STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 01-3211PL
REMO G. GAUDIEL, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

On November 5-6, 2001, a formal administrative hearing in this case was held in Tampa, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Britt Thomas, Esquire
Agency for Health Care Administration
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For Respondent: Ross L. Fogleman, III, Esquire
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STATEMENT OF THE ISSUE

The issue in the case is whether the allegations of the Administrative Complaint filed by the Petitioner against the

Respondent are correct and if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaint dated July 10, 2001, the Agency for Health Care Administration, Board of Medicine (Petitioner) alleged that Remo G. Gaudiel, M.D. (Respondent) violated various statutes in his treatment of a patient in March 1997. The Respondent disputed the allegations and requested a formal hearing. The Petitioner forwarded the request to the Division of Administrative Hearings, which scheduled and conducted the proceeding.

At the hearing, the Petitioner presented the testimony of five witnesses and had Exhibits numbered 1-7 admitted into evidence. The Respondent testified on his own behalf, presented the testimony of one witness, and had Exhibits lettered A-F admitted into evidence.

A Transcript of the hearing was filed on February 11, 2002. Both parties filed Proposed Recommended Orders that were considered in the preparation of this Recommended Order.

In order to protect the right to privacy of the patient, this Recommended Order does not identify the patient by name.

FINDINGS OF FACT

1. The Petitioner is the agency responsible for licensure and regulation of physicians practicing in the State of Florida.

2. The Respondent is a Florida licensed physician, holding license number ME 0034599. The Respondent is a board-certified general and thoracic surgeon.

3. In March of 1997, the Respondent was in private practice and a member of the medical staff at Englewood Community Hospital, in Englewood, Florida.

4. On March 25, 1997, emergency medical service personnel transported an 81-year-old male (patient) to the Englewood Community Hospital emergency room at about 5:00 p.m. The patient had fallen in his home, hitting his head on a door frame and sustaining an injury to this right chest, apparently near his ribs.

5. Upon arrival at the hospital, the patient was examined by Dr. William B. Caldwell, an ER physician employed by a company that provided emergency services by contract with the hospital. Dr. Caldwell did not have admitting privileges at the hospital. Only a physician who was a member of the hospital's medical staff could admit a patient.

6. Upon initial examination, Dr. Caldwell observed a laceration on the patient's forehead and pain on the patient's right side near the ribs. The patient was alert and described the event, stating that he fell, hit his head on the door frame and hurt his ribs. There was no indication of neurological

change or loss of consciousness. There was no indication of cervical injury. Bleeding was controlled.

7. According to the patient's history, the patient had chronic obstructive pulmonary disease, coronary artery disease, a prior heart attack, and periodic atrial fibrillation. The patient also had an abdominal aortic aneurysm of approximately four centimeters, apparently unaffected by the event based on the initial examination in the emergency room.

8. The patient was taking coumadin, commonly known as a blood "thinner" which delays clotting time.

9. The patient was sent for X-rays, which confirmed the chronic obstructive pulmonary disease and an old rib fracture.

10. Upon return from X-ray, Dr. Caldwell noticed that a developing hematoma on the right side of the patient's chest, indicating that there was active bleeding occurring in the chest cavity, apparently related to a new rib fracture. At that point, the patient was having breathing difficulty. Dr. Caldwell ordered breathing treatments for the patient, which resulted in some improvement.

11. Initial lab work indicated that the patient's "prothrombic time" was at a "panic value" level, according to the Petitioner's expert witness, which warranted admission to the hospital. According to the time of the lab report, the

information was available at 6:45 p.m. There is no credible evidence that Dr. Caldwell reviewed the lab report.

12. Dr. Caldwell discussed the case with a physician who was covering the practice of the patient's regular physician. Dr. Caldwell believed the patient should have been admitted to the hospital and discussed it with the general physician, who allegedly agreed.

13. At about 7:10 p.m., the Respondent was called in to examine the patient. The Respondent's notes indicate he was called in for a "thoracic and surgical consultation."

14. Dr. Caldwell discussed the case with the Respondent, and reviewed the X-ray information.

15. Dr. Caldwell testified that he "believed" the Respondent had assumed responsibility for the patient. The Respondent asserts that he was called in to consult on the case, and did not accept responsibility for patient care. The evidence fails to establish that the Respondent agreed to assume responsibility for the patient.

16. There is no credible evidence that Dr. Caldwell asked the Respondent to admit the patient to the hospital, or that Dr. Caldwell advised the Respondent that he and the general physician believed admission was appropriate.

17. Shortly after reviewing the X-rays with the Respondent, Dr. Caldwell left the hospital for the night, having

finished his work shift. He failed to dictate any records of his examination or treatment of the patient prior to leaving the hospital.

18. The Respondent sutured and bandaged the laceration on the patient's forehead. While suturing the wound, the Respondent discussed with the patient the advisability of being admitted to the hospital for observation based on his age and the nature of the fall. The patient wanted to return home and declined to be admitted to the hospital.

19. The Respondent thereafter advised the patient to discontinue the use of coumadin and prescribed a medication to remedy the prothrombin deficiency as well as an antibiotic. The Respondent advised the patient to follow up with his regular physician. Shortly thereafter, the Respondent left the emergency room.

20. The patient was discharged from the emergency room at 8:54 p.m. According to the nurse's notes, the Respondent approved the discharge. There is no documentation that the Respondent directed a nurse to discharge the patient. There is no direct evidence that the Respondent told the nurse to discharge the patient. Although the nurse expressed some concern about the patient's condition at the time of the discharge, there is no evidence that she relayed her concern to the Respondent.

21. The patient returned to his residence and, within two hours after his discharge, died. At approximately 10:56 p.m., emergency medical service personnel were called to the patient's residence and confirmed that the patient was dead.

22. An autopsy was performed on the body of the deceased patient. The autopsy report indicates that the cause of death was "blunt force cranio-cerebral, neck and thoraco-abdominal trauma." The autopsy report indicates the existence of an 11 x 9 centimeter contusion of the right flank with associated rib fractures, a fracture of the C4 level vertebral body with "posterior epidural blood extravasation of the C4 level spinal cord," and "traumatic leakage of the abdominal aortic aneurysm into the retroperitoneal and peripelvic soft tissue." Contributing factors were the patient's "severe chronic obstructive pulmonary disease and atherosclerotic cardiovascular disease."

CONCLUSIONS OF LAW

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

24. The Petitioner has the burden of proving by clear and convincing evidence the allegations against the Respondent. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

25. The Petitioner has charged the Respondent with violations of Section 458.331(1)(m) and (t), Florida Statutes. In relevant part, Section 458.331, Florida Statutes, provides as follows:

> 458.331 Grounds for disciplinary action; action by the board and department.--
> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
> * * *
> (m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and 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.
> * * *
> (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 $25,000 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.

26. In this case, the evidence establishes that the Respondent's failure to document the patient's refusal to be admitted to the hospital constitutes a violation of Section 458.331(1)(m), Florida Statutes.

27. As to the remaining allegations related to the standard of care provided to the patient, the evidence fails to establish that the Respondent violated Section 458.331(1)(t), Florida Statutes, because the evidence is insufficient to establish that the Respondent ever assumed responsibility for the patient's care.

28. The Petitioner's expert witness opined that based on his review of the medical records the patient should have been admitted to the hospital for observation, and that the failure to do so constitutes care below the acceptable standard. The witness stated that a CT scan of the patient's head should have been completed based on the patient's age and the head trauma, and that the patient should have been admitted until the blood

coagulation levels were adjusted to correct the patient's "bleeding time."

29. As to whether the patient should have been admitted to the hospital, the testimony of the Petitioner's expert witness has been credited; however, the evidence fails to establish that the Respondent was responsible for the failure to admit. Although Dr. Caldwell discussed the case with the Respondent, there is no credible evidence that Dr. Caldwell asked the Respondent to assume patient responsibility. There is no credible evidence that Dr. Caldwell and the Respondent discussed admitting the patient to the hospital.

30. Rule 64B8-9.003, Florida Administrative Code, establishes standards for adequacy of medical records. Such records are to be maintained with "sufficient detail to clearly demonstrate why the course of treatment was undertaken or why an apparently indicated course of treatment was not undertaken." Rule 64B8-9.003(2), Florida Administrative Code. The Petitioner's expert witness opined that, if the patient declined admission, such information should have been documented in the medical records, and that the failure to document the conversation constitutes a failure to maintain appropriate records justifying the course of treatment. The evidence establishes that the Respondent's failure to document the

conversation with the patient constitutes a violation of Section 458.331(1)(m), Florida Statutes.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Agency for Health Care Administration, Board of Medicine enter a Final Order reprimanding Remo G. Gaudiel for failure to maintain appropriate medical records and imposing a fine of $1000. It is further recommended that the Respondent be required to complete within six months of the Final Order, a continuing education course related to proper completion and maintenance of adequate medical records that is acceptable to the Petitioner, in addition to any other applicable continuing education requirements.

DONE AND ENTERED this 4th day of April, 2002, in Tallahassee, Leon County, Florida.

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 4th day of April, 2002.

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.