laboratory reports concerning serial testing and monitoring of Patient C.C.'s blood sugar. Respondent's medical records also document Respondent's plan to place Patient C.C. on a 1500-calorie diet and to begin her on a regimen of exercise. The elevated glucose readings in the hospital were not indicative of any specific problem and could have been addressed following the hospitalization. Respondent, however, was not given the opportunity to follow up and to monitor because Patient C.C. was discharged from Respondent's practice.

32. Respondent did not violate Subsection 458.331(1)(m), Florida Statutes, by failing to keep written medical records justifying the course of treatment of the patient.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Department of Health, Board of Medicine, enter a final order dismissing the August 17, 1999, Administrative Complaint against Respondent, Rajesh Bhagvatipras Dave, M.D.

DONE AND ENTERED this 6th day of March, 2001, in Tallahassee, Leon County, Florida.

WILLIAM R. PFEIFFER
Administrative Law Judge
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Filed with the Clerk of the
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this 6th day of March, 2001.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.