STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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| DEPARTMENT OF HEALTH, BOARD OF MEDICINE, | ) | |
| Petitioner, | ) | |
| vs. | ) | Case No. 02-1307PL |
| CHARLES S. EBY, JR., M.D., | ) | |
| Respondent. | ) | |

## RECOMMENDED ORDER

Administrative Law Judge (ALJ) Daniel Manry conducted the administrative hearing of this case on July 23 and 24, 2002, in Fort Myers, Florida, on behalf of the Division of Administrative Hearings (DOAH).

## APPEARANCES

For Petitioner: John E. Terrel, Esquire
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For Respondent: H. Roger Lutz, Esquire
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## STATEMENT OF THE ISSUES

The issues for determination are whether Respondent violated Subsections 458.331(1)(f) and (m), Florida Statutes

(1997), by assisting an unlicensed person to practice medicine contrary to Chapter 458 and by failing to maintain adequate medical records; and, if so, what discipline, if any, should be imposed against Respondent's license. (All references to chapters and statutes are to those promulgated in Florida Statutes (1997) unless otherwise stated.)

## PRELIMINARY STATEMENT

Petitioner filed an Administrative Complaint against Respondent on June 19, 2000. Respondent timely requested an administrative hearing.

Petitioner referred the matter to DOAH, and DOAH assigned the case to ALJ Susan B. Kirkland. On December 6, 2001, Petitioner moved to relinquish jurisdiction on the grounds that the parties had entered into a settlement agreement. ALJ Kirkland granted the motion, and Petitioner presented the proposed settlement to the Board of Medicine. The Board rejected the settlement and proposed a counter-offer that Respondent rejected. Petitioner referred the matter back to DOAH for an administrative hearing.

At the hearing, Petitioner presented the testimony of six witnesses, including one expert witness, and submitted 13 exhibits for admission into evidence. Respondent testified in his own behalf and submitted five exhibits for admission into

evidence. One of Respondent's exhibits is the deposition testimony of Respondent's expert witness.

The identity of the witnesses and exhibits, and any attendant rulings, are set forth in the Transcript of the hearing filed on September 18, 2002. The ALJ granted Respondent's unopposed motion for extension of time to file proposed recommended orders (PROs). Petitioner and Respondent timely filed their respective PROs on October 9 and 8, 2002.

The Administrative Complaint contains four counts. Two of those counts are not at issue in this Recommended Order.

Petitioner dismissed one count that charged Respondent with violating Subsection 458.331(1)(x) by performing surgery in an out-patient setting when Respondent did not have staff privileges to perform those procedures at a reasonably proximate hospital. Petitioner concedes a second count by acknowledging in its PRO that the evidence does not show that Respondent advertised his membership in an unapproved specialty board.

Two counts remain at issue. One charges that Respondent violated Section 458.331(1)(f) by aiding an unlicensed person to practice medicine contrary to Chapter 458. The second charges that Respondent violated Section 458.331(1)(m) by failing to maintain adequate medical records.

## FINDINGS OF FACT

1. Petitioner is the state agency responsible for regulating the practice of medicine in Florida. Respondent is licensed to practice medicine in Florida pursuant to license number ME 0015824.

2. Respondent owns and operates an ambulatory surgical center doing business as the Dermatologic & Cosmetic Surgery Center (Surgery Center). The Surgery Center is located at 2666 Swamp Cabbage Court, Fort Myers, Florida 33901.

3. Respondent is a Board-certified Dermatologist and also performs cosmetic surgery that includes breast augmentation. Dermatology and cosmetic surgery involve similar procedures. The procedures used to remove skin cancers from the face are similar to those used in face-lifts and eyelid surgery. Respondent performs approximately a thousand skin cancer surgeries a year, has been doing cosmetic surgery since 1986, and has practiced breast surgery since 1989.

4. Respondent is a member of the American Board of Cosmetic Surgery. That board is not approved by the American Board of Medical Specialties or the Florida Board of Medicine.

5. Respondent has attended numerous seminars and satisfied relevant continuing education requirements throughout his career. Respondent has never been sued by a patient and has no prior discipline against his license.

6. Prior to August 12, 1997, Respondent performed breast augmentations through the patient's nipple. Respondent made a small incision in the lower part of the binary nipple. He used his fingers to separate the overlying breast tissue from the muscle and create a pocket in which to place an implant. The incision left a scar at the nipple, and Respondent sought to develop competency in a different procedure identified in the record as the axillary method of breast augmentation.

7. The axillary method allows the surgeon to access the breast from the patient's armpit. The surgeon makes a 1.5 inch incision under the armpit, uses an instrument to create a pocket in the breast, inserts a partially inflated implant into the pocket, and repeats the same procedure in the other breast. The surgeon then checks the breasts for symmetry, fills the implants, closes the pockets, and concludes the procedure.

8. In the axillary method, a surgeon must use instruments rather than his fingers to create a pocket for the implant. The initial incision and placement of the implant do not require great skill. The greater skill is required in reaching the proper plane in the breast tissue and in creating the pocket.

9. The brachial plexis is just below the incision in the armpit and contains all of the nerves that make the arm work. From the armpit, the surgeon must proceed over the sternum. If

the surgeon applies too much pressure, the surgeon can cross the center of the chest and create a condition known as a unibreast.

10. Respondent developed a basic understanding of the axillary method by watching video tapes for several years and by attending seminars approved for professional education credit in the State of Florida. In May of 1997, Dr. Daniel Metcalf taught one of those seminars in Orlando, Florida.

11. Dr. Metcalf is licensed to practice medicine in Oklahoma. He is qualified by training and experience to perform the axillary method and to teach the method to other physicians. For approximately 25 years, Dr. Metcalf has limited his medical practice to breast surgery and performs approximately 650 surgeries each year.

12. At the time that Dr. Metcalf taught the accredited seminar in Orlando, his license to practice medicine in Oklahoma was suspended. On November 13, 1995, Dr. Metcalf pled guilty to a felony charge that he violated federal interstate commerce law by selling silicon implants during a moratorium on their sale.

13. The federal court fined Dr. Metcalf $5,000 and sentenced him to six months in federal prison beginning on April 5, 1996. The State of Oklahoma suspended Dr. Metcalf's medical license for one year beginning on the date of his release from prison. The suspension expired on or about October 5, 1997.

14. In May of 1997, Respondent discussed the axillary method with Dr. Metcalf during the seminar in Orlando. Respondent and Dr. Metcalf had known each other since the early 1980s, and Dr. Metcalf agreed to come to the Surgery Center and teach the axillary method to Respondent.

15. Respondent scheduled the teaching session at the Surgery Center for August 12 and 13, 1997. Five of Respondent's patients agreed to participate. The patients are identified in the record as B.D., T.R., R.K., M.P., and D.C.

16. Each patient acknowledged in writing that it would be the first time Respondent would perform the axillary method. Neither Respondent nor Dr. Metcalf charged the patients for a surgeon's fee, and Dr. Metcalf did not charge Respondent. However, the patients paid the costs of the implant, the operating room, and the blood work.

17. Respondent conducted a preoperative interview with each patient. He advised the patient that Dr. Metcalf would be in the operating room teaching Respondent.

18. On August 12 and 13, 1997, Respondent introduced Dr. Metcalf to each patient. Respondent and Dr. Metcalf then scrubbed, gloved, and proceeded with the teaching session.

19. Dr. Metcalf performed approximately 60 to 70 percent of the first surgery. Respondent performed progressively more of each successive surgery until Respondent performed the vast

majority of the surgery. The surgery that Dr. Metcalf performed included at least one incision and pocket, insertion of an implant, use of the appropriate surgical instruments, and closure of an incision on at least one patient.

20. Neither Respondent nor Dr. Metcalf caused any harm to a patient. The results of all five procedures were positive and without complication. No patients complained about their treatment. Two of Respondent's former employees are the complaining witnesses in this case.

21. The first issue is whether Dr. Metcalf practiced medicine within the meaning of Section 458.305(3). Section 458.305(3) defines the "practice of medicine" as:

> [T]he diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition.

22. Dr. Metcalf did not diagnose, treat, or prescribe medicine for any human disease, pain, injury, or deformity, or mental condition. The breast augmentations that he participated in were elective and cosmetic and did not treat any disease, pain, injury, or deformity. Dr. Metcalf must have performed an "operation" for some "other physical . . . condition" in order to practice medicine within the meaning of Section 458.305(3).

23. Respondent's counsel argued during the hearing that the issue of whether Dr. Metcalf practiced medicine was an issue

of law, rather than fact. Counsel argued that expert testimony would invade the province of the ALJ.

24. If Respondent's counsel were correct, the result could be problematic for Section 90.702. Although a physician would be qualified by training and experience to opine that a peer's activities satisfy the standard of care applicable to the practice of medicine, the physician would not be qualified to know whether he or his peer practiced medicine.

25. In an abundance of caution, the ALJ requested the parties to cite relevant legal authority in their respective PROs. Neither party cited any direct or analogous legal authority that resolves the issue raised by Respondent's counsel or construes the statutory definition of the practice of medicine in Section 458.305(3).

26. Each party submitted expert testimony concerning the issue of whether Dr. Metcalf practiced medicine. As the trier of fact and arbiter of credibility, the ALJ must resolve the evidential conflicts between the experts. Accordingly, the fact finder has carefully considered the substance of the testimony of the two experts and determined the appropriate weight to be accorded the testimony of each.

27. Respondent's expert based his opinion on a custom within the medical profession in which unlicensed persons, such as members of an emergency medical team, medical students, and

first year residents, train under a physician. Respondent's expert opined that an unlicensed person does not practice medicine because the person is learning under the auspices of a physician who has responsibility for the unlicensed person.

28. Respondent's expert relied on facts not in evidence. Unlike the custom described by Respondent's expert, the evidence shows that the person teaching was not licensed to practice medicine in the state where the teaching occurred. The person learning was the only person so licensed. While Respondent had ultimate responsibility, Respondent was not teaching Dr. Metcalf. Dr. Metcalf was teaching Respondent.

29. The custom described by Respondent's expert operates within a framework of laws and rules that are inapposite to this case. Residents who are not licensed to practice medicine in Florida may practice under the supervision of a physician only if the residents, and the hospitals in which they work, comply with registration and reporting requirements in Section 458.345 and Florida Administrative Code Rules 648-6.008 and 6.009. None of those provisions apply to the facts in this case. (All references to rules are to those promulgated in the Florida Administrative Code on the date of this Recommended Order.)

30. Respondent's expert also testified that doctors customarily teach other doctors in states where the teaching doctor is not licensed. In Florida, however, that custom is

limited by Section 458.303(1)(b) to activities that satisfy the definition of a consultation.

31. A consultation is defined in Rule 64B8-2.001(8) to include the taking of a medical history, the examination of a patient, the review of laboratory tests and x-rays, and the making of recommendations to a person licensed to practice medicine in Florida. A consultation is not a set of activities separate and apart from the practice of medicine. It is a subset of the "practice of medicine" in Section 458.305(3).

32. The opinion of Respondent's expert is limited, by operation of law, to that part of the practice of medicine that is a consultation within the meaning of Section 458.303(1)(b) and Rule 64B8-2.001(8). That part of the practice of medicine that is not a consultation is the practice of medicine that is at issue in Section 458.331(1)(f). Further references in this Recommended Order to the "practice of medicine" refer to those activities described in Section 458.305(3) that are not a consultation within the meaning of Section 458.303(1)(b) and Rule 64B8-2.001(8).

33. Some of the activities engaged in by Dr. Metcalf at the Surgery Center satisfied the definition of a consultation. Other activities comprised the practice of medicine. The proportion of each is not material in this case.

34. Dr. Metcalf performed at least 60 percent of the first "operation" for some "other physical . . . condition" within the meaning of Section 458.305(3). Dr. Metcalf practiced medicine progressively less with each successive operation and performed progressively more consultation.

35. One purpose of the teaching session was for Dr. Metcalf to first demonstrate the axillary method and then to assist Respondent in the practice of that medicine. As it turned out, this purpose was more qualitative than quantitative because Respondent quickly demonstrated competency. However, if it were unnecessary for Dr. Metcalf to first demonstrate the axillary method, Respondent could have gained the competency he sought by reviewing video tapes, attending seminars, and consulting with Dr. Metcalf.

36. Respondent aided, assisted, procured, or advised Dr. Metcalf to engage in the practice of medicine for at least 60 percent the first surgery performed on August 12, 1997. The next issue is whether Dr. Metcalf was an "unlicensed person" within the meaning of Section 458.331(1)(f).

37. Chapter 458 commonly uses the term "licensed" to refer to persons licensed outside of Florida. For example, Section 458.303(1)(b) refers to physicians "licensed" in another state. Section 458.3115(1) authorizes restricted licenses for "foreign-licensed" persons. Section 458.313(1)(c) authorizes licensure

by endorsement for those "licensed" in another jurisdiction, and Section 458.315 authorizes a temporary certificate for persons "licensed" in any other state.

38. Dr. Metcalf was a licensed person in Oklahoma when he practiced medicine at the Surgery Center in August of 1997. A person licensed to practice medicine is not an "unlicensed person" while the person's license is suspended. A contrary finding could be problematic under Florida law.

39. If a person with a suspended Florida license were an unlicensed person during the suspension and the person violated the terms of the suspension, the person would have no professional license against which the Board of Medicine could take further disciplinary action, including revocation of the license. Rather, the Board would be required to seek criminal prosecution pursuant to Section 458.327(1)(a).

40. During the period of suspension, Dr. Metcalf was a licensed person in Oklahoma. However, Dr. Metcalf was not authorized to exercise any privileges under the license or to enjoy the benefits of his license until the suspension expired.

41. Section 458.331(1)(f) does not prohibit Respondent from aiding, assisting, procuring, or advising an unauthorized person to practice medicine. Such a statutory prohibition would have been broad enough to proscribe the practice of medicine by a licensed person whose authority to practice was temporarily

suspended. Rather, Section 458.331(1)(f) prohibits Respondent from "aiding, assisting, procuring, or advising any unlicensed person" to practice medicine. (emphasis supplied) Relevant terms in Section 458.331(1)(f) must be construed strictly in favor of the licensee because this is a license disciplinary proceeding that is penal in nature.

42. A finding that Dr. Metcalf was a licensed person in Oklahoma does not resolve the issue of whether Dr. Metcalf was an unlicensed person for the purposes of Section 458.331(1)(f). An "unlicensed person" in Section 458.331(1)(f) is properly defined by reference to Section 458.327(1)(a).

43. Section 458.331(1)(f) prohibits Respondent from "aiding, assisting, procuring, or advising an unlicensed person to practice medicine contrary to this chapter . . . ." (emphasis supplied). Section 458.327(1)(a) prohibits the practice of medicine without "a license to practice in Florida." When the term "unlicensed person" in Section 458.331(1)(f) is harmonized with Section 458.327(1)(a), an "unlicensed person" means a person not licensed in Florida.

44. Sections 458.327(1)(a) and 458.331(1)(f) operate in concert. The former proscribes the practice of medicine inside this state without a Florida license. The latter prohibits a person licensed inside the state from assisting in the violation of the former. In August of 1997, Respondent violated Section

458.331(1)(f) by assisting an unlicensed person to practice medicine contrary to Section 458.327(1)(a).

45. Respondent did not intentionally violate Section 458.331(1)(f) and had no prior knowledge of the violation. The cause of the violation is rooted in multiple instances of miscommunication, confusing circumstances, and statutory ambiguity that Respondent did not create.

46. Respondent undertook reasonable efforts to comply with Florida law. Prior to the surgeries, Respondent contacted Ms. Anne Dean. Ms. Dean is the licensed risk manager for the Surgery Center and is qualified by training and experience to advise Respondent in matters of regulatory compliance.

47. Ms. Dean owns and operates a risk management company in Deland, Florida. She is the certified risk manager for over 450 domestic and foreign ambulatory surgery centers.

48. Ms. Dean provides a wide range of services including financial feasibility analysis and the processing of certificates of need. She also provides services to ensure that architectural design, equipment lists, inventories, and policies and procedures comply with applicable state and federal regulatory requirements. Ms. Dean also assists ambulatory surgical centers with other license certification, accreditation, and regulatory matters.

49. Since 1988, Ms. Dean has been the risk manager required under state law for the Surgery Center. Ms. Dean was responsible for the Surgery Center's state licensure and Medicare certification. She has been present during each license and risk management survey conducted by the Agency for Health Care Administration (AHCA). AHCA has never cited the Surgery Center for a violation. Ms. Dean has assisted Respondent in ensuring that renovations to the Surgery Center complied with applicable regulations and, except for the calendar year 2000, has advised Respondent in all matters of regulatory compliance and accreditation.

50. Respondent asked Ms. Dean to ensure that the teaching session to be conducted by Dr. Metcalf complied with applicable state law and any accreditation requirements. Ms. Dean spoke by telephone with unidentified representatives of both AHCA and Petitioner. The advice from those representatives was consistent for two areas of concern.

51. The first area of concern involved the accreditation needed for Respondent to be certified to perform the axillary method. Pursuant to the advice of the agency representatives, Ms. Dean created a surgical proctor report and gave the form to Respondent. After the teaching session, Dr. Metcalf completed a report for each patient and provided the reports to Ms. Dean. Ms. Dean reviewed the reports and met with a three-member

committee for the Surgery Center. The committee certified Respondent as qualified to perform the axillary method.

52. The second area of concern involved the status of Dr. Metcalf's license to practice medicine. Respondent was specifically concerned that Dr. Metcalf was not licensed to practice medicine in Florida and that Dr. Metcalf's Oklahoma license was suspended. Respondent requested Ms. Dean to ensure that the teaching session complied with Florida law.

53. Ms. Dean conferred with representatives for Petitioner and AHCA. Ms. Dean advised Respondent that if the person teaching were licensed in another state, the person would be entitled to practice medicine in Florida during the teaching session under the auspices of Respondent, a licensed person in Florida. However, if the person teaching were not licensed in another state, the person could not perform any function that required licensure. Ms. Dean conveyed the advice of the agency representatives to Respondent.

54. The advice from those qualified by training and experience in regulatory compliance is consistent with an educational custom among practitioners. It is common for doctors to practice medicine for educational purposes in states where they are not licensed.

55. Before Respondent began cosmetic surgery, Respondent spent four one-week periods with two different cosmetic surgeons

in Texas and Virginia. Respondent was not licensed to practice in Virginia. Respondent obtained similar experience in California where he is not licensed.

56. Respondent is 66 years old and did not attempt to become board certified in plastic surgery. That certification would have required two or three years of general surgery and plastic surgery. Respondent would have spent his time learning complex reconstructive procedures, including cleft lips and pallets, rather than simpler cosmetic surgery.

57. The advice from Ms. Dean and representatives for Petitioner and AHCA was incorrect and based on a mistake of law. The statement that a person licensed in another state can do more than consult in Florida purports to amend or modify the limited authority in Section 458.303(1)(b) as well as the prohibitions in Sections 458.331(1)(f) and 458.327(1)(a). An agency cannot amend, enlarge, or deviate from a statute.

58. The mistake of law arose from ambiguity in Chapter 458. Chapter 458 does not define the term "unlicensed person." An "unlicensed physician" is defined in Rule 64B8-6.001 to mean a medical doctor not licensed by the Board of Medicine. However, the term "unlicensed physician" applies only to Section 458.345 and does not apply to Section 458.331(1)(f).

59. The law implemented in Rule 64B8-6.001 is limited to Section 458.345. The rule refers only to interns, residents,

and fellows in a hospital setting. Rule 64B8-6.001 does not define an "unlicensed physician" for any purpose in Chapter 458 except Section 458.345.

60. A broader reading of Rule 64B8-6.001 would conflict with the definition of a "physician" in Section 458.305(4). Section 458.305(4) defines a "physician" to mean a person licensed by the Board of Medicine. The rule defines an "unlicensed physician" as a medical doctor not licensed by the Board. Even if the rule were construed to imply that a medical doctor is not a person, for purposes of Section 458.305(4), the implication would not avoid the apparent oxymoron.

61. Any ambiguity between Section 458.305(4) and Rule 64B8-6.001 must be resolved in a manner that effectuates the statute. Section 458.305(4) defines a physician "as used in this chapter. . . ." (emphasis supplied)

62. Neither the definition of an "unlicensed physician" in Rule 64B8-6.001 nor the definition of a "physician" in Section 458.305(4) defines the term "unlicensed person" in Section 458.331(1)(f). Chapter 458 does not expressly state that a person licensed to practice medicine in another state is an "unlicensed person." Moreover, Chapter 458 uses the term "licensed" interchangeably to mean persons licensed inside and outside of Florida.

63. The correct meaning of the term "unlicensed person" is not found in a single provision in Chapter 458. A licensee must glean the meaning from reading Sections 458.427(1)(a) and 458.331(1)(f) in a manner that harmonizes the two provisions.

64. The following hypothetical further illustrates the unintended ambiguity in Chapter 458. If Dr. Metcalf were licensed in Florida in August of 1997, Section 458.331(1)(f) would not have prohibited Respondent from assisting Dr. Metcalf to practice medicine contrary to Chapter 458, including gross and repeated malpractice. Section 458.331(1)(f) does not prohibit Respondent from helping a licensed person to violate Chapter 458.

65. Statutory ambiguity also exists in the distinction between a consultation and other activities defined as the practice of medicine. Although Chapter 458 recognizes a legal distinction between the two kinds of activity, the practical distinctions evidently ebb and flow on a daily basis through a custom in which practitioners teach others in states where the practitioners are not licensed.

66. The ambiguity in Chapter 458 gave rise to, confusion, mistakes of law by individuals qualified by training and experience in regulatory compliance and miscommunications to Respondent. Respondent reasonably relied on the advice of those qualified by training and experience to advise him in his

attempt at regulatory compliance. Respondent did not intend to violate Section 458.331(1)(f).

67. The remaining issue for determination is whether Respondent maintained adequate records for the teaching session at the Surgery Center. The statutory requirement for adequate medical records is set forth in Section 458.331(1)(m). In relevant part, Section 458.331(1)(m) provides that Respondent's license is subject to discipline if Respondent fails:

> [T]o keep . . . 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 . . . supervising, or billing for each . . . treatment procedure and that justify the course of treatment of the patient. . . . (emphasis supplied)

68. The parties do not dispute that the medical records adequately identify Respondent. The contested issue is whether the medical records justify the course of treatment by adequately identifying Dr. Metcalf by name and title.

69. The medical records include operative reports that identify Respondent by name but do not identify Dr. Metcalf. Petitioner argues that Section 458.331(1)(m) requires the operative reports to identify both Respondent and Dr. Metcalf. Petitioner argues that Respondent was the "licensed physician" and Dr. Metcalf was the "physician extender and supervising physician."

70. Dr. Metcalf was neither the "physician extender" nor the "supervising physician" during the teaching session. Section 458.305(4) defines a physician as a person who is licensed by the Board of Medicine. Dr. Metcalf was not licensed by the Board and was not a physician under Florida law.

71. Respondent was the "licensed physician." Petitioner admits that the medical records adequately identify the "licensed physician" in accordance with Section 458.331(1)(m).

72. If the definition of a physician in Section 458.305(4) were disregarded, the ALJ agrees with Petitioner that Section 458.331(1)(m) implicitly distinguishes a "licensed physician" from a "physician extender and supervising physician." However, the implicit distinction does not serve the ends that Petitioner seeks. Rather, the implicit distinction suggests that the physician extender and supervising physician may be someone other than a licensed physician.

73. If the implied distinction in Section 458.331(1)(m) were correct, it would need to be construed in pari materia with Section 458.331(1)(f) in a manner that gives force and effect to both subsections. The prohibition in Section 458.331(1)(f) could not prohibit Respondent from assisting an unlicensed person who is "physician extender and supervising physician" without nullifying the implied distinction in Section 458.331(1)(m).

74. The interplay between Subsections 458.331(1)(f) and (m) does not alter the outcome of this case. However, it further elucidates the statutory ambiguity that Respondent, his risk manager, and two different agency representatives faced in attempting to ascertain whether the teaching session complied with Florida law.

75. Assuming arguendo that Petitioner's view of Dr. Metcalf as the physician extender and the supervising physician were correct, Petitioner's statutory interpretation conflicts with the literal terms of Section 458.331(1)(m). Section 458.331(1)(m) requires the medical records to identify either the licensed physician or the physician extender and supervising physician. The statute does not require the medical records to identify the licensed physician and the physician extender and supervising physician. Relevant terms in Section 458.331(1)(m) must be construed strictly in favor of the licensee because this is a license disciplinary proceeding that is penal in nature.

76. If it were determined that Dr. Metcalf could be a physician extender without being a physician defined in Section 458.305(4), no statute or rule cited by the parties defines a "physician extender." Although the term may be a term of art within the medical profession, Petitioner failed to adequately explicate that form of art. The evidence was less than clear and convincing that Dr. Metcalf was a physician extender.

77. If it were determined that Dr. Metcalf could be a supervising physician without being a physician defined in Section 458.305(4), the definitions of "direct supervision and control" and "direct responsibility" in Rule 64B8-2.001(1) and (6) and Rule 64B8-4.026(1) aren't probative. The rules merely define the quoted terms by reference to physical proximity. Both Respondent and Dr. Metcalf were physically proximate.

78. The evidence shows that Respondent was ultimately responsible for the surgeries. Respondent had actual control of each surgery, could have stopped each surgery at any time, and was responsible for billing each patient.

79. Unlike the operative reports, the anesthetist reports identify Respondent and Dr. Metcalf by name and title. The parties agree that the anesthetist reports are part of the medical records.

80. Petitioner argues that the identification of Dr. Metcalf solely in the anesthetist reports is inadequate. Petitioner claims the operative reports must also identify Dr. Metcalf.

81. Each party submitted expert testimony concerning the issue of whether the identification of Dr. Metcalf solely in the nurse anesthetist reports was adequate. Petitioner's expert was tendered and accepted "as a physician, in general, and as a plastic surgeon." Respondent's expert practices emergency

medicine, rather than cosmetic or plastic surgery, but is an expert in quality assurance. Respondent's expert is better qualified by training and experience, within the meaning of Section 90.702, to assist the trier of fact in a determination of whether the medical records are adequate.

82. The testimony of Respondent's expert is consistent with the record-keeping requirements in Section 458.331(1)(m) and Rule 64B8-9.003. Neither the statute nor the rule requires medical records to identify Dr. Metcalf in multiple parts of the medical records or to identify Dr. Metcalf in any specific document. The anesthetist reports comprise adequate medical records that identify both Respondent and Dr. Metcalf.

83. Petitioner argues that the patient consent forms do not identify Dr. Metcalf; and that Respondent did not tell his patients that Dr. Metcalf would be operating on them or that Dr. Metcalf's license to practice medicine was suspended. No finding is made concerning these issues because they are not relevant to any allegation contained in the Administrative Complaint. The Administrative Complaint does not allege that Respondent failed to obtain informed consent from his patients.

84. If it were determined that Section 458.331(1)(m) requires the operative reports to identify Dr. Metcalf when the anesthetist reports already do so, Respondent did not cause the omission of Dr. Metcalf's name from the operative reports.

Respondent instructed his circulating nurse and surgical supervisor (circulating nurse) to identify Dr. Metcalf in the operative reports that Respondent signed but did not read. The regular duties of the circulating nurse included the identification of surgeons in the operative reports. Respondent reasonably relied on the circulating nurse to perform her assigned duties correctly. The Administrative Complaint does not charge Respondent with failure to supervise his employee or with failure to review the operative reports he signed.

85. The circulating nurse failed to identify Dr. Metcalf in the operative reports she prepared for Respondent. Sometime after the teaching session in August of 1997, the circulating nurse abruptly terminated her employment at the Surgery Center following several employment problems.

86. When Respondent hired the circulating nurse in July of 1996, she was in an impaired physician or nurses (IPN) program for treatment of a previous addiction to Xanex and Demerol that she developed during her divorce. However, representatives of the IPN program assured Respondent that the circulating nurse was successfully completing the program.

87. After the circulating nurse terminated her employment, Respondent discovered that drugs were missing from the Surgery Center. Respondent also learned that the circulating nurse had stopped going to the IPN program in August of 1997 and had

stopped taking her urine tests. In October, 1997, the IPN program dismissed the circulating nurse.

88. Sometime between August 13 and September 11, 1997, the circulating nurse told Respondent that she suspected the anesthetist of being addicted to drugs because he was falling asleep during surgeries. The circulating nurse also thought some drugs were missing from the Surgery Center.

89. Respondent barred the anesthetist from further surgeries and asked the circulating nurse to conduct a drug count. Respondent left the next day with his wife on a previously scheduled vacation but stayed in communication with the circulating nurse.

90. The circulating nurse conferred with the risk manager and conducted a drug count but did not comply with prescribed procedures. The circulating nurse entered her drug count on a form but did not make any written findings. The circulating nurse told Respondent that she thought some drugs were missing.

91. Respondent requested the circulating nurse to fax him the portion of the Surgery Center manual that prescribed drug audit procedures. The circulating nurse faxed the material and then terminated her employment. When Respondent returned from his vacation, the office keys used by the circulating nurse were in Respondent's mailbox. The circulating nurse quit her job because she felt Respondent expected too much of her.

92. Prior to January 1998, Respondent requested a pharmacy consultant to assist Respondent and his wife in a second narcotic count. The pharmacy consultant confirmed that some drugs were missing from the Surgery Center. The missing drugs included Versed, Demerol, Tylox, and Valium.

93. Respondent reported the missing drugs to the risk manager, and the risk manager reported the incident to the state. The appropriate state agency began an investigation in January of 1998 that included the potential involvement of the anesthetist and the circulating nurse. The anesthetist died shortly after January 1998, and the agency concluded the investigation without charging the circulating nurse.

94. The circulating nurse and Respondent's former insurance secretary are the complaining witnesses in this case. On September 11, 1997, the insurance secretary altered the computer entrees for the employee manual so that the number of hours needed to be eligible for insurance benefits conformed to the number of hours that the insurance secretary worked.

95. Respondent's wife is the office administrator. She discovered the changes and corrected them. She then instructed the insurance secretary not to come into the Surgery Center while Respondent was on vacation.

96. When Respondent and his wife returned from their vacation, they discovered that the insurance secretary had

copied all of the patient charts for August 12 and 13, 1997, and had resigned from her job. Neither Respondent nor his wife could locate any of the copied charts. The proctor forms that had been completed by Dr. Metcalf and reviewed by the risk manager and accreditation committee were missing from their files. Whole parts of the surgery manual were missing.

97. The risk manager conducted an independent search for the missing records without success. The risk manager had helped compile the compliance files, was familiar with the records, and would have recognized any misfiled records.

CONCLUSIONS OF LAW

98. DOAH has jurisdiction over the parties and subject matter of this proceeding. Sections 120.569, 120.57(1), 456.073. DOAH provided the parties with adequate notice of the administrative hearing.

99. Petitioner has the burden of proof in this proceeding. Petitioner must show by clear and convincing evidence that Respondent committed the acts alleged in the Administrative Complaint and the reasonableness of any proposed penalty. Sections 120.57(1)(h) and 458.331(3); Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern Company, 670 So. 2d 932 (Fla. 1996).

100. The evidence is less than clear and convincing that Respondent failed to maintain adequate medical records in

violation of Section 458.331(1)(m). This proceeding is penal in nature, and the ALJ must strictly construe statutory terms in a manner that favors the person sought to be penalized. Munch v. Department of Business and Professional Regulation, 592 So. 2d 1136, 1143 (Fla. 1st DCA 1992); Fleischman v. Department of Business and Professional Regulation, 441 So. 2d 1121, 1123 (Fla. 3d DCA 1983); Lester v. Department of Professional and Occupational Regulations, 349 So. 2d 923 (Fla. 1st DCA 1977).

101. In order for evidence to be clear and convincing:

> The evidence must be of such weight that it produces in the mind of the trier of fact a firm . . . conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983). The evidence is less than clear and convincing that Respondent failed to keep adequate medical records.

102. Evidence relevant to the remaining issue is clear and convincing. Petitioner showed by clear and convincing evidence that Dr. Metcalf practiced medicine at the Surgery Center in August of 1997 and that Respondent assisted, procured, and advised Dr. Metcalf to practice medicine.

103. By operation of law, Dr. Metcalf was an "unlicensed person." Section 458.331(1)(f) prohibits Respondent from assisting an unlicensed person to practice medicine contrary to Section 458.327(1)(a).

104. When the Board of Medicine finds a person guilty of violating any part of Section 458.331(1), Section 458.331(2) authorizes a range of penalties. The authorized penalties include revocation or suspension of a license, restriction of practice, imposition of an administrative fine for each count or separate offense, issuance of a reprimand, placement of the physician on probation, and issuance of a letter of concern.

105. Rule 64B-8.001 promulgates disciplinary guidelines for a violation of Section 458.331(1)(f). For a first offense, Rule 64B8-8.001(2)(f) prescribes a minimum penalty of probation and a $1,000 fine. The PRO seeks a $10,000 fine, continuing education, one-year probation, and a reprimand.

106. The evidence does not support the penalties that Petitioner proposes in its PRO. Rather, the evidence supports a finding that no penalty is reasonable in this case.

107. Rule 64B8-8.001(3) authorizes the Board to deviate from the recommended penalty in Rule 64B8-8.001(2)(f) based on aggravating and mitigating factors. No aggravating factors are present in this case but all of the mitigating factors enumerated in the rule are present.

108. The violation did not expose any patient or member of the public to physical injury or potential injury, no matter how slight. Rule 64B8-8.001(3)(a). Respondent was not subject to any legal constraints at the time of the offense. Rule 64B8-

8.001(3)(b). Petitioner sought to establish only three of the four counts in the Administrative Complaint but proved only one. Rule 64B8-8.001(3)(c). Respondent has not previously committed the same offense. Rule 64B8-8.001(3)(d). Respondent has no previous disciplinary history. Rule 64B8-8.001(3)(e). Respondent derived no pecuniary gain as a result of the statutory violation. Rule 64B8-8.001(3)(f). Respondent made a reasonable, good faith effort to comply with applicable laws and believed, after the risk manager consulted with representatives for two different state agencies, that he was in compliance with Florida law. Rule 64B8-8.001(3)(h).

109. The imposition of a penalty in this case does not serve any of the purposes adopted by the Board of Medicine in Rule 64B8-8.001(1). The purposes relevant to this case are those intended to punish the licensee, deter the licensee from future violations, and deter other licensees from violations. Rule 64B8-8.001(1). The imposition of a penalty in this case does not serve any of those purposes.

110. The evidence does not justify punishment of the licensee. Respondent did not intentionally violate Section 458.331(1)(f), had no anticipatory knowledge of noncompliance, and reasonably relied on advice from those qualified by training and experience in regulatory compliance.

111. The violation is rooted in multiple instances of confusion and miscommunication. Such a mitigating factor has been recognized by the Board of Medicine in other cases. Board of Medicine v. Peter A. Indelicato, DOAH Case Number 92-2203 (September 23, 1992), adopted in Final Order (February 17, 1993). The Board is bound by the principle of administrative stare decisis to follow its previous decisions involving similar facts. Gessler v. Department of Business and Professional Regulation, 627 So. 2d 501, 504 (Fla. 4th DCA 1993).

112. No discipline is needed to deter Respondent from future violations. Respondent is not likely to commit a similar violation in the future. The violation did not arise from any deficiency in Respondent's competence or method of practice. Respondent did not intend to violate the law, and the violation did not arise from a lack of reasonable care. Respondent is aware of the law and attempted to comply with it.

113. A finding of guilt is sufficient to deter other licensees and unlicensed persons from similar violations. It resolves any ambiguity in the statutory definition of an "unlicensed person" and in the statutory distinctions between a "consultation" and the "practice of medicine." It provides guidance to practitioners in their pursuit of the education they need to improve the quality and scope of medical care they provide to individuals.

## RECOMMENDATION

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

RECOMMENDED that the Board of Medicine enter a Final Order finding Respondent not guilty of violating Subsection 458.331(1)(m), guilty of violating Subsection 458.331(1)(f), and imposing no penalty.

DONE AND ENTERED this 3rd day of December, 2002, in Tallahassee, Leon County, Florida.

DANIEL MANRY
Administrative Law Judge
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Filed with the Clerk of the
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this 3rd day of December, 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.