STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. AIDEN MATTHEW O'ROURKE, M.D., Respondent.	)	Case No. 00-4183PL

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on December 11 and 12, 2000, in Miami, Florida, before Patricia Hart Malono, the duly-designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Eric S. Scott, Esquire
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For Respondent: Rose Marie Antonacci-Pollock, Esquire
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STATEMENT OF THE ISSUE

Whether the Respondent committed the violations alleged in the Administrative Complaint dated August 30, 2000, and, if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

In a two-count Administrative Complaint dated August 30, 2000, the Department of Health ("Department") charged Aiden Matthew O'Rourke, M.D., with having violated Section 458.331(1), Florida Statutes, with respect to the treatment he provided to patient R.F. In Count I, the Department charged that Dr. O'Rourke failed 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, in violation of Section 458.331(1)(t), Florida Statutes, by failing to anticipate and plan for excessive blood loss during R.F.'s surgery; failing to take appropriate intraoperative measures to stop R.F.'s blood loss; failing to consult a cardiologist preoperatively regarding R.F.'s condition; failing to anticipate the cirrhotic state of R.F.'s liver; and/or inappropriately electing to proceed with a non-anatomic hepatic resection in spite of R.F.'s blood loss. In Count II, the Department charged that Dr. O'Rourke failed to keep written medical records documenting a preoperative assessment of R.F., documenting appropriate preoperative planning, and/or documenting R.F.'s existent medical conditions, in violation of Section 458.331(1)(m), Florida Statutes.

Dr. O'Rourke timely requested a hearing pursuant to Sections 120.569 and 120.57(1), Florida Statutes, and the

Department forwarded the matter to the Division of Administrative Hearings for assignment of an administrative law judge. Following notice, the hearing was held on December 11 and 12, 2000.

At the hearing, the Department presented the testimony of Dorothy Grisham and John W. Kilkenny, III, M.D. Petitioner's Exhibits 1 through 4 were offered and received into evidence. Dr. O'Rourke testified in his own behalf and presented the testimony of Danny Sleeman, M.D. Respondent's Exhibits 1 through 3 were offered and received into evidence.

The two-volume Transcript of the hearing was filed with the Division of Administrative Hearings on December 20, 2000, and the parties timely filed proposed findings of fact and conclusions of law, which have been considered in preparing this Recommended Order.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The Department of Health, Board of Medicine, is the state agency charged with regulating the practice of medicine in Florida. Section 20.43 and Chapters 455 and 458, Florida Statutes (1997).

2. Dr. O'Rourke is, and was at the times material to this proceeding, a physician licensed to practice medicine in Florida, having been issued license number ME 0044786. He has been in private practice in Fort Lauderdale, Florida, since 1985 and was board-certified by the American Board of Surgery in 1987 and re-certified in 1997. Dr. O'Rourke has been the Chief of Surgery at Broward General Medical Center since 1997.

3. In early 1996, R.F., a 65-year-old woman, was referred to Dr. O'Rourke by Dr. Rajendra P. Gupta, a physician who had treated R.F. at the Broward General Medical Center Clinic ("Clinic") in 1995 and early 1996. The purpose of the referral was for a surgical consultation regarding a mass on R.F.'s liver. 1/

4. Dr. O'Rourke first saw R.F. at the Clinic on February 14, 1996, and on February 21, 1996, R.F. returned to see Dr. O'Rourke for preoperative testing. Dr. O'Rourke examined R.F., took a patient history, and ordered several preoperative tests. Dr. O'Rourke also reviewed R.F.'s medical records from the Clinic and her hospital chart from Broward General Medical Center ("Broward General"). These documents included, among other things, the record of prior consultations with physicians at Broward General, the films from a recent M.R.I. and a recent CT scan, and the results of a CT-guided biopsy, x-rays, sonograms, blood tests, and an esophageal

endoscopy. The CT-guided biopsy did not confirm or rule out the possibility that the mass on R.F.'s liver was cancerous. However, because tests showed that R.F.'s alpha-fetoprotein levels 2/ were abnormal, Dr. O'Rourke considered the mass to be a cancerous tumor and, therefore, lethal.

5. Based on the results of the tests ordered by Dr. Gupta and by Dr. O'Rourke and on the information in R.F.'s medical records and hospital chart, Dr. O'Rourke decided that it would be appropriate to perform an exploratory laparotomy on R.F. to evaluate the mass and, if indicated, perform a right hepatic segmentectomy, or resection, to remove the mass. Dr. O'Rourke explained the gravity of the situation to R.F. and told her that he wanted to perform exploratory surgery to determine if the mass on the liver could be removed and to remove it, if possible. R.F. discussed the proposed surgery with her family and notified Dr. O'Rourke that she would have the surgery.

6. In deciding that an exploratory laparotomy was appropriate for R.F., Dr. O'Rourke considered and evaluated the risk that R.F. would have excessive bleeding during the procedure. The presence of significant cirrhosis of the liver is one indication that a patient might bleed excessively during a hepatic resection. 3/ The results of the esophageal endoscopy performed on R.F. in October 1995 did not show the presence of esophageal varices, nor did the results of R.F.'s CT

scan show the presence of ascites. Both of these conditions are indicative of portal hypertension, which is increased blood pressure in the portal triad that provides blood to the liver. 4/ Portal hypertension is caused by a slowing of the blood flow through the liver, which is, in turn, caused by cirrhosis of the liver. Because there was no evidence of portal hypertension in R.F.'s test results, there was no conclusive preoperative evidence that R.F.'s liver was cirrhotic. 5/

7. Nonetheless, based on other indications in R.F.'s medical records and test results, Dr. O'Rourke considered it highly probable that R.F.'s liver was cirrhotic. R.F. was at high risk of cirrhosis because she had a positive hepatitis profile for Hepatitis B and C, because she had a probable primary cellular carcinoma in the liver, and because her outpatient medical records revealed a persistent elevation of cellular enzymes in her liver. However, the extent of R.F.'s cirrhosis could not be precisely determined through preoperative testing; it could only be conclusively determined intraoperatively. The more important consideration in Dr. O'Rourke's evaluation of R.F. as a candidate for an exploratory laparotomy and possible hepatic resection was the functional ability of R.F.'s liver. There was no preoperative evidence that R.F.'s liver function was abnormal; her PT levels

and her bilirubin levels, both important indicators of liver function, consistently tested within the normal range.

8. Dr. O'Rourke also considered the possibility that R.F.'s tumor was particularly vascular, 6/ which would also indicate that R.F. would bleed excessively during surgery. It is not possible to determine conclusively before surgery if a tumor is vascular; that determination can only be made once the tumor is visible and can be manipulated. However, there was no preoperative evidence that R.F.'s tumor was particularly vascular. R.F. tolerated a CT-guided biopsy of the liver prior to surgery; there was nothing in the biopsied tissue that indicated the tumor was particularly vascular, nor was there any significant bleeding as a result of the biopsy. This would indicate that R.F.'s tumor was not particularly vascular.

9. Dr. O'Rourke did not request a preoperative cardiology consultation for R.F. because there were no indications of a cardiac risk in her medical records or in her test results. Although R.F. had diagnoses of systemic hypertension and of atrial fibrillation, both of which are very common, the hypertension was controlled by Accupril and a diuretic, and neither the hypertension nor the atrial fibrillation would indicate the need for a cardiology consultation. R.F.'s EKG was interpreted as borderline; and there were no indications in her medical records that R.F. had ischemic heart disease. In

addition, the anesthesiologist who was to administer anesthesia to R.F. during the surgery did not request a cardiology consultation. 7/ Had the anesthesiologist been concerned about R.F.'s cardiac fitness to tolerate general anesthesia, he or she would likely have cancelled or deferred the surgery.

10. The only documentation of the location of the hepatic mass that Dr. O'Rourke included in R.F.'s medical records was a notation that the indicated procedure was a right hepatic segmentectomy. However, even though Dr. O'Rourke did not more precisely set forth the location of the mass in the documentation, he knew the exact location of the mass from having examined the film of the CT scan and of the M.R.I. performed on January 3, 1996, which showed an "ovoid solitary mass along the dome of the right lobe of the liver." In addition, the report of the sonogram performed on November 21, 1995, which was available to and reviewed by Dr. O'Rourke, showed a "focal mass on the diaphragmatic surface of the right lobe of the liver."

11. On February 27, 1996, Dr. O'Rourke performed exploratory surgery on R.F. to determine the resectability of the liver tumor. Ultimately, Dr. O'Rourke performed a non-anatomic hepatic resection to remove the tumor.

12. Dr. O'Rourke prepared adequately for the possibility that R.F. would experience blood loss during the exploratory

laparotomy. As noted above, however, there were no preoperative indicators that R.F. would experience excessive blood loss. Dr. O'Rourke requested that a cell saver be available in the operating room during R.F.'s surgery, 8/ and the anesthesiologist ordered R.F.'s blood to be typed and screened to identify the correct blood type. Dr. O'Rourke did not order R.F.'s blood to be typed and cross-matched, which provides the most specific information about the particular type of blood required by the patient. Although the better practice is to have the patient's blood typed and cross-matched prior to surgery, it takes only ten minutes to obtain typed and cross-matched blood from the blood bank should the patient lose more blood than can be replaced by the cell saver. 9/

13. R.F.'s blood pressure was monitored during the surgery by an arterial line, and good access was provided for the introduction of fluids into R.F. through two intravenous lines placed by the anesthesiologist, one 16-gauge line and one 18-gauge line. Dr. O'Rourke did not place a "central line," or central venous pressure ("CVP") line, 10/ into R.F. preoperatively. The anesthesiologist usually makes the decision to insert a CVP line preoperatively, and, in R.F.'s case, Dr. O'Rourke agreed with the anesthesiologist that it was not necessary. Some surgeons routinely insert CVP lines preoperatively when performing an exploratory procedure such as

Dr. O'Rourke was performing on R.F.; other surgeons prefer to wait until they are sure that they will perform the hepatic resection because there are a multitude of risks attendant to the insertion of a CVP line, a bleeding pneumothorax being the most common. 11/

14. Dr. O'Rourke began the exploratory laparotomy by opening R.F.'s belly and removing scar tissue that resulted from prior surgery. He dissected into the abdomen, down to the fascia, and again removed scar tissue that resulted from prior surgery. He divided the falciform ligament and removed it at the point where it attaches to the liver, a procedure that is necessary before the liver can be mobilized. Dr. O'Rourke moved the falciform ligament further up to its diaphragmatic attachment so that he could have full access to the dome of the liver, where R.F.'s tumor was located.

15. Once the falciform ligament was separated from the liver, Dr. O'Rourke palpated the tumor and determined that it was very fragile and tended to crumble.

16. Dr. O'Rourke then mobilized R.F.'s liver. 12/ When he did so, the tumor ruptured, and R.F. started to bleed from the posterior of the liver. R.F.'s blood pressure fell dramatically, a condition known as hypotension, and she became unstable. Dr. O'Rourke's first priority was to stop the bleeding and stabilize R.F.'s blood pressure, and he decided to

pack the liver, the most extreme technique used to stop bleeding in or around the liver. Unfortunately, once a patient undergoing hepatic surgery begins to bleed, it is very difficult to stop the bleeding. 13/

17. The Pringle maneuver is one technique that can be used to control bleeding in and around the liver. This technique requires dissecting around the portal triad and clamping the hepatic artery and the portal vein in order to stop temporarily the blood flow from the portal triad into the liver. Dr. O'Rourke's decision to pack R.F.'s liver rather than attempt the Pringle maneuver was based on several factors. First, R.F. had a significant amount of scar tissue on her anterior abdominal wall, and Dr. O'Rourke anticipated that, given her rapidly deteriorating condition, it would take too much time to dissect through the scar tissue to expose the portal triad. Second, the Pringle maneuver provides only a temporary solution because the portal triad can be clamped and the blood flow into the liver stopped for no more than 15 minutes at a time; the maneuver can be repeated if necessary when working with a healthy liver but it is very risky to do so when working with a cirrhotic liver such as R.F.'s. Third, although it can be helpful to a surgeon trying to find the source of bleeding to temporarily stop the blood flow from the portal triad,

Dr. O'Rourke already knew that the bleeding originated in the posterior of the liver, behind the tumor.

18. At the same time that Dr. O'Rourke was packing the liver, the anesthesiologist was resuscitating R.F. with fluids and calling the blood bank to order cross-matched blood.

19. After packing the liver, Dr. O'Rourke observed the site of the bleeding for 15 to 20 minutes, during which time the bleeding decreased slightly but not significantly. R.F.'s parameters did not improve, and Dr. O'Rourke decided to close the abdomen. After closing the abdomen, Dr. O'Rourke inserted a CVP line; the CVP line was inserted primarily for the purpose of more quickly introducing fluids and blood products into R.F. Once he had placed the CVP line, Dr. O'Rourke assisted the anesthesiologist in attempting to resuscitate R.F. by the rapid infusion of fluid and blood. At this point, Dr. O'Rourke anticipated that R.F. would stabilize, and, once she had stabilized, Dr. O'Rourke intended to wait 24-to-48 hours, reopen the abdomen, remove or replace the lap packing, and close the abdomen without removing the tumor. He decided that, when he re-opened the abdomen, it would be too risky to proceed with the tumor resection because of the likelihood that R.F. would again begin bleeding.

20. Dr. O'Rourke's plans changed because R.F.'s blood pressure did not significantly improve after approximately 20

minutes, and the degree of her hypotension was out of proportion to her actual blood loss, which Dr. O'Rourke estimated as 300-to-400 cubic centimeters. Under these circumstances, Dr. O'Rourke felt that he had two alternatives: to do nothing and let R.F. die or to re-explore the liver. He, therefore, re-opened the incision, removed the packing, and confirmed that the packing had not controlled the bleeding. When packing fails to control the bleeding, the surgeon has a serious problem and a limited number of options: The surgeon can temporarily stop the flow of blood into the liver by using the Pringle maneuver; the surgeon can extend the incisions under the ribs or into the side and fully mobilize the liver 14/ to expose its posterior and possibly locate the source of the bleeding; or, the surgeon can remove the tumor to try to gain access to the vessels that are bleeding so that they can be suture-ligated.

21. Dr. O'Rourke had already rejected the Pringle maneuver as too time-consuming and unlikely to be successful in stopping the bleeding. He decided not to fully mobilize the liver because R.F.'s liver was cirrhotic, and therefore somewhat brittle, so that, had he attempted to mobilize the liver fully, he risked exacerbating the bleeding. In any event, the tumor was completely accessible to Dr. O'Rourke without fully mobilizing the liver.

22. Dr. O'Rourke decided that, under the circumstances, the best chance of saving R.F. was to remove the tumor, thereby gaining access to the posterior of the liver and to the hepatic veins, which he suspected were the source of the bleeding. Once the tumor was removed, he could suture-ligate the blood vessels from which the bleeding originated. Accordingly, Dr. O'Rourke performed a non-anatomic hepatic resection. He found that the tumor resection itself was easy and presented no problems. He individually suture-ligated the vessels that provided the tumor's blood supply and brought the bleeding down to a low level. Dr. O'Rourke felt that he had controlled the bleeding, and R.F.'s hepatocrit level was brought back to a low-normal, but acceptable, level. Nonetheless, R.F.'s blood pressure did not improve and actually deteriorated.

23. Despite the successful efforts to control the bleeding and the efforts to resuscitate R.F. by transfusing blood and fluids, her condition continued to deteriorate, and she was pronounced dead at 6:23 p.m. on February 27, 1996. Dr. O'Rourke spoke with R.F.'s family and told the family members that the amount of R.F.'s blood loss did not explain why her blood pressure fell so low or why her condition continued to deteriorate in spite of his having controlled the bleeding and in spite of the efforts to resuscitate her with blood and fluids. He asked the family for permission to do an autopsy to

determine what had happened. The family refused, although they later had a private autopsy done at Jackson Memorial Hospital in Miami, Florida. The cause of death stated in the autopsy report was "[e]xsanguination post subtotal hepatic resection."

24. The evidence submitted by the Department is not sufficient to establish with the requisite degree of certainty that Dr. O'Rourke failed to keep adequate medical records to justify the course of his treatment of R.F. Because R.F. was a Clinic patient, Dr. O'Rourke had access to the medical records kept since her first consultation with Dr. Gupta in October 1995, as well as access to all of the results of the tests performed on her from October 1995 through the date of surgery. In the record of his examination of R.F., Dr. O'Rourke included her surgical history, her medical history, a list of the medications R.F. was taking, and the results of his physical examination of R.F. His proposed treatment of R.F. was identified in the documentation as a right hepatic resection. Taken altogether, the documentation in this case adequately justifies Dr. O'Rourke's decision to do an exploratory laparotomy and a right hepatic resection, if indicated, and there is no evidence that additional documentation was required. 15/

25. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty

that Dr. O'Rourke's preoperative examinations, testing, or planning fell below that level of care, skill, and treatment that is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

a. R.F.'s medical records and chart establish that she was given a battery of pre-operative tests, and the Department's expert witness could not identify any additional pre-operative test that should have been given. Dr. O'Rourke examined the patient and noted the results of his examination, as well as the medications she was taking, on the Outpatient/Short Stay Record. Dr. O'Rourke knew the exact location of the mass on R.F.'s liver, he adequately noted the location of the tumor as the right posterior lobe of the liver, and he knew that, although R.F.'s liver was most likely cirrhotic, her liver function was normal, albeit low normal. A pre-operative cardiology consult was not indicated by R.F.'s medical records or test results.

b. It is uncontroverted that Dr. O'Rourke's decision to do an exploratory laparotomy on R.F. was not inappropriate. Dr. O'Rourke anticipated that R.F. would suffer blood loss during the surgery, and he planned for the anticipated blood loss by ordering a cell saver for the operating room. Although Dr. O'Rourke perhaps should have had R.F.'s blood typed and cross-matched prior to the surgery, his failure to do so did not appreciably delay the delivery of additional blood to R.F.

26. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. O'Rourke's intraoperative efforts to control R.F.'s bleeding fell below that level of care, skill, and treatment that is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. Dr. O'Rourke's decisions to pack the liver to control the bleeding and then, when that failed, to remove the tumor in an effort to expose the vessels that were bleeding were not inappropriate under the circumstances. Although there were options other than packing available to help control the bleeding, Dr. O'Rourke rejected these options as too time-consuming, as temporary solutions, as unnecessary, or as unlikely to be successful. Dr. O'Rourke's decision to remove the tumor to gain access to the vessels that were the source of the bleeding and to attempt to stop the bleeding by suture-ligating these vessels was a decision that could only have been made intraoperatively, based on all of the information available to Dr. O'Rourke at the time. Although R.F. was very unstable, the cell-saver was recycling the blood she was losing and re-infusing it, and R.F. was receiving other blood products and fluids. Given the available options, Dr. O'Rourke's decision was not inappropriate.

CONCLUSIONS OF LAW

27. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2000).

28. Section 458.331, Florida Statutes (1996), provides in pertinent part as follows:

> 1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
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> (m) Failing to keep written medical records justifying 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.
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> * * *
>
> (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. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $10,000 each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. 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.
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> * * *
>
> (3) In any administrative action against a physician which does not involve revocation or suspension of license, the division shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.

29. In its Administrative Complaint, the Department seeks the revocation or suspension of Dr. O'Rourke's license to practice medicine and/or the imposition of an administrative fine. Therefore, the Department has the burden of proving the allegations in the Administrative Complaint by clear and convincing evidence. Section 458.331(3), Florida Statutes (1996). See also Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); and Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

30. Judge Sharp, in her dissenting opinion in Walker v. Florida Department of Business and Professional Regulation, 705 So. 2d 652, 655 (Fla. 5th DCA 1998)(Sharp, J., dissenting), reviewed recent pronouncements regarding clear and convincing evidence:

> Clear and convincing evidence requires more proof than preponderance of evidence, but less than beyond a reasonable doubt. In re Inquiry Concerning a Judge re Graziano, 696 So. 2d 744 (Fla. 1997). It is an intermediate level of proof that entails both qualitative and quantative [sic] elements. In re Adoption of Baby E.A.W., 658 So. 2d 961, 967 (Fla. 1995), cert. denied, 516 U.S. 1051, 116 S. Ct. 719, 133 L. Ed. 2d 672 (1996). The sum total of evidence must be sufficient to convince the trier of fact without any hesitancy. Id. It must produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Inquiry Concerning Davie, 645 So. 2d 398, 404 (Fla. 1994).

31. Based on the findings of fact herein, the Department has failed to satisfy its burden of proving by clear and convincing evidence that Dr. O'Rourke violated Section 458.331(1)(m), Florida Statutes (1996), by failing "to keep written medical records justifying the course of treatment of the patient." The evidence establishes that the medical records kept for R.F. include her medical and surgical history, the drugs that she was taking at the time of the surgery, the results of Dr. O'Rourke's physical examination, and the results

of the many tests administered to R.F. between October 1995 and February 27, 1996. In the absence of evidence that any additional records were required, these records would appear to be adequate to justify Dr. O'Rourke's decision to do an exploratory laparotomy and perform a right hepatic resection to remove the mass that was located on the right posterior lobe of R.F.'s liver.

32. The Department's burden with respect to its charge that Dr. O'Rourke violated Section 458.331(1)(t), Florida Statutes, is proof by clear and convincing evidence that Dr. O'Rourke failed "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". The Department cannot meet this burden without first establishing the standard of care against which Dr. O'Rourke's acts and/or omissions can be judged. See McDonald v. Department of Professional Regulation, Board of Pilot Commissioners, 582 So. 2d 660, 670 (Fla. 1st DCA 1991)(Zehmer, J., specially concurring)(When an agency charges a professional with the "failure to exercise the degree of care reasonably expected of [such] a professional, the agency must present expert testimony that proves the required professional conduct as well as the deviation therefrom."); accord Purvis v. Department of Professional Regulation, 461 So. 2d 134, 136 (Fla.

1st DCA 1984). Here, the proof offered by the Department did not establish what a reasonably prudent surgeon would do in circumstances similar to those in this case, and, accordingly, the proof did not identify the manner in which Dr. O'Rourke deviated from the standard of care. 16/ The evidence presented by the Department, therefore, does not support a finding that the decisions made by Dr. O'Rourke were either incorrect or not among the options that were acceptable under the circumstances. Consequently, based on the findings of fact herein, the Department did not satisfy its burden of proving by clear and convincing evidence that Dr. O'Rourke violated Section 458.331(1)(t), Florida Statutes (1996).

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a final order dismissing the Administrative Complaint against Aiden Matthew O'Rourke, M.D.

DONE AND ENTERED this 26th day of January, 2001, in Tallahassee, Leon County, Florida.

PATRICIA HART MALONO
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 26th day of January, 2001.

ENDNOTES

1. The liver is located in the upper right portion of the abdominal cavity and is the largest organ in the abdominal cavity. The liver functions as a filtration system for the body, and therefore, it is an extremely vascular organ, having a significant amount of blood flow through it both from the body's arterial system and from the gut. The liver is composed of two lobes, the right lobe and the left lobe, which are further broken down into the lateral and median right and left lobes. In a healthy liver, a lobe of the liver can be removed without significant damage to the other lobe, and the procedure by which a lobe is removed is called a lobectomy. The liver is further divided into eight discrete segments, which, for the most part, do not share blood vessels or blood flow, such that a segment can be removed from a healthy liver without interrupting the blood flow to the rest of the liver. The procedure for removing a segment of the liver is referred to as a segmentectomy.

2. Alpha-fetoprotein levels are known as "tumor markers" because abnormal levels are indicative of a hepatic tumor.

3. Cirrhosis of the liver is the generalized scarring of the liver that occurs secondary to the inflammatory response of the liver when fighting disease. The scar tissue is firm, almost brittle, and is distributed throughout the liver, so that there

are "islands" in the liver that are functioning, surrounded by damaged tissue. The extent to which a cirrhotic liver functions depends on the amount of liver tissue that has been replaced by scar tissue.

4. The portal triad consists of the hepatic artery, the portal vein, and the main bile duct.

5. R.F.'s autopsy report revealed that she had esophageal varices, but this information was not available to Dr. O'Rourke preoperatively.

6. A vascular tumor is one that has a very rapid growth rate and requires a very rich blood supply to sustain its growth.

7. The anesthesiologist always conducts an independent assessment of the patient because, although the surgeon and the anesthesiologist work together, each must assess a different risk. The surgeon must assess the risk to the patient of a surgical procedure, and the anesthesiologist must assess the risk to the patient of anesthesia. If indicated, an anesthesiologist will request a cardiology consultation.

8. A cell saver is used to recover the blood that a patient loses during surgery. The blood is suctioned into a chamber in the cell saver, washed and filtered, and re-infused into the patient. Use of a cell saver eliminates the possibility of blood transfusion reactions.

9. It should be noted as well that, once blood is typed and cross-matched, the blood is committed to the particular patient and must be discarded if it is not used.

10. A CVP line is essentially a large intravenous line, and its primary function is to allow the rapid introduction of fluids into the patient's blood stream. A CVP line also can be used to monitor venous blood pressure, although a CVP line has limited use as a monitoring device. Once a patient starts bleeding heavily during surgery, it is not necessary to have a CVP line placed to know that the patient's blood pressure is low.

11. The Department's expert testified that it was below the acceptable standard of care for Dr. O'Rourke to fail to insert a CVP line into R.F. preoperatively to allow monitoring of R.F.'s venous pressure; this testimony is not persuasive, however, because the expert did not explain why it would have been

necessary during the exploratory portion of the surgery to monitor R.F.'s venous pressure.

12. This is a technique by which the surgeon slides his hand around the side of the liver, lifts it, and places lap pads behind the liver to raise it into the abdominal cavity where it can be worked on more easily than if it were left in its normal anatomic position.

13. The Department's expert witness testified that it is often helpful to lower a patient's blood pressure during the dissection of the liver, because the patient would likely lose less blood during the surgery with lowered blood pressure than with higher blood pressure. In the opinion of the Department's expert, Dr. O'Rourke fell below the standard of care in failing to consider lowering R.F.'s blood pressure through medication during the surgery. This opinion is not credited because the Department's expert testified only that the technique is "often helpful"; he failed to explain how Dr. O'Rourke's failure to use the technique was below the acceptable standard of care.

14. This involves completely removing the liver from its anatomic position so that the entire liver is accessible.

15. The Department's expert witness testified that Dr. O'Rourke failed to document adequately his preoperative planning, but there was no evidence establishing a standard for such documentation. In any event, the gist of the expert's testimony regarding Dr. O'Rourke's failure to document preoperative planning seems to be that, because he did not list in the medical records each test result he considered, each risk he considered, each technique he considered and rejected, and each step he intended to take during the exploratory laparotomy and possible hepatic resection, Dr. O'Rourke failed to plan adequately for R.F.'s surgery. The extent to which Dr. O'Rourke adequately planned for R.F.'s surgical procedure is an issue separate from the sufficiency of his medical records.

16. The Department's expert testified as to his ultimate conclusions that, in various respects, Dr. O'Rourke's treatment of R.F. deviated from the acceptable standard of care. He then supported these conclusions with testimony that merely identified various options available to Dr. O'Rourke, things Dr. O'Rourke could have done, techniques that might have been helpful for Dr. O'Rourke to use, and procedures that the expert himself might use in similar situations. The Department's evidence did not, however, identify those things that a

reasonably prudent surgeon must do under circumstances similar to those in this case, nor did the evidence establish those things that a reasonably prudent surgeon must not do under circumstances similar to those in this case.

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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.