STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 00-4413PL
ROBERT A. ROSS, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to Notice, this cause was heard by Linda M. Rigot, the assigned Administrative Law Judge of the Division of Administrative Hearings, on January 25, 2001, in Miami, Florida.

APPEARANCES

For Petitioner: Kim M. Kluck, Esquire
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For Respondent: Mark A. Dresnick, Esquire
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STATEMENT OF THE ISSUE

The issue presented is whether Respondent is guilty of the allegations contained in the Administrative Complaint filed

against him, and, if so, what disciplinary action should be taken against him, if any.

PRELIMINARY STATEMENT

On July 27, 2000, Petitioner issued an Administrative Complaint alleging that Respondent had violated a statute regulating his conduct as a physician licensed in the State of Florida, and Respondent timely requested an evidentiary hearing regarding the allegations in that Administrative Complaint. Thereafter, this cause was transferred to the Division of Administrative Hearings to conduct the evidentiary proceeding.

Petitioner presented the testimony of Harold Schulman, M.D., by way of deposition, and Respondent presented the testimony of Steven D. McCarus, M.D., by way of deposition. Additionally, Joint Exhibits numbered 1 and 2, Petitioner's composite Exhibit numbered 1, and Respondent's Exhibit numbered 1 were admitted in evidence.

Both parties submitted proposed recommended orders after the conclusion of the final hearing. Those documents have been considered in the entry of this Recommended Order.

FINDINGS OF FACT

1. At all times material hereto, Respondent has been a physician licensed in the State of Florida and has been Board-certified in obstetrics and gynecology.

2. On May 7, 1998, Patient A. J. underwent a laparoscopic procedure due to a complex left ovarian cyst at Columbia Surgical Park Center, an ambulatory care center located in Miami, Florida. The operation consisted of a laparoscopy with laparoscopic lysis of adhesions and a laparoscopic left ovarian cystectomy. Respondent performed the surgical procedure under general anesthesia. Gerald Kranis, M.D., was the anesthesiologist during the procedure.

3. Respondent made a small vertical incision in the umbilicus and insufflated the abdomen with carbon dioxide gas. Respondent then entered the abdomen through a visiport with a 10-millimeter scope. He initially examined the upper abdomen. The patient’s liver and gall bladder appeared normal. Respondent next turned the laparoscope caudally.

4. Inspection of the pelvic organs revealed numerous adhesions of the omentum and bowel to the anterior abdominal wall and to the uterus. Respondent took down the adhesions with sharp dissection with no bleeding. Respondent noted that there was adherence of the bowel to the anterior uterus. This was dissected away with sharp dissection.

5. Inspection of the right adnexa showed a hemmoraghic cyst of the left ovary, and this was dissected by sharp dissection. In the process, the cyst ruptured extruding chocolate-appearing material. The cyst wall was grasped with an

atraumatic grasper and teased out. Hemostasis was secure, and the cyst was retained to be sent to pathology. Inspection of the cul-de-sac revealed numerous adhesions of the bowel to the posterior uterus, and these were lysed with sharp dissection.

6. At the end of the procedure, just before Respondent exited the abdomen, the patient's blood pressure dropped. Inspection of the abdomen revealed no increased bleeding, but there was one area when viewed through the laparoscope that was suspicious of a hematoma. Respondent removed the laparoscope and placed a Foley catheter in the bladder.

7. Respondent then performed a laparotomy, entering the abdomen through a Pfannenstiel incision. There were numerous adhesions of the bowel to the anterior abdominal wall, and Respondent lysed them with sharp dissection.

8. Respondent then discovered a retroperitoneal hematoma. Respondent applied pressure on this area, and a vascular surgeon was summoned. Although the medical records do not specify that pressure was applied with a wet pad, the Department's expert and Respondent's expert interpret the description in the medical records to show that Respondent applied direct pressure with a wet pad.

9. Upon his arrival, Manuel Torres-Salich, M.D., a vascular surgeon, assumed responsibility for managing the patient. He noted that the systolic pressure was 60 MMHG, and

he extended the Pfannenstiel incision to a long midline vertical incision. Upon entering the abdominal cavity, he noticed a massive amount of blood throughout the abdominal cavity. However, he did not quantify the amount of blood he observed.

10. Dr. Torres-Salich attempted the surgical repair of the patient's vascular injuries. He discovered a large anterior laceration of the right proximal common iliac artery at the bifurcation of the aorta and a laceration of the anterior wall of the iliac vein.

11. During the course of the surgical repairs, the patient experienced cardiac arrest, and CPR was administered while the vascular surgical repairs continued. As Dr. Torres-Salich continued to repair the vascular injuries, the patient experienced further cardiac complications. Cardiac massage and CPR were performed. The patient did not respond and expired.

12. No evidence was offered as to the medical equipment available at Columbia Surgical Park Center. Specifically, no evidence was offered as to whether vascular clamps were available for use by Respondent, and, if available, whether these were the type of clamps appropriate for controlling a vascular injury of the iliac artery or iliac vein by a gynecologist. Further, no evidence was offered as to the types of medical personnel available at Columbia Surgical Park Center to assist Respondent other than anesthesia personnel.

13. The record in this cause is clear, however, that a vascular surgeon was not in attendance at Columbia Surgical Park Center during patient A. J.'s procedure but was summoned on an emergency basis. The vascular surgeon arrived within about 20 to 25 minutes after the vascular emergency was discovered.

14. The vascular lacerations that occurred to the iliac artery and iliac vein were lacerations to two of the largest blood vessels in the body. There is no evidence that any improper technique by Respondent during the laparoscopic procedure caused the lacerations of the iliac artery and iliac vein. The exact cause of these lacerations is not known. However, there are three possible causes: from insertion of the Voorhees needle, from insertion of the trocar, or from dissection of adhesions.

15. A gynecologist who experiences a significant vascular injury, such as a laceration of an iliac artery, is trained to abandon the laparoscopic approach immediately, make an incision via laparotomy, and place direct pressure right on the area with a hand or pack. Respondent handled the laparoscopic complication appropriately by performing a laparotomy and applying direct pressure to the retroperitoneal hematoma. Respondent also handled the laparoscopic complication appropriately by calling for the emergency assistance of a vascular surgeon.

16. General gynecologists are not trained to repair vascular injuries, and the immediate objective of a gynecologist once a vascular injury is identified is to do one of two things: apply direct pressure to the area of the bleed or try to clamp the vessel. Visualization of the specific vessel causing the bleed is required to properly use a clamp.

17. Visualization of the specific blood vessels causing this patient’s retroperitoneal hematoma would require Respondent to perform a retroperitoneal dissection, which general gynecologists are not trained to perform. The standard of care in such a situation is for the gynecologist to summon a vascular surgeon. Further, if a gynecologist is not able to identify the exact point of injury, then direct pressure to the hematoma is sufficient and within the standard of care.

18. There is no evidence that Respondent ever attended a gynecologic oncology fellowship where a general gynecologist would get additional training to be able to perform a retroperitoneal dissection. Respondent did not deviate from the standard of care by failing to perform a retroperitoneal dissection to visualize the specific blood vessels causing the hematoma.

19. Respondent did not deviate from the prevailing standard of care by failing to apply pressure above the injury

to stop the bleeding. Respondent's application of pressure at the site of the hematoma was proper.

20. Respondent did not fail to adequately prepare for and deal with a known complication of laparoscopy. He complied with the standard of care by stopping the laparoscopic approach, performing a laparotomy, applying pressure to the bleeding site, and immediately calling a vascular surgeon.

CONCLUSIONS OF LAW

21. The Division of Administrative Hearings has jurisdiction over the subject matter and the parties hereto. Sections 120.569 and 120.57(1), Florida Statutes.

22. The Administrative Complaint filed in this cause alleges that Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent physician as being acceptable under similar conditions and circumstances in that Respondent: (1) failed to recognize that the right iliac artery had been lacerated, (2) failed to visualize the site of injury, (3) failed to use pressure above the injury to stop the bleeding, and (4) in, general, failed to adequately prepare and deal with a known complication of laparoscopy. The Administrative Complaint alleges, therefore, that Respondent violated Section 458.331(1)(t), Florida Statutes. The Department has failed to meet its burden of proof in this proceeding.

23. The Department presented only the deposition testimony of one expert witness, and the Respondent presented only the deposition testimony of one expert witness. Both of those experts agree that there is no factual basis for the first allegation, i.e., that Respondent failed to recognize that the right iliac artery had been lacerated. Accordingly, Respondent cannot be found guilty of that allegation.

24. As to the other three allegations, the two experts disagree. It is necessary, therefore, to evaluate the weight to be given to each expert's testimony. The Department's expert is Board-certified in obstetrics and gynecology and is semi-retired. He has never taught laparoscopy, and laparoscopic procedures are not one of his primary interests.

25. On the other hand, Respondent's expert is also Board-certified in obstetrics and gynecology and has a special interest in laparoscopic procedures. He has taught laparoscopic surgery since 1986 and has published several articles on the subject. He limits his practice to gynecological surgery, and approximately ninety percent of his gynecological surgery is laparoscopic surgery. He has performed approximately ten times the number of laparoscopic procedures as the Department's expert and focuses on the most difficult ones.

26. Respondent's expert is, therefore, more qualified than the Department's to render an opinion in this case and his

opinion is afforded more weight. Respondent's expert testified that Respondent did not deviate from the prevailing standard of care by failing to visualize the site of the injury because the site of the injury cannot be visualized, and Respondent applied direct pressure at the site of the hematoma, which was the site of the injury. Respondent's expert testified that Respondent did not deviate from the prevailing standard of care by failing to use pressure above the injury to stop the bleeding because Respondent applied pressure in the proper location. Respondent's expert further testified that Respondent did not fail to adequately prepare for and deal with a known complication of laparoscopy. Since Respondent did exactly what the prevailing standard of care calls for, he obviously knew how to deal with that known complication.

27. Respondent's expert testified, and it has been found, that Respondent performed in accordance with the prevailing standard of care for gynecologists in all respects during the procedure he performed on patient A. J.

28. Interestingly, both experts recognized as an expert in the field a Dr. Nezhat, who authored an article entitled "Delayed Recognition of Iliac Artery Injury During Laparoscopic Surgery." In that article Dr. Nezhat advises physicians performing laparoscopic procedures who notice an injury to a major vessel such as the iliac artery or vein to immediately do

a laparotomy, put a wet pad over the area, apply heavy pressure or vascular clamps, and call for help. That is precisely what Respondent did, according to the medical records admitted in evidence in this cause.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a final order be entered finding Respondent not guilty of the allegations contained in the Administrative Complaint and dismissing the Administrative Complaint filed against him in this cause.

DONE AND ENTERED this 28th day of March, 2001, in Tallahassee, Leon County, Florida.

LINDA M. RIGOT
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 28th 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.