STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. AGUSTIN CARMONA, M.D., Respondent.	)	Case No. 99-4377
DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. AGUSTIN CARMONA, M.D., Respondent.	)	Case No. 99-4378

RECOMMENDED ORDER

This cause came on for a disputed-fact hearing on March 15, 2000, in Malone, Florida, before Ella Jane P. Davis, a duly-assigned Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Carol A. Lanfri, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317-4229

For Respondent: Agustin Carmona, M.D., pro se
DC# U03774
Jackson Correctional Institute
5563 Tenth Street
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STATEMENT OF THE ISSUES

1. The Administrative Complaint in DOAH Case No. 99-4377, charged Respondent with violating Section 458.331(1)(t), Florida Statutes (failure to practice medicine with care, skill and treatment); Section 458.331(1)(m), Florida Statutes (failure to keep written records justifying treatment); Section 452.331(1)(x), Florida Statutes (violation of a rule of the Board or Department) by violating Rule 64B8-9.003(2), Florida Administrative Code, relating to legibility of medical records, in connection with Respondent's emergency room treatment of Patient B.W. on July 21, 1995.

2. The Administrative Complaint in DOAH Case No. 99-4378, charges Respondent with violation of Section 458.331(1)(s), Florida Statutes (being unable to practice medicine with reasonable skill and safety to patients by reason of illness, use of any material, or as the result of any mental or physical condition).

PRELIMINARY STATEMENT

On or about October 20, 1999, these cases were referred to the Division of Administrative Hearings due to Respondent's request for hearing upon disputed issues of material fact.

At all times material, Respondent has been incarcerated at Jackson Correctional Institute in Malone, Florida, because of his conviction for "driving under the influence" which is the focus of DOAH Case No. 99-4378.

Upon information and belief that Respondent would not be released for several years, that his appeal had been concluded, and that no further criminal trials were anticipated, and balancing Respondent's right to remain silent against the Agency's right to reach finality of the prosecution herein, the undersigned consolidated these administrative cases and scheduled the disputed-fact hearing in the Jackson Correctional Institute with enough time prior to the hearing date to allow Respondent to obtain legal counsel and to allow both parties to engage in discovery under difficult circumstances.

On December 13, 1999, Respondent filed a detailed response to the Administrative Complaints. No response is required at law.

During a telephonic hearing concerning Petitioner's Motion in Limine, approximately a week before the scheduled disputed-fact hearing, the undersigned determined that Respondent had had the opportunity to be present by telephone at all depositions scheduled by Petitioner, and had, in fact, been present by telephone at all such depositions. The undersigned inquired whether a continuance was requested, and Respondent indicated in the negative.

However, by the Pre-Hearing Stipulation and at the commencement of the disputed-fact hearing, on March 15, 2000, Respondent indicated for the first time that the incident which was the focus of DOAH Case No. 99-4378, was currently on appeal,

that he was represented by an attorney on that appeal, and that he wanted a continuance until that appeal was concluded and until he could obtain some out-of-state medical records. At the commencement of the hearing, Respondent twice stated that he had never discussed the instant administrative cases with any lawyer and had not sought a lawyer to represent him herein, because he had insufficient funds. He stated that he preferred not to defend on DOAH Case No. 99-4378, for those reasons.[1] Respondent ultimately stated to the undersigned that he had everything he needed to defend.

Petitioner presented a July 1, 1998, letter it had received from Respondent's original criminal attorney giving notice of termination of representation and requesting that all further administrative pleadings be sent directly to Respondent. Petitioner also effectively argued, with supporting exhibits, that Respondent's 1997 conviction for driving under the influence had already been affirmed and that a Rule 3.850 "Appeal" had likewise been decided against Respondent while he was represented by a different attorney than the one who withdrew. (Petitioner's Exhibits 1-4).

Respondent had never been deposed by Petitioner with regard to either Administrative Complaint herein.

Respondent voluntarily filed his December 13, 1999, Answer without consulting any attorney.

Upon the foregoing, the undersigned determined that had Respondent elected to remain silent he could have done so, but he voluntarily filed his written response which waived any right against self-incrimination in these administrative cases; that he had five months to obtain legal counsel or obtain evidence for use at the disputed-fact hearing, but he did not do so; and that a continuance of the disputed-fact hearing on these administrative actions was not mandated by further collateral criminal appeals, even had it been established that such collateral appeals were in progress, which it was not. Accordingly, Respondent's oral motion for continuance to another date was denied.

Nonetheless, prior to any evidence being presented on the merits, Respondent was twice offered a continuance until later the same day so that he could return to his living quarters in the same correctional facility in order to get copies of all proposed exhibits and depositions which had been provided to him by Petitioner as well as any exhibits Respondent might wish to offer. Respondent twice declined.[2] Petitioner's counsel provided Respondent with copies of all of Petitioner's exhibits for Respondent's use during hearing.

Upon Petitioner's motion, official recognition was taken of Rules 64B8-8.001 and 64B8-9.003, Florida Administrative Code (1992 and currently).[3]

Petitioner presented the oral testimony of Raymond M. Pomm, M.D., and Lija G. Scherer. Petitioner's Exhibits 5-14 were admitted on the merits. They included depositions of Walter Muller, M.D.; Lt. Roger Chilton; Selena Bowers, Records Clerk of Kenneth Stark, M.D.; Dorothy Lee, Manager of Medical Records at Florida Hospital Waterman; Jennifer Louer, Records Clerk of Louis Radnothy, D.O., and Robert Tober, M.D.,[4] each with attachments.

Respondent testified on his own behalf and had no exhibits admitted in evidence.

At the conclusion of the disputed-fact hearing on March 15, 2000, Petitioner agreed to provide Respondent with a free copy of the transcript and the undersigned explained to Respondent that, pursuant to his oral agreement on the record with opposing counsel, he would not have to file his proposed recommended order until 35 days after the transcript was filed with the Division of Administrative Hearings. One reason for granting 35 days in which to file proposals was due to an anticipated delay between the time the Transcript was mailed as "Legal Mail" and delivery of the Transcript to Respondent by the correctional facility where he is incarcerated.

On March 31, 2000, Respondent filed a letter of complaint that he had not been provided with a copy of the Transcript.

On April 10, 2000, the original Transcript was filed with the Division.

On April 13, 2000, Petitioner's counsel filed a notice of service on Respondent of a copy of the Transcript.

On April 14, 2000, an Order was entered notifying Respondent that the Transcript had been filed with the Division and explaining how to prepare and file proposed recommended orders.

On April 20, 2000, Respondent filed his "Court Directed Proposal" a/k/a Proposed Recommended Order, with a complaint that he had not yet received his copy of the Transcript.

On May 1, 2000, Petitioner filed its Proposed Recommended Order and a Motion to Strike Respondent's Proposed Recommended Order.

By an Order entered May 12, 2000, only the exhibits attached to Respondent's proposal were struck.

Thereafter, Respondent also filed various papers/pleadings which have been addressed by sequential Orders in the file.

Both parties' proposals have been considered in preparation of this Recommended Order.[5]

FINDINGS OF FACT

1. At all times material to the incidents alleged in the Administrative Complaints, Respondent was a licensed medical physician in the State of Florida, having been issued License No. ME 0016828.

2. Respondent specialized in internal medicine and emergency medicine but has never been board certified in any specialty.

3. Respondent's license has been delinquent since January 31, 2000, but because delinquent licenses may be subject to renewal, the Petitioner has persisted in prosecuting these cases.

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4. On July 21, 1995, B.W., a 56-year-old female, presented to Respondent in the emergency room of Florida Hospital Waterman, with complaints of chest, epigastric, and left shoulder pain. B.W. had a history of dermatomyositis, for which she had been taking 100 mg of Prednisone for a month, along with other medications. Prednisone in such large doses can cause gastrointestinal irritation, ulceration, and bleeding. The day before, B.W. had been prescribed Imuran by her rheumatologist for immunologic problems.

5. Dermatomyositis is a degenerative disease of skeletal muscle that can lead to a multitude of complications, including rheumatologic problems evidenced by abnormal laboratory results.

6. The standard of care in the examination and treatment of a patient with chest pain requires an emergency physician to obtain a history including a complete medical history, family history, and social history. Additionally, in order to meet the standard of care, the emergency physician must perform a complete physical examination, including a review of systems.

7. The emergency room records for Respondent's treatment of B.W. show the information contained above in Finding of Fact No. 4.

8. The emergency room records do not show that Respondent obtained or documented a complete medical history, family history, or social history of B.W. Respondent violated the standard of care in that he failed to obtain or document a complete medical history, family history, or social history of B.W.

9. Respondent also violated the standard of care in that he failed to perform or document a complete physical examination, including a review of systems.

10. Respondent ordered an electrocardiogram (EKG), a chest X-ray, a complete blood count (CBC), complete cardiac enzymes testing (CPK and CKMB), and a metabolic profile or chemistry panel (MPC). He also did a rectal exam which was negative for blood. He did all appropriate tests. He did not fail to order any appropriate tests.

11. The EKG and the chest X-ray yielded normal results, but B.W.'s blood count revealed several abnormal values, including a decreased platelet of 21,000 and a markedly elevated white count of 24,000. A platelet count of 21,000 is extremely low and grounds for major concern, as is the elevated 24,000 white count. Together, in the presence of the other symptoms and abnormal blood values present, which included low RBC, anemic hemoglobin, and low hemocrit, the standard of care requires that an emergency physician obtain a consultation with a specialist, such as a rheumatologist or a hematologist. In light of all the foregoing

results and normal corpuscular volume, which B.W. also had, the emergency physician should have recognized that B.W. did not have simple iron deficiency anemia.

12. Under some circumstances, the emergency room physician's consultation with B.W.'s primary care physician, who in this case was also a rheumatologist, would have been sufficient.

13. Respondent maintained that he had obtained a history from B.W. as set forth in Finding of Fact No. 4, and an oral report from the hospital lab technician to the effect that a blood test ordered by B.W.'s treating rheumatologist the preceding day, July 20, 1995, had shown a platelet count of 18,000, and that because Respondent presumed B.W.'s platelets were increasing with the use of Imuran plus other factors, Respondent did not admit B.W. to the hospital, but, instead, discharged her without even consultation.

14. Despite Respondent's foregoing explanation, it is clear that Respondent did not record or document on B.W.'s chart his oral conversation with the lab technician, if, in fact, such a conversation occurred. This was below the acceptable standard of medical care and record-keeping for an emergency room physician.

15. Respondent stated that he felt that because the treating rheumatologist had not admitted B.W. to the hospital or transfused B.W. the previous day, she should not be admitted or transfused on July 21, 1995. He stated that he also relied on a

medical text (Merck's Manual) which allegedly states that platelet transfusions should not be given until the count falls to 10,000.

16. Respondent stated that he ruled out a myocardial infarction on the basis that both the CKMB on B.W. and the CKMB Index were not elevated and B.W.'s EKG was normal.

17. However, Dr. Tober, who is certified in emergency medicine, testified more credibly that he had never seen a CPK test so high; that interpretation of CPK and CKMB in such a patient as B.W. would be confounded by the co-existence of the dermatomyositis, grossly throwing off these tests in an acute cardiac setting, sometimes causing several EKGs to come back normal in the course of a myocardial infarction; that B.W.'s extremely low platelet count should cause great concern about the hemologic system and clotting response if B.W. started to hemorrhage; and that the suspiciously low lymphocytes and all blood parameters should have caused Respondent not to discharge B.W. prior to a consultation with a specialist.

18. Respondent failed to meet the standard of care by the treatment he rendered to B.W., in that he did not obtain a consultation from either the primary care physician, another rheumatologist, or a hematologist, before discharging her.

19. That standard of care requires an emergency physician to determine an appropriate diagnosis and treatment as related to the patient's complaint and results of examinations.

20. Respondent violated the standard of care in that he merely wrote into B.W.'s chart a portion of her medical history, "dermatomyositis," instead of a current diagnosis which addressed her current abnormalities when she presented in the emergency room. Thus, Respondent did not discern an appropriate diagnosis while appropriately treating B.W.[6]

21. Respondent's chart on B.W. is illegible to the extent that Dr. Tober was unable to read most of 23 lines of it.

22. Because proper care of patients requires that medical records be sufficiently legible for successive professionals to discern what the writer has done and analyzed, I find that Respondent is guilty of keeping written medical records that are illegible and difficult to decipher. I do not consider Hospital Waterman's failure to provide dictation or transcription equipment and/or personnel to excuse this flaw.

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23. On or about July 14, 1995, Respondent was convicted of driving under the influence and placed on probation for 12 months, and his driver's license was revoked for 12 months.

24. About two years later, on July 12, 1997, Respondent's vehicle collided with another vehicle. Respondent and the driver of the other car were injured. Blood was drawn from Respondent at the hospital. Laboratory studies performed by the Florida Department of Law Enforcement revealed that Respondent's blood alcohol level was 0.10 grams of ethyl alcohol per 100 ml. Under

Florida law, a driver is legally intoxicated when his blood alcohol level is 0.08 grams of ethyl alcohol per 100 ml or higher.

25. On August 12, 1997, Respondent was arrested and charged with one count of serious bodily injury while driving under the influence, and two counts of property damage while driving under the influence. On July 2, 1998, Respondent entered a plea of guilty[7] to one count of serious bodily injury while driving under the influence and was sentenced to imprisonment for a period of seven years, one month, and eight days.

26. On or about January 13, 1998, Walter J. Muller, M.D., a board-certified psychiatrist, performed a psychiatric evaluation of Respondent. Dr. Muller diagnosed Respondent with major depression, dysthymic disorder, and alcohol abuse, pursuant to The Diagnostic and Statistical Manual-IV. At that time, these conditions were active and not in remission. The diagnosis of major depression correlates with impaired social and occupational functioning.

27. A diagnosis of dysthymic disorder is an indication of impairment and the inability to practice medicine with skill and safety to patients.

28. A diagnosis of alcohol abuse can be an indication of inability to practice medicine with skill and safety to patients, but would depend upon when the abuse is occurring and how long it has been since the abuse occurred.

29. In the expert opinion of Dr. Raymond Pomm, who is board certified in adult psychiatry and general psychiatry, with added qualifications in addiction psychiatry, and who relied on Dr. Muller's evaluation, the combined three diagnoses of major depression, dysthymic disorder, and alcohol abuse revealed that, to a degree of reasonable medical certainty, Respondent was unable to practice medicine with skill and safety to patients on the date of Dr. Muller's report.

30. Respondent was evaluated at Menninger Clinic in Kansas, on or about May 26, 1998, and diagnosed with alcohol dependence.

31. After six weeks of treatment at the Menninger Clinic, Respondent was released as being "in early remission." The treating physician made a number of recommendations for rehabilitation of Respondent, including treating his alcohol dependence by entering into a monitoring contract with the Physician's Resource Network in Florida and requiring a further evaluation by a neurologist of Respondent's apparently diminished cognitive skills.

32. Dr. Pomm did not have the opportunity to read the entire evaluation by the Menninger Clinic, and did not rely upon it in forming his opinion of Respondent's inability to practice medicine with skill and safety to patients. However, according to Dr. Pomm, there is no cure for alcohol dependence. It is a life-long illness, which is incurable, and which at best, can only be "in remission." In Dr. Pomm's opinion, one who is

alcohol-dependent cannot practice with skill and safety to patients without undergoing a monitoring program.

33. While I accept Respondent's testimony that he has remained sober since approximately May 27, 1998, because he has been in prison, I also note that Respondent has not entered into a monitoring contract or been monitored in a recovery program because he has been in prison.

34. Accordingly, there is no evidence that Respondent's circumstances have changed sufficiently since January 13, 1998, so as to demonstrate that he is able to practice medicine with skill and safety to patients in the real world.

CONCLUSIONS OF LAW

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

36. The Board of Medicine is empowered to discipline the license of a medical physician, such as Respondent, for the following violations of Section 458.331(1), Florida Statutes:

> (m) Failing to keep written medical records, justifying the course of treatment of the patient. Including, but not limited to, patient history; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.
>
> (t) Failing to practice medicine with that level of care, skill and treatment which is recognized by reasonably prudent similar physicians as being acceptable under similar conditions and circumstances.

> (s) By being able to practice medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition.
>
> (x) By violating a provision of Chapter 458, a rule of the Board or Department, or a lawful order of the Board or Department previously entered in disciplinary hearing or failing to comply with a lawfully issued subpoena of the Department.

37. Rule 64B8-9.003(2), provides as follows:

> A licensed physician shall maintain patient medical records in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken or why an apparently indicated course of treatment was not undertaken.

38. The Board of Medicine may impose one or more of the penalties as set out in Section 458.331(2), Florida Statutes.

39. Herein, Petitioner must go forward and prove by clear and convincing evidence the alleged violations. Department of Banking and Finance v. Osborne Stern, 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1st DCA 1987).

40. Petitioner has proven by clear and convincing evidence the allegations of Count I of the Administrative Complaint in DOAH Case No. 99-4377, in that Respondent violated Section 458.331(1)(t), Florida Statutes, by practicing medicine below the acceptable standard of care in that Respondent discharged B.W. from the emergency room without implementing proper treatment, making an appropriate diagnosis, or obtaining the necessary

consultation, despite the fact that B.W. had a dangerously low platelet count and a significant history.

41. Petitioner has proven by clear and convincing evidence the allegations of Count II of the Administrative Complaint in DOAH Case No. 99-4377, that Respondent violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying treatment. The evidence proves this violation in that the history Respondent recorded in the medical records was marginal, test results were not documented, and an assessment was not recorded.

42. Petitioner established by clear and convincing evidence the allegations of Count III of the Administrative Complaint in DOAH Case No. 99-4377, that Respondent violated Section 458.331(1)(x), Florida Statutes, in that Respondent is guilty of violating Rule 64B8-9.003(2), Florida Administrative Code, by failing to maintain patient medical records in a legible manner and with sufficient detail to clearly demonstrate why a course of treatment was undertaken, or why an apparently indicated course of treatment was not undertaken.

43. Petitioner established by clear and convincing evidence the Administrative Complaint in DOAH Case No. 99-4378, to the effect that Respondent violated Section 458.331(1)(s), Florida Statutes, in that Respondent is unable to practice medicine with reasonable skill and safety to patients because Respondent has

been diagnosed as suffering from major depression, dysthymic disorder, and alcohol abuse.

44. The disciplinary guidelines of the Board of Medicine, set out at Rule 64B-8.001, Florida Administrative Code, provide a range of penalties for violations of the provisions of Section 458.331, Florida Statutes, including suspension.

RECOMMENDATION

Upon the foregoing findings of fact and conclusions of law, it is

RECOMMENDED that the Board of Medicine enter a final order finding Respondent guilty of all violations charged, and as a penalty therefore, suspending Respondent's license to practice medicine in Florida until such time as Respondent presents to the Board and proves that he can practice with skill and safety.

DONE AND ENTERED this 15th day of June, 2000, in Tallahassee, Leon County, Florida.

ELLA JANE P. DAVIS
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 15th day of June, 2000.

ENDNOTES

[1]/ The undersigned notes that during Dr. Muller's deposition, page 24, Respondent told Petitioner's counsel that he was represented by a lawyer in a collateral criminal case, was not represented in these administrative cases, and had been advised not to speak in these cases.

[2]/ Much later in the proceedings, Petitioner requested to go back to his dormitory to get another exhibit. This motion was denied at that time on the basis of his two prior waivers before evidence began to be presented.

[3]/ Respondent did not object timely to the request for official recognition. His objections contained in his Proposed Recommended Order are late, without merit, and denied.

[4]/ Dr. Tober is board certified in emergency medicine. Respondent's Motion to Strike contained in his Proposed Recommended Order is denied.

[5]/ Petitioner's "challenges" of Section 458.331(1)(s) and (1)(m), Florida Statutes, first contained in his Proposed Recommended Order are untimely and are denied for that reason and because determinations of constitutionality vel non are outside the jurisdiction of the Division of Administrative Hearings.

Likewise, Respondent's attacks on the sufficiency of the Administrative Complaint(s) first raised in his Proposed Recommended Order, are untimely under Rule 28-106.204, Florida Administrative Code, and the prayer to dismiss/strike based thereon is denied. Respondent is not charged with "wrongful death" under Chapter 766, Florida Statutes, or any other statute.

[6]/ Respondent defended in part on the basis that four days after B.W.'s emergency room visit with Respondent, another physician also did not admit B.W. to the hospital and begin transfusions of platelets. The evidence shows that ultimately B.W. was admitted and transfused but that the source of her internal bleeding was never definitively pinponted and B.W. died. Respondent is not charged with allowing B.W. to die. However, Respondent's actions or lack thereof also are not necessarily excusable due to actions or inactions of other physicians at a later date, under different circumstances. He is held to a standard of care for emergency room physicians.

[7]/ Despite Lt. Chilton's testimony that he testified at a "trial," I have relied on other exhibits showing that Respondent pled guilty. I can only assume that Lt. Chilton testified in some proceeding prior to the entry of the guilty plea due to a plea bargain.

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.