STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 01-4925PL
CHRISTOPHER BAKER, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

A formal hearing was held before Daniel M. Kilbride, Administrative Law Judge, Division of Administrative Hearings, on April 23, 2002, in Orlando, Florida.

APPEARANCES

For Petitioner: Shirley J. Whitsitt, Esquire
Agency for Health Care Administration
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For Respondent: Michael R. D'Lugo, Esquire
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STATEMENT OF THE ISSUES

Did Respondent's failure to intervene in the post-operative period immediately after learning the CT scan results of Patient C.O. near midnight on April 12, 1997, constitute treatment that fell below the standard of care and that he 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?

PRELIMINARY STATEMENT

On November 19, 2001, an Administrative Complaint was filed against Respondent alleging that he failed to practice medicine with that level of care, skill, and treatment which is recognized by the profession. Respondent denied the allegations and requested a formal hearing. This matter was referred to the Division of Administrative Hearings on December 27, 2001, and discovery ensued. The case was set for hearing, but was continued once at the request of Respondent.

At the hearing, certain facts were stipulated as not in dispute. Petitioner offered one exhibit, which was admitted in evidence, and presented the testimony of Dean Lohse, M.D., an expert witness, who appeared by videoconference from Jacksonville, Florida. The parties stipulated to the admission of certain medical records, identified as pages 62 through 288, which were admitted in evidence as Joint Exhibit 1. Respondent testified in his own behalf, two exhibits were admitted into evidence, and offered the late-filed deposition of R. Patrick Jacob, M.D., an expert witness, taken on May 8, 2002. Exhibits received in conjunction with the deposition are admitted in

evidence and lettered Petitioner's Exhibits A-D and numbered Respondent's Exhibits 1-4.

A Transcript of the hearing was filed on May 20, 2002, and the deposition of Dr. Jacob was filed on May 28, 2002. Petitioner filed its proposed findings of fact and conclusions of law on June 3, 2002. Respondent filed his proposals on June 7, 2002. Both proposals have been given careful consideration in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Petitioner is the state agency charged with regulating the practice of medicine in Florida.

2. Respondent is a licensed physician in the State of Florida at all times material to the times alleged in the Complaint, having been issued license number ME 0070668.

3. Respondent, as of May 2001, is board-certified in the area of neurological surgery.

4. On April 3, 1997, Patient C.O., a 50-year-old male, presented to an Otolaryngologist (ear, nose and throat surgeon) with complaints of right side nasal polyps.

5. On April 7, 1997, Patient C.O.'s surgeon ordered a radiological consult and a Coronal CT (up, down, front and back) scan of the right maxillary sinus. The CT scan revealed "complete opacification (blockage) of the left frontal, right

ethmoid, right maxillary sinus, as well as the right nasal cavity with complete opacification of right sphenoid sinus."

6. On April 9, 1997, Patient C.O. underwent a surgical procedure to remove nasal polyps. The surgeon removed an extremely large right nasal polyp, measuring approximately 10 cm in length. After removing the large mass, the surgeon noted smaller polyps and removed these also. After removing the polyps, the surgeon noted a "large pulsatile mass," which he biopsied. Biopsy results indicated that the "mass" was brain tissue.

7. During the course of this procedure, the patient's cribriform plate had been pierced. This plate forms a barrier between the nasal cavity and the base of the brain. As a result of this puncture, the surgeon had removed a portion of Patient C.O.'s brain.

8. The surgeon requested an intraoperative consult with Respondent. The surgeon and Respondent talked by telephone and Respondent recommended sealing off the brain tissue with a surgical flap and packing. An arteriogram was performed on Patient C.O. to determine if bleeding was from an artery or vein. It was determined that the bleeding was from a vein. He also, recommended placing Patient C.O. in the neurological intensive care unit, which was done, and the patient was stabilized.

9. A CT scan, ordered by the surgeon, noted a right frontal hemorrhage and pneumoncephalus (air at the top of the skull).

10. On April 10, 1997, drainage was noted from the right nostril of Patient C.O. Respondent noted that drainage was suspicious for cerebrospinal fluid (CSF). Respondent then considered various options in order to stop the leakage of CSF.

11. On April 10, 1997, Respondent performed a surgical procedure which placed a spinal drain in Patient C.O. to control the intracranial pressure and to permit an outlet for the CSF. Respondent was attempting to allow the rupture to the cribriform plate to heal on its own.

12. On April 11, 1997, a CT scan revealed large areas of air in the frontal areas of the skull.

13. On April 12, 1997, it was determined that the rupture of the cribriform plate had not healed on its own. Patient C.O. had persistent drainage from the right nostril. He was taken to the operating room for a direct intracranial surgical repair of the defect. A CT scan demonstrated an increase in the frontal hemorrhage, a large left subdural hematoma, and brain swelling. On the afternoon of April 12, 1997, Respondent performed a bi-frontal craniotomy on Patient C.O. to close off the leaking of spinal fluid from the brain in the area behind the patient's

forehead (CSF leak). The surgery began at 12:15 p.m. and anesthesia was initiated at approximately 12:30 p.m. on April 12, 1997, and surgery concluded at about 5:00 p.m. The procedure involved making an incision across the top of the scalp, from ear to ear, gaining access to the brain by making incisions in the cranium, then lifting the brain to allow access to the cribriform plate. This was accomplished without incident.

14. During the post-operative period, the anticipated reaction of the patient was to return to post-operative status, or to improve neurologically beginning within two hours after the surgery ended.

15. During the course of post-operative care, Patient C.O.'s vital signs and neurological statistics were constantly monitored. Patient C.O. did not show any improvements several hours after surgery as would be expected, but began to show signs of neurological deterioration. Because Patient C.O. did not improve neurologically after the surgery, Respondent, at about 9:30 p.m. on April 12, 1997, ordered a CT scan to be done immediately. Patient C.O. was taken for his CT scan around 10:45 p.m. The CT scan report by radiologist at Florida Hospital was called in to the hospital unit at 11:50 p.m. on April 12, 1997.

16. Respondent was at home in bed, sleeping, when he was paged. Respondent called in and was told by telephone of the "wet read" results of the CT scan by the neuroradiologist. After obtaining the CT scan report, Respondent disagreed with the neuroradiologist's recommendations, ordered the continuation of the interventions which he had previously ordered, and issued no new medical orders.

17. The April 12, 1997, CT scan results were reduced to writing and showed the following findings, when compared to the CT scan taken of Patient C.O., on April 11, 1997:

> Noncontrast examination shows numerous abnormal findings. Compared to the 04/11/97 study acute left subdural hemorrhage is similar. There is a large intraparenchymal frontal hemorrhage that has a similar appearance . . . .
>
> (a) DIFFUSE INTRACEREBRAL SWELLING PROBABLY WORSE IN THE POSTERIOR FOSSA. OBLITERATED FOURTH VENTRICLE. VENTRICLE SIZE SIMILAR.
> (b) INCREASED BLOOD FRONTAL REGION.
> (c) UNCHANGED SUBDURAL LEFT POSTERIOR PAREITAL REGION.
> (d) VENTRICULAR SIZE STABLE.
> (e) PNEUMOCEPHALUS UNCHANGED.
> (f) INTRAVENTRICULAR BLOOD STABLE.

18. At 5:15 a.m. on April 13, 1997, Patient C.O.'s neurological status took a significant turn for the worse. The patient was interbated, and all appropriate measures were taken to attempt to revive the patient. Patient C.O. lapsed into coma and was unable to breathe sufficiently for himself; he sustained

respiratory failure and coma. In the early morning hours of April 13, 1997, Patient C.O's neurological status was discussed with his family, and the decision was made to execute a do-not-resuscitate order. The patient never recovered and died two days later on April 15, 1997.

19. Petitioner alleges that the standard of care required Respondent to take some affirmative or new action to intervene post-operatively on the night of April 12 through 13, 1997, to determine the cause of the deterioration and prevent irreversible brain damage.

20. In support of Petitioner's position with regard to Respondent's standard of care, it presented the testimony of Dean C. Lohse, M.D. Dr. Lohse is a board-certified neurosurgeon who is licensed to practice medicine in the State of Florida. Dr. Lohse is a similar health care provider to Respondent, and he qualifies as an expert witness under Florida law. Dr. Lohse testified that he had several criticisms of the manner in which Respondent managed Patient C.O.'s post-operative care. Dr. Lohse was critical of the manner in which Respondent reacted to the information which was provided to him regarding the CT scan which was taken on the night of April 12, 1997, and which was communicated to Respondent at approximately midnight on that same night. In response to this information, Dr. Lohse was of the opinion that Respondent should have initiated some new

intervention, including returning Patient C.O. to surgery, initiating medications to reduce swelling, introducing a pressure monitor, or changing the position of the lumbar drain. However, during the course of cross-examination, Dr. Lohse conceded that he could not say whether a return to surgery would have resulted in a different outcome for Patient C.O. Likewise, he could not state to within a reasonable degree of medical probability whether the introduction of medications to reduce the swelling would have worked. He could not state within a reasonable degree of medical probability whether the placement of a pressure monitor would have created a different result. Finally, he conceded that the issue of changing the lumbar drain was best left to the clinical judgment of the physician who is presiding over the care of the patient.

21. Respondent testified on his own behalf at the final hearing. Respondent explained the April 12, 1997, craniotomy which he performed. He also explained the course of treatment which was followed with Patient C.O. in the hours subsequent to the conclusion of the craniotomy. Respondent explained his rationale behind ordering a stat CT scan, and he described the basis for his response to the information received at that time. Respondent testified that although he considered a return to surgery based upon the information contained within the CT scan, he decided against this option, as performing another surgery

would only have been for the purpose of removing additional portions of Patient C.O.'s brain, including areas of the brain which are designed to control significant elements of an individual's personality. Respondent made the determination at that time that performing another surgical procedure would likely have caused more harm than good. Respondent testified that brain swelling reducing medication had been introduced previously and that the introduction of more or different brain swelling-reducing medications would not have addressed Patient C.O.'s condition. Respondent testified that the placement of a pressure monitor would have been pointless, given the information which he was able to obtain during the course of the craniotomy procedure.

22. A pressure monitor is designed to measure increased levels of pressure on the brain. Patient C.O. was suffering from the opposite problem. Patient C.O.'s brain was actually flaccid, suffering from an absence, rather than an overabundance, of pressure. Therefore, the placement of a pressure monitor was never considered, as it would not have been of any use under the circumstances.

23. Respondent testified that there was no need to change the aspect of the lumbar spinal drain. The lumbar spinal drain in this particular case was adequately controlled, at 5 ccs per

hour. Thus, the use of the spinal drain was appropriate under the circumstances. Respondent's testimony is credible.

24. Respondent also presented expert testimony, via deposition, of R. Patrick Jacob, M.D. Dr. Jacob is a board-certified neurosurgeon who currently works at the University of Florida in Gainesville. Dr. Jacob testified as to his education, training, and experience. He is a similar health care provider to Respondent, qualifies as an expert under Florida law, and can render expert medical opinions regarding the applicable standard of care in this case.

25. Dr. Jacob testified that in his opinion, to within a reasonable degree of medical probability, Respondent met the applicable standard of care. He addressed each of the specific criticisms raised by Dr. Lohse. He specifically rejected the idea that another surgical procedure should have been performed, stating that to do so would have done more harm than good. He rejected Dr. Lohse's contention that the introduction of additional medications to reduce swelling would have been appropriate. Dr. Jacob disagreed with Dr. Lohse's suggestion that the placement of a pressure monitor would have been appropriate under the circumstances of this case. Finally, Dr. Jacob took issue with Dr. Lohse's opinion that a change in the lumbar spinal drain was warranted given Patient C.O.'s condition. On cross-examination, Dr. Jacob testified that he

felt that Respondent's response to the information contained within the April 12, 1997, CT scan was appropriate. He was then presented with hypothetical questioning regarding whether doing nothing in response to the information contained within the CT scan would have been appropriate. Dr. Jacob testified that doing nothing in response to the information contained within the CT scan report may have constituted a deviation from the accepted standard of care.

26. However, according to Dr. Jacob's review of the records, and Respondent's testimony at the final hearing, it is apparent that a decision was made by Respondent to continue with the interventions which had already been initiated, which under the circumstances of this case constitutes an affirmative act by Respondent to address the treatment and care of Patient C.O. Dr. Jacob's testimony is both credible and persuasive.

27. The evidence is not clear and convincing that Respondent failed to intervene in the post-operative period immediately after learning the CT scan results of Patient C.O. around midnight on April 12, 1997.

28. Respondent did not fail to take appropriate action after learning the results of the CT scan at midnight on April 12, 1997. Respondent ruled out several options and elected to continue with the interventions already initiated.

29. Therefore, Respondent did not fall below the standard of care for similarly situated neurosurgeons and his actions on April 12 through 13, 1997, did not constitute a failure to practice medicine with that level of skill, care, and treatment recognized by a reasonably prudent similar neurosurgeon as being acceptable under similar conditions and circumstances.

CONCLUSIONS OF LAW

30. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding, pursuant to Sections 120.569 and 120.57(1), Florida Statutes, and Section 456.073, Florida Statutes.

31. Pursuant to Section 458.331(2), Florida Statutes, the Board of Medicine is empowered to revoke, suspend or otherwise discipline the license of a physician for the following violations of Section 458.331(1)(t), Florida Statutes:

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

32. When the Board finds any person guilty of any of the grounds set forth in Subsection (1), it may enter an order imposing one or more of the following penalties:

> (a) Refusal to certify, or certification with restrictions, to the department an application for licensure, certification, or registration.

(b) Revocation or suspension of a license.
(c) Restriction of Practice.
(d) Imposition of an administrative fine not to exceed $10,000 for each count or separate offense.
(e) Issuance of a reprimand.
(f) Placement of the physician on probation for such a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, to attend continuing education courses, to submit to reexamination, or to work under the supervision of another physician.
(g) Corrective action.

Rule 64B8-8.001(2)(t), Florida Administrative Code.

33. License disciplinary proceedings are penal in nature. State ex rel, Vining v. Florida Real Estate Commission, 281 So. 2d 487 (Fla. 1973). In this disciplinary proceeding, Petitioner must prove the alleged violations of Section 458.331(1)(t), Florida Statutes, by clear and convincing evidence. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne, Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); and see Addington v. Texas, 441 U.S. 418 (1979).

34. The definition of "clear and convincing" evidence is adopted from Solmowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), which provides:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses

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

See also Smith v. Department of Health and Rehabilitative Services, 522 So. 2d 956 (Fla. 1st DCA 1988).

35. Applying this standard, Petitioner has not met its burden of proving be clear and convincing evidence that Respondent violated Section 458.331(1)(t), Florida Statutes.

36. Based upon the testimony elicited at the final hearing, the medical records, and Dr. Jacob's deposition testimony, the proof presented does not produce a firm belief or conviction, without hesitancy, that Respondent deviated from the standard of care in this case. At best, the testimony is conflicting as to whether such a deviation occurred.

37. Dr. Lohse testified as to numerous areas in which he felt Respondent's care of Patient C.O. did not meet the applicable standard of care. However, as to each of these points, Dr. Lohse later contradicted himself; he testified that he could not say to within a reasonable degree of medical probability if Respondent had performed the acts which Dr. Lohse claimed were required would have resulted in Patient C.O. surviving, or simply that the determination of the issue

was best left to the clinical judgment of the practitioner presiding over the case. In addition, a number of the factual bases which Dr. Lohse used to formulate his opinions were specifically contradicted by Respondent during the course of his testimony, including the introduction of brain swelling-reducing medications, and the restriction placed upon the lumbar spinal drain.

38. Respondent's testimony was credible and Dr. Jacob's testimony, presented via deposition testimony taken after the April 23, 2002, final hearing, pursuant to the order entered prior to the final hearing, is credible and persuasive. Dr. Jacob is of the opinion that Respondent did not deviate from the standard of care in his treatment of Patient C.O. Dr. Jacob did appear to concede during the course of his deposition that if certain hypothetical facts were assumed to be true, then the failure of Respondent to take any affirmative steps in response to the information contained within the CT scan report of April 12, 1997, might constitute a deviation from the standard of care. However, it is not readily apparent that this hypothesis is based upon the actual facts of this case, as the proposed hypothesis is contradicted not only by Respondent's own testimony, but also by the medical records which were submitted into evidence at the final hearing.

39. Therefore, Petitioner has not met its burden of proof in this case, and no disciplinary action should be taken against Respondent.

RECOMMENDATION

Based on the foregoing, it is

RECOMMENDED that the Board of Medicine issue a final order finding that Respondent has not violated Section 458.331(1)(t), Florida Statutes, and dismissing the Administrative Complaint.

DONE AND ENTERED this 19th day of July, 2002, in Tallahassee, Leon County, Florida.

DANIEL M. KILBRIDE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 19th day of July, 2002.

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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.