STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF OSTEOPATHIC MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 03-1615PL
DAVID VASTOLA, D.O.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted on June 24 and 25, 2003, in West Palm Beach, Florida, before Administrative Law Judge Claude B. Arrington of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Kim M. Kluck, Esquire
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For Respondent: Roy R. Watson, II, Esquire
Adams, Coogler, Watson, Merkel,
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STATEMENT OF THE ISSUE

Whether Respondent, a doctor of osteopathic medicine, committed the offenses alleged in the Amended Administrative Complaint and the penalties, if any, that should be imposed.

PRELIMINARY STATEMENT

Petitioner's "Amended [sic] Administrative Complaint" (AAC) against Respondent dated February 5, 2003, alleged certain facts pertaining to Respondent's care of a male patient who will be referred to as R.S. R.S. is now deceased.

Count One of the AAC alleged that Respondent violated the provisions of Section 459.015(1)(x), Florida Statutes (1999), by failing to practice osteopathic medicine with the level of care, skill, and treatment recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar circumstances. Specifically, paragraph 52 of the ACC charged as follows:

> 52. Respondent failed to practice osteopathic medicine with that level of care, skill and treatment, which is recognized by a reasonably prudent similarly situated osteopathic physician, in one or more of the following ways:
>
> (a) Respondent did not order additional tests to determine the cause of the lesion visible on the November 9, 1999, chest x-ray, January 25, 2000, chest x-ray, February 11, 2000, chest x-ray, and May 25, 2000, chest x-ray taken of Patient R.S.;
>
> (b) When a radiologist dictated a report, on or about September 11, 2000, indicating a questionable rounded area of density on the

September 11, 2000, chest x-ray, Respondent waited six weeks before further evaluating Patient R.S. to determine the cause; and

(c) Respondent failed to evaluate Patient R.S. in order to determine the cause of repeated abnormal elevated serum calcium levels.

Count Two of the AAC alleged that Respondent violated Section 459.015(1)(o), Florida Statutes (1999), by failing to keep legible medical records that justify the course of treatment of R.S. Specifically, paragraph 56 of the AAC charged as follows:

> 56. Respondent failed to keep medical records that justify the course of treatment in one or more of the following ways:
>
> (a) Respondent failed to document the lesion visible on the November 9, 1999, January 25, 2000, February 11, 2000, and May 25, 2000, chest x-rays;
>
> (b) Respondent failed to document justification for failing to further evaluate Patient R.S. to determine the cause of the lesion visible on four repeated chest x-rays;
>
> (c) Respondent failed to document in his medical records justification for waiting six weeks before further evaluating the area of density noted by a radiologist who viewed the September 11, 2000, chest x-ray; and
>
> (d) Respondent failed to document justification for failing to determine the cause of repeated elevated serum calcium levels.

Respondent denied the material allegations of the AAC, the matter was referred to the Division of Administrative Hearings, and this proceeding followed.

At the final hearing, the parties offered two joint exhibits, both of which were composite exhibits and both of which were admitted into evidence. Joint Exhibit 1 consists of medical records from Respondent's office for R.S. Joint Exhibit 2 consists of x-rays taken of R.S. by Respondent. Petitioner presented the testimony of E.S.,[1] Dr. Lionel J. Gatien, and, by deposition, Dr. Daniel Siragusa. Petitioner offered two exhibits, each of which was admitted into evidence. Respondent testified on his own behalf, and presented the additional testimony of Gail Vastola (Respondent's wife), Dr. Allen Marcus, and Dr. Norman Henry Pevsner. Respondent offered five exhibits, four of which were admitted into evidence.

A Transcript of the proceedings, consisting of three volumes, was filed on July 30, 2003. Each party filed a Proposed Recommended Order, which has been considered by the undersigned in the preparation of this Recommended Order.

All statutory citations are to Florida Statutes (2002), unless otherwise indicated.

FINDINGS OF FACT

1. Petitioner is the agency of the State of Florida charged with regulating the practice of medicine pursuant to Section 20.43, Chapter 456, and Chapter 459.

2. At all times material to this proceeding, Respondent has been licensed as an osteopathic physician in the State of Florida, having been issued license number OSSO3793.

3. Respondent is board-certified in internal medicine and gastroenterology and has been in the private practice of medicine in Palm Beach County, Florida, since 1978.

4. Respondent was the primary care physician for Patient R.S. from 1994 to November 2000. R.S., a male born in November 1936, was a retired physician at the times material to this proceeding. R.S. was a compliant, informed patient while under Respondent's care.

5. R.S.'s medical history included elevated serum calcium levels, prostate cancer, thyroidectomy, and chronic, obstructive pulmonary disease, referred to as COPD. In addition, R.S. suffered from bipolar disorder and was a long-time user of Lithium. At the times pertinent to this proceeding, R.S. was being followed by the doctor in Seattle, Washington, who treated his prostate cancer, and by an endocrinologist in West Palm Beach, Florida. In addition to the foregoing history, when he was a teenager, R.S. had a melanoma on his back that was surgically removed. Respondent testified, credibly, that he did not know of that melanoma at the times material to this proceeding.

6. As the primary care physician, Respondent was responsible for providing the patient's basic care, performing routine physical examinations, performing diagnostic testing as indicated, keeping his prescription medicines current, and coordinating specialty care when needed.

Serum Calcium

7. Serum calcium is a necessary mineral in the body that forms a matrix for bones and controls other reactions in the body. It is controlled by the parathyroid glands. With slight variations among testing laboratories, the values considered to be in the normal range are from 8.8 to 10.5.

8. Lab studies dated February 24 and March 24, 1998, reflected, among other information, that R.S. had an elevated serum calcium level. The values reflected by these studies were 11.4 and 11.3, respectively.

9. R.S.'s medical history contained several conditions that could have a potential impact on his serum calcium level. The thyroidectomy included the removal of most of the parathyroids and should have lowered the serum calcium levels. In addition, R.S.’s long-time use of Lithium could have caused an elevation of serum calcium levels.

10. An elevated serum calcium level can be the result of a variety of causes, including malignancies, hematological

disorders, and medications (Lithium and hyperthyroid medications).

11. Respondent concluded that Respondent's elevated serum calcium level was the result of taking Lithium without investigating other causes for the elevated reading.

12. There was a conflict between Dr. Gatien, an expert on behalf of Petitioner, and Dr. Marcus, an expert on behalf of Respondent, as to whether Respondent practiced below the standard of care in concluding that Lithium was causing the elevated serum calcium readings without further investigation. The undersigned has carefully considered the conflicting testimony of these two experts and the underlying evidence and rationale that support their respective opinions. Succinctly stated, Dr. Gatien opined that because Respondent did not look for other causes of the elevated calcium serum readings, he could not know what caused the elevated readings. Dr. Marcus, on the other hand, opined that Respondent had sufficient information based on his knowledge of the patient to reasonably conclude that Lithium caused the elevated readings and that further testing was unnecessary. Dr. Gatien opined that Respondent failed to meet the standard of care; but Dr. Marcus opined that Respondent met the standard of care. The undersigned finds both experts to be qualified and sincere in their testimony. The undersigned further finds no reason to

credit one expert's testimony over that of the other.[2] Consequently, the undersigned finds that the evidence does not clearly and convincingly establish the violation alleged in subsection (c) of paragraph 52 of the AAC.

13. Respondent's medical records merely noted the elevated readings, but they did not set forth Respondent's theory of causation or explain why Respondent believed that further testing was unnecessary. Petitioner proved by clear and convincing evidence the violation alleged in subsection (d) of paragraph 56 of the AAC.

X-Rays

14. In November 1999, R.S. presented to Respondent with complaints of a cough. The complaints of a cough persisted between November 1999 and October 2000.

15. A chest x-ray is of limited diagnostic value. An MRI of the chest (involving magnet imaging) typically is of higher diagnostic value. A CT of the chest (involving computer technology) typically is of even higher diagnostic value, but is considerably more expensive than either an x-ray or an MRI.

16. In November 1999, Respondent recommended that R.S. undergo a CT of the chest. Respondent testified that R.S. declined that recommendation. Respondent's medical records do

not reflect that R.S. refused the recommended test or mention any reason for his decision.

17. Respondent took chest x-rays of R.S. on the following dates between November 9, 1999, and October 23, 2000: November 9, January 24, January 25, February 11, May 25, September 11, and October 23. Each x-ray was taken in Respondent's office using Respondent's equipment, and the x-rays were of varying quality. The x-rays taken January 24 were the only x-rays that could not be read because of the poor quality of the film. On each date at least two views were taken. The x-rays included a front to back view or a back to front view and a lateral view. The front to back view is referred to as an AP (anterior to posterior) view, while the back to front view is referred to as a PA (posterior to anterior) view.

18. An over-read of an x-ray occurs when one doctor reads the film and then a radiologist reads it a second time (the over-read). Dr. Pevsner, a board-certified radiologist, and Respondent testified that Dr. Pevsner over-read all chest x-rays taken by Respondent at his office, including the x-rays at issue in this proceeding.[3] Dr. Pevsner furnished Respondent a written report for the x-rays taken January 24, January 25, and September 11. He did not furnish Respondent a report for the other x-rays, and he had no independent recollection of having reviewed them.

19. Certain assumptions have been built in to the arrangement between Dr. Pevsner and Respondent. Dr. Pevsner assumed that he read all of Respondent's chest x-rays and that he had found nothing worth reporting if he did not generate a written report. Respondent assumed, for the x-rays that had no report, that Dr. Pevsner had received the x-ray, had reviewed the x-ray, and had found nothing worth reporting.[4]

20. The x-rays taken November 9, 1999, depicted an abnormal density.[5] The standard of care required Respondent to order follow-up testing for R.S. The follow-up x-rays taken on January 25 met the standard of care.

21. The x-rays taken January 24, 2000, could not be read because of their poor quality. Dr. Pevsner's report to Respondent recommended that the x-rays be repeated.

22. The x-rays taken January 25, 2000, depicted an abnormal density in the same region as the density depicted on the November 9 x-ray. Dr. Pevsner's report referred to this as a "nodular density" that "may be artifact or merely vessel" and concluded with the following recommendation:

> . . . Recommend repeat PA view and comparison to old films to see if this is a nodule or a vessel on the blurred lateral.

23. Respondent found the January 25 x-rays to be clear. Respondent went over the x-rays with R.S. and E.S. and told them

that the x-rays were okay. Respondent testified that he believed the density to be a blood vessel.

24. Respondent followed Dr. Pevsner's recommendation to repeat the PA view. Respondent was entitled to rely on Dr. Pevsner's written recommendation, and he practiced within the standard of care in ordering follow-up x-rays, which were taken February 11.

25. There was a dispute as to whether the x-rays taken February 11 showed an abnormal density. The greater weight of the credible evidence clearly and convincingly established that those x-rays showed an abnormal density in the same location as the previous x-rays. There was no apparent change from the January 25 x-rays as far as the size and shape of the density.

26. Respondent found the chest x-rays taken February 11 to be normal. As he had done in January, Respondent went over the x-rays with R.S. and E.S. and told them that the x-rays were okay. Respondent testified at trial that he believed the density to be a pulmonary vein.

27. Dr. Pevsner did not submit a written report for the x-rays taken February 11. Dr. Pevsner testified while he would have routinely over-read the February 11 x-rays, he did not submit a written report, and he had no independent recollection of having over-read those x-rays. Dr. Pevsner reviewed the February 11 x-rays at the final hearing and agreed with

Dr. Gatien and Dr. Siragusa that the x-rays depicted a questionable density.

28. Respondent should have been able to see the questionable density on the February 11 films observed by Dr. Pevsner, Dr. Gatien, and Dr. Siragusa. The standard of care required that Respondent proceed with a more definitive test, either an MRI or a CT, following the chest x-rays taken February 11.

29. There was a dispute as to whether the x-rays taken May 25 showed an abnormal density. The greater weight of the credible evidence clearly and convincingly established that those x-rays showed an abnormal density in the same location as the previous x-rays. The density was slightly larger than previously seen. Respondent testified at trial that he believed the area in question to be the head of a rib. Dr. Pevsner testified while he would have routinely over-read the May 25 x-rays, he did not submit a written report, and he had no independent recollection of having over-read those x-rays. Dr. Pevsner reviewed the May 25 films at the final hearing and testified that they depicted an area of questionable density. Dr. Pevsner further testified that the finding was too vague to make any conclusion and that he may not have detected the area of the questionable density if it had not been marked by some unknown person who had previously reviewed the films.

30. The chest x-rays taken September 11 continued to show an area of questionable density in the location of the prior chest x-rays. This area appeared to have increased from 14 millimeters in May to 18 millimeters in September. Dr. Pevsner found the x-rays of September 11 to contain an area of questionable density and recommended that Respondent compare the film to prior x-rays or take follow-up x-rays that were better penetrated.

31. Although Respondent viewed the September 11 x-rays as being clear, he ordered follow-up x-rays for October 23. Because he was acting on the recommendation of Dr. Pevsner, it is found that Respondent acted within the standard of care in ordering follow-up x-rays instead of ordering more definitive tests.

32. The greater weight of the credible evidence, including the prior abnormal x-rays and the fact that R.S. continued to complain of a persistent cough, established clearly and convincingly that Respondent deviated from the standard of care by waiting approximately six weeks for the follow-up x-rays.

33. The chest x-rays taken October 23 continued to show an area of questionable density in the location of the prior chest x-rays.

34. Respondent ordered an MRI, which was performed on October 24. A CT scan followed on October 26. Those tests

revealed the presence of an abnormality. A subsequent biopsy confirmed the presence of a malignant melanoma. Specialists treated R.S. after the discovery of the malignant melanoma.

35. The melanoma detected in October 2000 was located in different part of the chest than the area of questionable density that had been revealed by x-ray. There was no evidence that there existed any connection between the melanoma and the areas of questionable density that had been detected by the x-rays involved in this proceeding.[6]

36. A melanoma in the lungs is a fast-moving malignancy that inevitably results in death, usually within a year of its discovery. Had Respondent ordered an MRI or CT scan prior to October 2000, it is doubtful that the melanoma would have been detected. Clearly, the detection of the melanoma at an earlier date would not have altered the ultimate outcome, which was the death of R.S.

37. Petitioner did not prove by the clear and convincing evidence that Respondent's failure to meet the standard of care as set forth above caused harm to the patient.

38. The CT scan taken October 26 revealed no abnormality in the area of questionable density detected by the x-rays discussed above.[7]

Medical Record

38. Respondent did not document in his medical records the existence of a questionable density on the x-rays taken November 9, January 25, February 11, and May 25, and he did not document justification for not further evaluating the questionable density because he did not believe a questionable density existed on those films. The failure to detect the area of questionable density and to order appropriate follow-up testing constituted practice below the standard of care. There was no justification for that failure.

39. Petitioner charged Respondent with failing to document justification for waiting six weeks before further evaluating the area of density noted by Dr. Pevsner following his reading of the September 11 x-rays. That delay has been found to be below the standard of care. Consequently, there was no justification for the delay.

CONCLUSIONS OF LAW

40. The Division of Administrative Hearings has jurisdiction over the subject matter of and the parties to this cause pursuant to Sections 120.569 and 120.57(1).

41. Chapter 459 creates the Board of Osteopathic Medicine and regulates the practice of osteopathic medicine in Florida. Section 459.015(1), Florida Statutes (1999), provides, in pertinent part, as follows:

(1) The following shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

* * *

(o) Failing to keep legible, as defined by department rule in consultation with the board, medical records 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.

* * *

(x) Gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances. … As used in this paragraph, "gross malpractice" or "the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic 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 an osteopathic physician be incompetent to practice osteopathic medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice, "repeated malpractice," or "failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar

> conditions and circumstances," or any combination thereof, and any publication by the board shall so specify.

42. Petitioner has the burden of proving by clear and convincing evidence the allegations against Respondent. See Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Evans Packing Co. v. Department of Agriculture and Consumer Services, 550 So. 2d 112 (Fla. 1st DCA 1989); and Inquiry Concerning a Judge, 645 So. 2d 398 (Fla. 1994). The following statement has been repeatedly cited in discussions of the clear and convincing evidence standard:

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the evidence 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 the firm belief of [sic] 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).

43. Petitioner proved by clear and convincing evidence that Respondent violated the provisions of Section 459.015(1)(o), Florida Statutes (1999), by failing to document justification for failing to determine the cause of repeated elevated serum calcium levels as alleged in subsection (d) of paragraph 56 of the AAC.

44. There are no medical records that Respondent could have kept that would have justified the failures alleged in subsections (a), (b), and (c) of paragraph 56 of the AAC. Consequently, no separate violations should be found based on those allegations.

44. Petitioner proved by clear and convincing evidence that Respondent violated the provisions of Section 459.015(1)(x), Florida Statutes (1999), by failing to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances as alleged in subsections (a) and (b) of paragraph 52 of the AAC. The violation pertaining to subsection (a) of paragraph 52 is limited to the failure to timely order more definitive follow-up exams (an MRI or a CT) following the February 11 x-rays.

45. Petitioner did not prove by clear and convincing evidence the violation alleged in subsection (c) of paragraph 52 of the AAC.

45. Rule 64B15-19.002, Florida Administrative Code, provides disciplinary guidelines pertinent to this proceeding. For a first violation of Section 459.015(1)(o), the guideline is from a minimum of reprimand and a $5,000 fine to a maximum of probation and a $5,000 fine.

46. For a first violation of Section 459.015(1)(x), the guideline is from a minimum of probation and a $5,000 fine to a maximum of suspension followed by probation and a $7,500 fine.

47. Rule 64B15-19.003, Florida Administrative Code, provides aggravating and mitigating circumstances pertinent to this proceeding. There are no aggravating circumstances. There are, however, mitigating circumstances that have been considered by the undersigned in the recommended penalty set forth below. The first mitigating factor is that Respondent has practiced in Florida for many years without prior discipline. The second mitigating factor is that there was no damage to the patient, physical or otherwise, caused by the violations found in this proceeding.

48. Because of the mitigating factors, the undersigned concludes that Petitioner should not place Respondent on probation, nor should it impose an administrative fine against him.

RECOMMENDATION

Based on the foregoing findings of fact and conclusions of Law, it is RECOMMENDED that Petitioner enter a final order finding Respondent guilty of violating Section 459.015(1)(o) and (x), Florida Statutes (1999), as set forth in this Recommended Order. Respondent should be found not guilty of the other

alleged violations. It is further RECOMMENDED that Petitioner issue Respondent a written reprimand for each violation.

DONE AND ENTERED this 1st day of October, 2003, in Tallahassee, Leon County, Florida.

CLAUDE B. ARRINGTON
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 1st day of October, 2003.

ENDNOTES

1/ E.S. is the widow of R.S. At the times pertinent to this proceeding, E.S. and R.S. were engaged, but they had not married.

2/ The testimony of Dr. Marcus should not be discredited because he has known Respondent for a long period of time and formerly practiced medicine with him.

3/ The reason Dr. Pevsner performed this service for Respondent was not clear. Respondent did not pay him for doing so, but he did refer patients to him. Dr. Pevsner testified he began reading x-rays for Respondent as part of a study he was conducting. Since Dr. Pevsner did not keep a record of the x-rays he reviewed or a copy of any report he generated, the study would be, at best anecdotal.

4/ The undersigned rejects Respondent's contention that he was entitled to rely on the assumption that Dr. Pevsner had read an

x-ray and found it to be clear if Dr. Pevsner did not generate a written report. The working relationship between Dr. Pevsner and Respondent is called into question by the fact that Dr. Pevsner did, on at least some occasions, generate a written report when he found an x-ray to be normal. Moreover, Dr. Pevsner testified that he sometimes made verbal reports to Respondent and that he recalled discussing some of the x-rays at issue in this proceeding with Respondent. Respondent's medical records do not note any such conversations, nor do they reflect that Dr. Pevsner was over-reading x-rays for which no report had been generated.

5/ The testimony presented by Petitioner as to the issue of x-rays (from Dr. Gatien and Dr. Siragusa) and the testimony presented by Respondent as to that issue (from Respondent and Dr. Pevsner) contain conflicts. That testimony has been carefully considered by the undersigned. The findings of fact pertaining to the x-rays reflect the resolution of those conflicts.

6/ It should also be noted that there was no evidence that the elevated serum calcium readings in February 1998 were related to the melanoma discovered in October 2000.

7/ The fact that there was, in retrospect, no abnormality in the area of the questionable density is not relevant to whether Respondent breached the standard of care based on x-rays taken between November 1999 and October 2000, because that determination should be made prospectively, not retrospectively. That fact, and the fact that Respondent’s care of R.S. did not cause harm to the patient, can and should be considered in determining the penalties to be imposed in this proceeding.

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.