STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 03-1954PL
ROBERT H. HUNSAKER, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on September 23 through 25, 2003, in Miami, Florida, before Administrative Law Judge Michael M. Parrish of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Kim M. Kluck, Esquire
Department of Health
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For Respondent: Andrew Cotzin, Esquire
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STATEMENT OF THE ISSUES

This is a license discipline case in which Petitioner seeks to take disciplinary action against Respondent, a licensed medical doctor, on the basis of alleged violations of paragraphs

(j), (m), (t), and (x) of Section 458.331(1), Florida Statutes. The alleged violations are set forth in two administrative complaints, both of which were docketed as a single case when they were referred to the Division of Administrative Hearings.[1]

PRELIMINARY STATEMENT

The alleged violations of paragraphs (j) and (x) are based on allegations that Respondent engaged in acts of sexual misconduct with each of four patients on whom he had performed plastic surgery procedures. The alleged violations of paragraphs (m) and (t) are based on allegations that Respondent failed to keep a post anesthesia record tracking the recovery of each of the same four patients.

The violations alleged in the administrative complaints were disputed by Respondent, and he requested an evidentiary hearing. In due course, the case was forwarded to the Division of Administrative Hearings where it was initially docketed as DOAH Case No. 00-2551. DOAH Case No. 00-2551 was subsequently closed in anticipation of a settlement. Settlement negotiations failed and the matter was referred back to DOAH on May 22, 2003, with a request that DOAH Case No. 00-2551 be re-opened. By order dated May 27, 2003, DOAH Case No. 00-2551 was re-opened under a new case number, 03-1954PL. The newly re-opened case was scheduled for final hearing on September 23-25, 2003.

At the hearing on September 23-25, 2003, the parties offered six joint exhibits, all of which were received in evidence.[2] Petitioner offered three exhibits, which were received in evidence.[3] Petitioner also presented the testimony of three witnesses; Patient E.R., Patient S.C., and Carmen LeClair (a friend who drove one of the patients home after surgery).

Respondent testified on his own behalf and also called three additional witnesses: Steven Roadruck (a private investigator); Ronald Samson, M.D. (an anesthesiologist); and Arthur Handal, M.D. (a plastic and reconstructive surgeon). Respondent also offered eleven exhibits that were received in evidence.[4]

Further, during the course of the final hearing both parties made requests for official recognition of specified documents, which requests were granted.

During the course of the final hearing the parties also presented arguments on several motions, including the following: Petitioner’s Motion in Limine to Preclude the Testimony of Phillip Haber, Ph.D. (the motion to preclude Haber's testimony was granted), Respondent’s Motion in Limine to Exclude the Testimony of Petitioner’s Alleged Expert Witness Dr. Scott A. Greenberg at Final Hearing (the motion to exclude Greenberg's testimony was denied), and Respondent’s Motion for Partial

Dismissal of Petitioner's Administrative Complaint on the Doctrine of Issue Preclusion. The essence of the relief sought in this last-mentioned motion was granted in substantial part, although not in the precise terms sought by the motion. Certain findings of fact made in a prior case[5] involving the same parties as the parties in this case were deemed to be binding on the parties to this case, and Petitioner in this case was precluded from attempting to relitigate those previously established facts.

The transcript of the final hearing was filed with the Division on December 8, 2003. The parties were allowed twenty days from the date of the filing of the transcript to file their proposed recommended orders. The due date for the parties' proposals was December 29, 2003. Both parties filed timely Proposed Recommended Orders containing proposed Findings of Fact and Conclusions of Law. The post-hearing submissions of the parties have been carefully considered during the preparation of this Recommended Order.

FINDINGS OF FACT

1. Respondent, Robert H. Hunsaker, M.D., is now, and was at all material times, licensed as a physician in the State of Florida, having been issued license number ME0051546. Respondent, a board certified plastic surgeon, was employed by the Premiere Center for Cosmetic Surgery ("Premiere Center") in

Coconut Grove, Florida, when the surgeries that led to the matters at issue in this proceeding were performed.

2. All acts of alleged sexual misconduct at issue in this proceeding are alleged to have occurred in the recovery room at the Premiere Center following surgery by Respondent. The recovery room at the Premiere Center is a small area with walls on three sides and a curtained entrance. Just outside the curtained portion of the recovery room there is a large reclining chair. There are two beds in the recovery room. The bed against the left wall can be tilted up or down, and both patients E.R. and S.C. were placed in the bed on the left side of the room with their heads toward the rear wall and their feet toward the curtained entrance. This bed has railings, which are raised at all times when a patient is in the bed to prevent the patient from falling out. The recovery room is adjacent to the operating room. To benefit the patient, the recovery room is kept dimly lit.

3. People frequently walked through the area just beyond the curtained portion of the recovery room. Any of 8 or 10 Premiere Center employees would have occasion to walk through this area at one time or another. Furthermore, the only ingress and egress to the operating room and recovery room was through the door located in the area just beyond the curtained recovery room.

4. When a patient at the Premiere Center was transferred from the operating room to the recovery area, the patient routinely was placed in the middle of the bed, with the bedrail up to prevent the patient from falling out of the bed. Any patient at the Premiere Center routinely had an I.V. line in his or her left arm or hand, with a pulse oximeter clipped to a finger on the left hand. If the pulse oximeter clip were to become detached from the patient’s finger, an alarm would sound. The pulse oximeter monitors heart rhythm with an audible “beep” sound, and monitors oxygen saturation with a steady tone that lowers in frequency if oxygen saturation drops. Thus, if the surgeon is in the room immediately adjacent to the recovery area, the surgeon can be aware of the status of the pulse and the oxygen saturation of a patient in the curtained recovery area.

5. During, as well as immediately following, all of the surgical procedures that led to the matters at issue in this proceeding, Respondent was wearing surgical garb, including scrub pants that did not have a fly. The scrub pants he wore were fastened at the waist by a drawstring, which consisted of a piece of non-elastic stout cord or lace, similar to a very long shoelace. It was Respondent's practice then (and still) to tie the drawstring in the same type of bow as is typically used to tie shoelaces.

6. At all times pertinent to the issues in this case, Respondent tried to be one of the last people the patient saw before going under anesthesia and one of the first people the patient saw upon waking up. He did this in an effort to provide each patient with a sense of reassurance and to relax the patient. At the times pertinent to this proceeding, Respondent employed a post-operative practice of establishing physical contact with a patient while the patient was regaining consciousness following surgery. This practice was applied to both male and female patients. This contact usually consisted of holding the patient's hand or touching the patient's arm or shoulder. The purpose of the contact was to reassure and relax the patient. As part of this routine, Respondent would speak to the patient in soft and reassuring tones, asking the patient how he or she felt and telling the patient that the surgery was successful.[6]

7. Both patients E.R. and S.C. were administered general endotracheal anesthesia. Among the anesthetic agents administered to E.R. and S.C. were: Brevital, Fentanyl, Forane, Inapsine (also called Droperidol), and Nitrous Oxide. In addition, both E.R. and S.C. were pre-medicated with a drug belonging to the benzodiazepine class – Valium, in the case of E.R., and Versed (also called Midazolam), in the case of S.C.

8. Experts for both Petitioner and Respondent agree that the purpose of anesthesia is to alter the sensory perception of the patient so that noxious stimuli will not be processed, and the patient will not remember the surgical event. Some anesthetic agents are strong amnesics, meaning that they cause the patient to not remember the noxious stimuli for a time following administration. Other anesthetic agents are analgesic, altering the patient's sensation to noxious stimuli.

9. Versed is a strong amnesic, as is Valium. Both Versed and Valium are in the same class of drugs known as benzodiazepines. Benzodiazepines can cause post-operative hallucinations, and dreaming during emergence from the effect of the drug.

10. Nitrous Oxide, Forane, and Fentanyl all change the patient's perception of touch. Inapsine provides a state of mental detachment. Inapsine can cause post-operative hallucinations, as is stated in the drug package insert. The effects of all of these drugs can be enhanced when they are taken in combination. These anesthetic agents can contribute to a confabulation, and cause an environment ripe for confusion.

11. The anesthesia used on these patients greatly altered their ability to perceive sensory input, including touch.[7] While in the recovery room following their respective surgeries, both

E.R. and S.C. were on the verge of unconsciousness, could not stay awake, and could not judge time.[8]

12. Although it was Respondent's practice to monitor his patients post-surgery by listening to the equipment and visually checking on the patient “at least two times,” this monitoring was supplemental to the monitoring activities of the Premiere Center employees whose primary job was to monitor the patients’ recovery and make the recovery room notations on the patients’ charts. Respondent often did this type of supplemental patient monitoring while making notes in medical charts or dictating operative reports at a work area in the room immediately outside the curtained portion of the recovery area. While doing these other tasks, he could also be aware of any significant change in the sounds made by the monitoring equipment. The Premiere Center employees primarily responsible for recovery room monitoring and notations were the Certified Registered Nurse Anesthetist ("CRNA") and the “circulator.”

13. In May of 1996, Patient E.R., a female patient who was 43 years old at that time, met with Dr. Hunsaker to discuss plastic surgery to modify the shape of her nose. Following this consultation, E.R. consented to rhinoplasty surgery, and after a pre-operative workup, E.R. presented to the Premiere Center early in the morning on May 21, 1996. E.R. met with Dr. Hunsaker, and was then prepped for surgery. E.R. was pre-

medicated with intravenous Valium (2.5 mg) and taken to the operating room, where she was administered general anesthesia. Dr. Hunsaker performed the surgery without incident and Patient E.R. was then moved to the recovery room. There was a lady in the bed next to her in the recovery room.

14. In the recovery room, Patient E.R. awoke briefly from the anesthesia and called out for Suzanne DeRibeaux. No one answered her call and E.R. then fell asleep again.

15. When Patient E.R. awoke again, she recalled being very frightened because she could not see. Dr. Hunsaker was standing at her bed, on the left side, and holding her left hand. Patient E.R. asked why she could not see and if she had lost her eyesight. Dr. Hunsaker told her not to be scared and that she could not see because she had ice packs on her eyes.

16. The ice packs blocked Patient E.R.'s vision directly in front of her face. However, she was able to look underneath the pack and see her feet and the wall to the right of her bed. She was not able to see to her left without turning her head to the left. She did not turn her head to the left while Respondent was in the recovery room.

17. Although Patient E.R. could not see Dr. Hunsaker, she could hear his voice. He asked her how she was feeling and if she could feel what was in her hand. Dr. Hunsaker pressed her hand around his fingers and she answered that she could feel

what was in her hand. Dr. Hunsaker then asked Patient E.R. what was in her hand and she answered, “Those are your fingers.”

18. When Patient E.R. awoke again, Dr. Hunsaker was still present at her bedside and had his hand underneath her left hand. Patient E.R. still had ice packs on her eyes, but was able to hear members of the Premiere staff walking and talking.

19. Respondent held her hand and she believes he was trying to get her to squeeze something with her hand. Patient E.R. was frightened and did not say anything at the time. Patient E.R. was afraid to turn her head to the left to look at Respondent.[9]

20. After Dr. Hunsaker left Patient E.R. in the recovery room area, a nurse came into the room and helped Patient E.R. out of the bed and into a wheelchair. At that time, Patient E.R.’s friend, Carmen LeClair, was at the surgery center to pick up Patient E.R. and drive her to her mother's home. Ms. LeClair helped Patient E.R. to get dressed.

21. Eventually, E.R. sat up, was put into a wheelchair, and, assisted by a nurse and by Carmen LeClair, walked to Ms. LeClair’s car. Ms. LeClair then drove Patient E.R. to the home of E.R.'s mother.

22. At some time while she was in the bed in the recovery room, Patient E.R. began to think that perhaps Respondent might have placed his penis in her hand or might have placed her hand

on his penis. During the time she was in the recovery room and shortly after she left the recovery room, Patient E.R. was not certain whether the sexual misconduct she believed might have occurred had in fact occurred or was instead something she had dreamed or hallucinated.[10] More than a year later, Patient E.R. still could not be certain whether her recollection of sexual misconduct by Respondent was a recollection of an event that actually happened, or was a recollection of a dream or a hallucination. More than a year after the her surgery by Respondent, when Patient E.R. discussed the matter with Valerie McAllister for the first time, Patient E.R. was more inclined to believe that she had been hallucinating, rather than to believe that the misconduct had actually taken place.[11]

23. In May of 1997, Patient E.R. returned to the Premiere Center for some additional plastic surgery on her nose. Until that time, Patient E.R. had not told anyone at the Premiere Center anything about any alleged sexual misconduct by Respondent. In May of 1997 when she presented to the Premiere Center for the second surgery, Patient E.R. made a request to the Premiere Center's CRNA, Valerie McAllister, that she not receive the same anesthesia as the previous year. She told Ms. McAllister that the reason for this request was because the last time, in E.R's own words, "I believe I was hallucinating that the doctor had put his penis in my hand." Ms. McAllister

told Patient E.R. that she should discuss the matter with Suzanne DeRibeaux. Suzanne DeRibeaux was an employee of Premiere Center who had testified against Respondent in the 1997 hearing. About a week later, Patient E.R. discussed her concerns about the 1996 surgery with DeRibeaux. At that time, Ms. DeRibeaux informed E.R. that there were several other women (perhaps as many as six) that, in Ms. DeRibeaux's words, Respondent “had done this to.” Ms. DeRibeaux handed E.R. a business card for AHCA investigator, Susan DeCerce. E.R. met the investigator at the State Attorney’s Office (“SAO”) on June 4, 1997, where E.R.’s statement was taken by DeCerce. Patient E.R. was informed by both DeCerce and by personnel from the SAO that there were other women making the same allegations against Dr. Hunsaker. In her statement to DeCerce, Patient E.R. told DeCerce she thought she was squeezing a “pressure gauge” and not Dr. Hunsaker’s penis.

24. Patient S.C. is a female who was 19 years old when she went to the Permiere Clinic seeking plastic surgery services. After initial and pre-operative consultations with Dr. Hunsaker, Patient S.C. presented on May 7, 1996, at the Premiere Center for bilateral breast augmentation. The patient's mother and boyfriend took her to the Premiere Center on the morning of the surgery.

25. Patient S.C. was duly prepped, pre-medicated with Versed, and taken to the operating room where she was administered general anesthesia, consisting of the same anesthetic agents that were administered to E.R. Surgery was performed without incident by Dr. Hunsaker and Patient S.C. was then moved to the recovery room.

26. While in the recovery room, Patient S.C. woke up and fell asleep again at least three times that she remembers. On at least two of those times when she woke up in the recovery room, her mother was standing beside her bed. On at least one of the occasions when she woke up in the recovery room, Respondent was standing beside her bed.[12] Patient S.C. recalls that shortly after she woke up she heard Respondent asking how she felt and asking if she was O.K. Patient S.C. also recalls that at some point in her recovery room experience, Respondent held her hand.

27. Consistent with his usual practice, Respondent held S.C.'s hand as she was emerging from anesthesia in the recovery room and asked how she was feeling. Respondent never held Patient S.C.'s hand against his penis, nor did he place Patient S.C.'s hand inside his surgical scrub pants.

28. At some time while she was in the bed in the recovery room, Patient S.C. began to think that perhaps Respondent might have held her hand and then might have placed her hand on his

penis. During the time she was in the recovery room and during the period shortly after she left the recovery room, Patient S.C. was not certain whether the sexual misconduct she believed might have occurred had in fact occurred, or was instead something she had dreamed or hallucinated.[13]

29. When she woke up the last time, Patient S.C. recalls that her mother was at S.C.'s bedside. S.C.'s mother assisted her in getting dressed, and S.C.'s mother and boyfriend took S.C. home. S.C. did not say anything to her mother about any alleged sexual misconduct by Respondent until many months later, following a television newscast about Respondent. S.C. did mention something vague to her boyfriend as he was carrying her to the car in the Premiere Center parking lot, which was to the effect that, "I thought something had happened in the room."[14]

30. Well over a year after her surgery, Patient S.C. saw a television newscast on Channel 10 in which it was stated that a number of other women had come forward with allegations that Respondent had manipulated their hands onto his penis during their recovery from anesthesia. The newscast also stated that anyone else who had been through a similar experience should come forward. Patient S.C. contacted the news station. The newscaster took Patient S.C.'s name and telephone number, and shortly thereafter AHCA field investigator Susan DeCerce contacted S.C.

31. Respondent emphatically denied that he engaged in sexual misconduct with any of his patients.[15] Respondent's testimony, including his denial of any sexual misconduct, is found to be credible.[16]

32. During the course of his treatment of Patient L.P., Respondent did not engage in any sexual misconduct of any kind with the patient. Specifically, Respondent did not at any time, in the recovery room or elsewhere, place his penis in Patient L.P.'s hand or cause Patient L.P.'s hand to come in contact with his penis.[17]

33. During the course of his treatment of Patient A.V., Respondent did not engage in any sexual misconduct of any kind with the patient. Specifically, Respondent did not at any time, in the recovery room or elsewhere, place his penis in Patient A.V.'s hand or cause Patient A.V.'s hand to come in contact with his penis.

34. During the course of his treatment of Patient E.R., Respondent did not engage in any sexual misconduct of any kind with the patient. Specifically, Respondent did not at any time, in the recovery room or elsewhere, place his penis in Patient E.R.'s hand or cause Patient E.R.'s hand to come in contact with his penis.

35. During the course of his treatment of Patient S.C., Respondent did not engage in any sexual misconduct of any kind

with the patient. Specifically, Respondent did not at any time, in the recovery room or elsewhere, place his penis in Patient S.C.'s hand or cause Patient S.C.'s hand to come in contact with his penis.

36. During the course of his treatment of Patients L.P., A.V., E.R., and S.C., Respondent did not keep a post-anesthesia record tracking the recovery of any of these four patients while they were in the recovery room.

37. Respondent learned for the first time that vital signs were not recorded during the recovery of patients E.R., S.C., A.V., and L.P. only after the Administrative Complaints in this case were filed. None of the four patients suffered any harm from the absence of recordation of vital signs during the recovery period.

38. During the time period in which Respondent was treating patients L.P., A.V., E.R., and S.C. (calendar year 1996), in a private office surgery setting, in the normal course of events, the anesthesia provider (either anesthesiologist or CRNA) would chart the patient’s immediate post-anesthesia recovery. Further recovery room charting would normally be the responsibility of the person assigned to take over the recovery from the anesthesia provider. During that time period and under those circumstances, the surgeon's responsibility to make a record of events in the recovery room existed only where the

surgeon actually intervened during the recovery room period to provide some form of treatment (such as changing I.V. fluid or administering medication) or if there were a dramatic or unusual event during the course of the recovery. With the exception of Respondent's administration of Droperidol to Patient S.C. (which was noted in the medical record), there were no such events in the recoveries of Patients E.R., S.C., A.V., and L.P., and, consequently, no requirement that Respondent make recovery room notations during the recoveries of these patients.

39. During the time period in which Respondent was treating Patients L.P., A.V., E.R., and S.C. (calendar year 1996), and under the circumstances in which Respondent was treating those patients (in an office surgery setting in which the facility was providing the CRNA anesthesia provider and was also providing an employee to recover patients in the recovery room), Respondent was not responsible for preparing the record of the patient's recovery room experience. Rather, at that time and under those circumstances, the person responsible for preparing the recovery room record was either the person who administered the anesthesia (the CRNA) or the employee of the facility who was assigned to monitor the patient in the recovery room and who was the person to whom the CRNA would entrust the patient's recovery room care once the CRNA was satisfied that the patient was sufficiently stable.

40. During the time period in which Respondent was treating Patients L.P., A.V., E.R., and S.C. (calendar year 1996), and under the circumstances in which Respondent was treating those patients, a reasonably prudent similar physician under the same or similar circumstances would have recognized Respondent's failure to keep a post-anesthesia record tracking the recovery of any of these four patients while they were in the recovery room as being acceptable, because such a reasonably prudent similar physician would have expected the recovery room record to have been prepared by the anesthesia provider or other person assigned to monitor the patient in the recovery room.

41. During the time period in which Respondent was treating Patients L.P., A.V., E.R., and S.C. (calendar year 1996), and under the circumstances in which Respondent was treating those patients, Respondent's failure to keep a post-anesthesia record tracking the recovery of any of these four patients while they were in the recovery room was not a failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

42. During the time period in which Respondent was treating Patients L.P., A.V., E.R., and S.C. (calendar year 1996), and under the circumstances in which Respondent was

treating those patients, Respondent's failure to keep a post-anesthesia record tracking the recovery of any of these four patients while they were in the recovery room was not a failure to keep written medical records justifying the course of treatment of the patient, because the responsibility for the preparation of such records was a responsibility of the anesthesia provider or other person assigned to monitor the patient while the patient was in the recovery room. In such time and circumstances the surgeon was not responsible for the preparation of such records in the absence of some unusual circumstances, which unusual circumstances did not occur in any of the recovery room experiences following the surgeries at issue here.[18]

CONCLUSIONS OF LAW

General matters

43. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to Sections 120.569, 120.57(1), and 456.073(5), Florida Statutes (2003).

44. Where the revocation or suspension of the physician's license is sought, proof greater than a mere preponderance of the evidence must be submitted before the Board of Medicine (Board) may take punitive action against a licensed physician. Clear and convincing evidence of the physician's guilt is

required. § 458.331(3), Fla. Stat. See also Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Company, 670 So. 2d 932, 935 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); McKinney v. Castor, 667 So. 2d 387, 388 (Fla. 1st DCA 1995); Tenbroeck v. Castor, 640 So. 2d 164, 167 (Fla. 1st DCA 1994); Nair v. Department of Business and Professional Regulation, 654 So. 2d 205, 207 (Fla. 1st DCA 1995); Pic N' Save v. Department of Business Regulation, 601 So. 2d 245 (Fla. 1st DCA 1992); Munch v. Department of Professional Regulation, 592 So. 2d 1136 (Fla. 1st DCA 1992); Newberry v. Florida Department of Law Enforcement, 585 So. 2d 500 (Fla. 3d DCA 1991); Pascale v. Department of Insurance, 525 So. 2d 922 (Fla. 3d DCA 1988); § 458.331(3), Fla. Stat.; § 120.57(1)(h), Fla. Stat. ("Findings of fact shall be based on a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute.").

45. "'[C]lear 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 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.'" In re Davey, 645 So. 2d 398, 404 (Fla. 1994), quoting, with approval, from Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

46. When the Board seeks to take punitive action against a physician, such action may be based only upon those offenses specifically alleged in the administrative complaint. See Cottrill v. Department of Insurance, 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996); Chrysler v. Department of Professional Regulation, 627 So. 2d 31 (Fla. 1st DCA 1993); Klein v. Department of Business and Professional Regulation, 625 So. 2d 1237, 1238-39 (Fla. 2d DCA 1993); Arpayoglou v. Department of Professional Regulation, 603 So. 2d 8 (Fla. 1st DCA 1992); Willner v. Department of Professional Regulation, Board of Medicine, 563 So. 2d 805, 806 (Fla. 1st DCA 1992); Celaya v. Department of Professional Regulation, Board of Medicine, 560 So. 2d 383, 384 (Fla. 3d DCA 1990); Kinney v. Department of State, 501 So. 2d 129, 133 (Fla. 5th DCA 1987); Sternberg v. Department of Professional Regulation, 465 So. 2d 1324, 1325 (Fla. 1st DCA 1985); Hunter v. Department of Professional Regulation, 458 So. 2d 842, 844 (Fla. 2d DCA 1984).

47. Furthermore, in determining whether Section 458.331(1), Florida Statutes, has been violated in the manner charged in the administrative complaint, one "must bear in mind that it is, in effect, a penal statute. . . . This being true

the statute must be strictly construed and no conduct is to be regarded as included within it that is not reasonably proscribed by it. Furthermore, if there are any ambiguities included such must be construed in favor of the . . . licensee." Lester v. Department of Professional and Occupational Regulations, 348 So. 2d 923, 925 (Fla. 1st DCA 1977).

New legislation

48. By operation of new legislation enacted during the 2003 session of the Florida Legislature, effective September 15, 2003, "[t]he determination of whether or not a licensee has violated the laws and rules regulating the profession, including a determination of the reasonable standard of care, is a conclusion of law to be determined by the board . . . and is not a finding of fact to be determined by an administrative law judge." See Chapter 2003-416, Laws of Florida, at Section 20 (amending Section 456.073(5), Florida Statutes (2002)). Because this proceeding is one of the very first cases to be tried following the effective date of the above-quoted amendments, there does not yet appear to be any decisional guidance from the Department of Health, from any of the boards, or from any appellate court, as to what extent, if any, the above-quoted amendment requires any changes in the manner in which hearings before the Division of Administrative Hearings should be conducted, or requires any changes in the content of the

recommended orders prepared by the DOAH administrative law judges. Nor have the parties to this case offered much in the way of guidance regarding the new legislation. By their conduct at hearing both parties seemed to be of the view that the above-quoted statutory amendments did not change the nature of the evidence to be offered in cases of this nature, because both parties requested, and were granted, the opportunity to offer expert witness testimony on the subject matter of whether Respondent "has violated the laws and rules regulating the profession," as well as on the subject matter of what constitutes the "reasonable standard of care."

49. The proposed recommended orders submitted by the parties do not suggest that the above-quoted statutory language requires any changes to the type of content that has customarily been included in recommended orders in cases of this nature. In fact, the parties' proposed recommended orders do not even mention these statutory amendments.

50. It has been suggested in other recent cases that the subject amendments perhaps are not applicable to cases that were pending prior to the effective date of the amendments. However, because the amendments appear to address matters of procedure rather than matters of substance, the amendments appear to be applicable to cases pending as of the effective date of the law that created the amendments. See Basel v. McFarland & Sons,

Inc., 815 So. 2d 687 (Fla. 5th DCA 2002), in which the court noted at page 692: "In the absence of clear legislative intent, a law affecting substantive rights is presumed to apply prospectively only while procedural or remedial statutes are presumed to operate retrospectively. See Young v. Altenhaus, 472 So. 2d 1152 (Fla. 1985)." See also Life Care Centers of America, Inc. v. Sawgrass Care Center, Inc., 683 So. 2d 609 (Fla. 1st DCA 1996).

51. The language of the subject amendments to Section 456.073(5), Florida Statutes (2002), is sufficiently broad for it to be interpreted and applied in more than one way. And some of the possible interpretations and applications might at some future date provide a basis for modification of the manner in which administrative hearings in such cases are conducted. But such possible interpretations and applications are merely possibilities; they are not certainties. Therefore, unless and until there is some authoritative interpretation or implementation of the subject amendments directing otherwise, the most prudent course appears to be for the DOAH administrative law judges to continue to receive evidence and to continue to make "determinations" (by findings of fact or by conclusions of law) as to what constitutes the "reasonable standard of care" and as to whether a licensee "has violated the laws and rules regulating the profession"; especially in cases

like this one in which both parties requested such a course of action by the administrative law judge.[19]

The specific statutes and charges

52. At all times material to the events that form the basis for the charges in this case, Section 458.329, Florida Statutes (1995),[20] read as follows:

> The physician-patient relationship is founded on mutual trust. Sexual misconduct in the practice of medicine means violation of the physician-patient relationship through which the physician uses said relationship to induce or attempt to induce the patient to engage, or to engage or attempt to engage the patient, in sexual activity outside the scope of the practice or the scope of generally accepted examination or treatment of the patient. Sexual misconduct in the practice of medicine is prohibited.

53. At the time of the events that form the basis for the charges in this case, paragraphs (j),(m), (t), and (x) of Section 458.331(1), Florida Statutes (1995), authorized the Board to revoke, suspend, or otherwise discipline the license of a physician for reasons that included the following:

> (j) Exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity. A patient shall be presumed to be incapable of giving free, full and informed consent to sexual activity with his physician.
>
> * * *
>
> (m) Failing to keep written medical records justifying 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.
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> * * *
>
> (t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. . . . As used in this paragraph, "gross 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," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.
>
> * * *
>
> (x) Violating any provision of this chapter, a rule of the board or department, or a lawful order of the board or department previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the department.

54. Florida Administrative Code Rule 64B8-9.008 states in part that sexual contact with a patient is sexual misconduct, which includes, but is not limited to, verbal or physical behavior which may reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it;

may reasonably be interpreted as intended for the sexual arousal or gratification of the physician, the patient, or any third party; or may be reasonably interpreted as being sexual.

55. In Counts One and Two of the two administrative complaints in this case, Respondent is charged with having violated Section 458.331(1)(x), Florida Statutes, in two different ways by reason of allegations of sexual misconduct with each of the four patients, L.P., A.V., E.R., and S.C. In Count Three of the two administrative complaints, Respondent is charged with having violated Section 458.331(1)(j), Florida Statutes, by reason of allegations that Respondent exercised influence within a patient-physician relationship for the purpose of engaging in sexual activity with each of the four patients, L.P., A.V., E.R., and S.C. All of the counts described in this paragraph are predicated upon a factual assertion that Respondent engaged in sexual misconduct with each of the four patients that consisted of "placing his penis in the hands of" each of the four patients. Those acts of sexual misconduct were not proved by clear and convincing evidence. To the contrary, the undersigned is convinced that Respondent did not engage in any sexual misconduct with any of his patients. Such being the case, all of the violations charged in Counts One, Two, and Three of both administrative complaints should be dismissed.

56. Count Four of each of the two administrative complaints in this case charge Respondent with violation of Section 458.331(1)(t), Florida Statutes, by reason of allegations that he "failed to keep a post anesthesia record tracking the recovery of" each of the four patients, L.P., A.V., E.R., and S.C. It is undisputed that Respondent did not prepare such a record for any of these four patients. Nevertheless, the evidence does not establish violations of Section 458.331(1)(t), Florida Statutes, because the most persuasive expert witness testimony (including testimony by Petitioner's expert witnesses) was to the effect that, in the normal course of events, such record-keeping was not the responsibility of the surgeon.[21] It can hardly be a violation of Section 458.331(1)(t), Florida Statutes, for a physician to fail to perform an act which is not the physician's responsibility.[22] Therefore, all of the violations charged in Count Four of both administrative complaints in this case should be dismissed.

57. Count Five of each of the two administrative complaints in this case charge Respondent with violations of Section 458.331(1)(m), Florida Statutes, on the basis of what are, for all practical purposes, the identical record-keeping failures alleged in Count Four, and discussed immediately above. The violations charged in Count Five should be dismissed for the same reasons as the violations alleged in Count Four: the

preparation of such records was not the responsibility of Respondent.

RECOMMENDATION

On the basis of all of the foregoing, it is RECOMMENDED that a Final Order be issued in this case to the following effect:

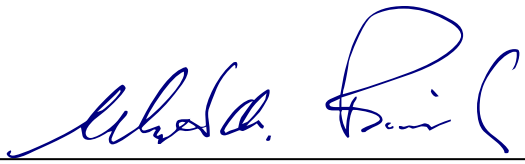
(1) Adopting all of the findings of fact in this Recommended Order,

(2) Adopting all of the conclusions of law in this Recommended Order,

(3) Concluding that the evidence is insufficient to establish any of the charges in either of the administrative complaints at issue in this case, and

(3) Dismissing all charges contained in both of the administrative complaints at issue in this case.

DONE AND ENTERED this 26th day of February, 2004, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 26th day of February, 2004.

ENDNOTES

1/ The earliest of the charging documents is a document titled AMENDED ADMINISTRATIVE COMPLAINT signed on August 3, 1998. That document was identified at the Department of Health as the Department's Case Number 97-17509. The allegations in that document concern events that allegedly took place during Respondent's treatment of a person identified as Patient S.C. The other charging document is a document titled ADMINISTRATIVE COMPLAINT signed on November 5, 1998. That document was identified at the Department of Health as the Department's Case Numbers 97-10367, 98-12056, and 98-12059. The allegations in this last-mentioned document concern events that allegedly took place during Respondent's treatment of three individuals identified as Patient E.R., Patient L.P., and Patient A.V.

2/ The first four joint exhibits were the medical records of the subject patients. Joint Exhibit 5 was a videotape depicting portions of the Premiere Center, and Joint Exhibit 6 was a still photograph.

3/ Petitioner Exhibit 1 consists of portions of the transcript of Respondent's pre-hearing deposition testimony, Petitioner Exhibit 2 consists of the transcript of the deposition testimony of Scott Greenberg, M.D. (a plastic surgeon) and the doctor's CV, and Petitioner Exhibit 3 consists of the transcript of the deposition testimony of David Michael Glener, M.D. (an anesthesiologist) and the doctor's CV.

4/ Some of Respondent's exhibits had subparts. Details regarding the offer and disposition of all of Respondent's exhibits are contained in the transcript of the final hearing for those who might need to know such details.

5/ The prior case was Department of Health, Board of Medicine vs. Robert Huson Hunsaker, M.D., DOAH Case No. 97-0377, in which a Recommended Order was issued on July 23, 1997, and a Final Order was issued by the Board of Medicine on October 20, 1997. In the 1997 final hearing two witnesses, L.P. and A.V., testified as so-called "Williams Rule" witnesses. The essence of their testimony was that, while in the recovery room following surgery by Respondent, Respondent had engaged in

sexual misconduct which consisted of causing the patient's hand to be placed in contact with his penis. The Administrative Law Judge (ALJ) in Case No. 97-0377 found that the testimony of witnesses L.P. and A.V. was not persuasive and was not worthy of belief. Consistent with that view of their testimony, and upon consideration of Respondent's testimony in Case No. 97-0377, the ALJ's findings of fact included a finding that Respondent did not commit the misconduct testified to by L.P. and A.V. In its Final Order in Case No. 97-0377, the Board of Medicine stated, among other things, that "[t]he findings of fact set forth in the Recommended Order are approved and adopted and incorporated herein by reference." In this case Respondent was charged with having committed the sexual misconduct previously testified to by L.P. and A.V. in the 1997 hearing. At the final hearing in this case, Petitioner sought to have L.P. and A.V. testify again to the same alleged misconduct by Respondent that they had testified to in the 1997 hearing. The ALJ in this case concluded that the findings of fact regarding L.P. and A.V. in the 1997 Recommended and Final Orders were binding on both parties. Consistent with that view, Petitioner was precluded from relitigating any allegations of sexual misconduct by Respondent involving either L.P. or A.V.

6/ David Glener, M.D., one of Petitioner's expert witnesses, agrees that it is common practice for a surgeon to hold a patient's hand in the recovery room.

7/ This, of course, is why the anesthetic agents are administered to the patients. The purpose of the anesthesia is to cause the patient to be unable to perceive or to remember the pain associated with the surgical process. In other words, the anesthetic agents are intended to cause the patient to be unaware of what is happening during surgery. These effects of the anesthesia continue for a while after the administration of anesthetic agents has been discontinued.

8/ In this regard it is also noteworthy that neither Patient E.R. nor Patient S.C. visually observed any act of sexual misconduct. Specifically, neither E.R. nor S.C. claimed to have seen Respondent's penis. Nor did either of them claim to have seen their hand in contact with the genital area of Respondent's scrub pants.

9/ Patient E.R. described the reason for her fear as follows: "I was afraid of turning my face to the side because . . . for some reason I thought my brain was going to come out of my nose or something or I was petrified of moving." This type of

muddled thinking suggests that at that time the patient was still substantially under the influence of the anesthetic agents.

10/ For example, on the drive to her mother's house following the surgery, Patient E.R. told her best friend, "I think the doctor put his penis in my hand." (Emphasis supplied.) The friend replied, "You're kidding, right?" Then, more than a year went by before Patient E.R. again mentioned anything to her best friend about any alleged misconduct by Respondent. Similarly, Patient E.R. waited more than a year before mentioning any allegations of misconduct by Respondent to either her boyfriend (now fiancé) or to her father.

11/ The conduct of Patient E.R. during the year between her two surgeries at Premiere Center also suggests that during that period she believed she had had a dream or a hallucination, because during that period she visited Respondent at least nine times at the Premiere Center. Further, during some of those visits she discussed having Respondent perform some additional plastic surgery procedures for her.

12/ Patient S.C. is not certain whether Respondent was standing beside her bed in the recovery room when she woke up the first time, or whether he was there when she woke up the second time. Patient S.C. has no recollection of Respondent administering medication through her I.V. line to treat her nausea and vomiting, at which time he was, of necessity, at the patient's bedside.

13/ For example, right after the surgery S.C. "had a feeling that something may have happened," and when her boyfriend was carrying her to the car after the surgery, S.C. told him only that she thought "something had happened in the room"; not that she was certain "something had happened." Shortly after the surgery, when Patient S.C. first got home, she was not certain of what, if anything, had happened. Although S.C. made several follow-up visits to the Premiere Center (including a follow-up visit the very next day after her surgery), she never mentioned to anyone at the Premiere Center anything about any possible sexual misconduct by Respondent. And she waited well over a year before mentioning to anyone else her thoughts that Respondent might have engaged in sexual misconduct in the recovery room.

14/ Not only was much of S.C.'s testimony vague, or lacking in detail, or qualified by statements indicating uncertainty on her

part, but her credibility was cast into substantial doubt by the fact that at different times she has testified to very different versions of the alleged sexual misconduct. One version testified to by Patient S.C. is that Respondent placed her hand on the outside of his scrub pants against the part of the pants that covered Respondent's penis. Another version of the same incident testified to by S.C. is that her hand was inside Respondent's scrub pants and was touching Respondent's penis inside the pants. The credibility of S.C.'s testimony was further eroded by her statements near the end of her testimony that included ". . . I can't really say for sure if it was on the outside or the inside because it is something I have tried so hard to forget. . . . I don't want to say for sure that I was inside his pants or not." Also detracting from credibility is the fact that S.C. (like E.R.) does not remember whether the penis she thinks she felt (but never saw) was soft or firm.

15/ The defense to the allegations of sexual misconduct is that there were no acts of sexual misconduct. The parties stipulated that there is no legitimate medical purpose for a surgeon to place his penis in the hand of a post-operative patient and that it would be below acceptable standards of care for a surgeon to do so.

16/ Respondent's emphatic and credible denials of any sexual misconduct with any of his patients were made both in his testimony at the 1997 hearing in DOAH Case No. 97-0377 and in his testimony at the final hearing in this case on September 23-25, 2003. This finding of fact is based on both the facts found in Case No. 97-0377 (which facts the parties have been precluded from relitigating) and on the testimony received in this case at the final hearing on September 23-25, 2003. So much of this finding of fact as relates to Patient A.V. and Patient L.P. is based on the facts found by Judge Arrington in DOAH Case No. 97-0377, which facts were adopted by the Board of Medicine in its Final Order in that case. In endnotes 5 and 6 of Judge Arrington's Recommended Order he further explains the basis for his finding that Respondent did not engage in any sexual misconduct with Patient L.P. or Patient A.V. Those footnotes read:

> 5/ A. V. testified that as she was coming out of anesthesia she thought that Respondent had placed his penis in her hand. A. V. also testified that she looked at her hand and that what she thought was Respondent's penis was only his hand holding

her hand. P. S. testified that she was not aware that A. V. had seen that it was Respondent's hand in her hand and not his penis.

6/ Another female patient, L. P., testified that Respondent placed his penis in her hand while she was coming out of anesthesia. Like P. S., L. P. was in the middle of the bed in a position where Respondent could not have physically done what she claimed he did.

So much of this finding of fact as relates to Patient E.R. and Patient S.C. is based on the evaluation by the ALJ in this case of the credibility of Respondent, as well as on the ALJ's careful consideration of the testimony of Patient E.R. and Patient S.C., and an evaluation of the credibility of those two witnesses. On all material issues, the testimony of Respondent was credible, clear, and convincing. The testimony of Patient E.R. and Patient S.C. was not persuasive or credible, and most certainly was not clear and convincing. This is not to say that E.R. and S.C. were intentionally presenting testimony they knew to be false. It is possible that they both sincerely <u>believe</u> that events such as those they testified to <u>probably</u> happened. But sincere belief that something probably happened is quite a different matter from certainty that a specific event actually took place. In the final analysis, it appears that at the time of the alleged events, E.R. and S.C. simply were too impaired by the lingering effects of the anesthetic agents for their accounts to be relied upon as persuasive proof of what actually transpired in the recovery room. Petitioner simply has not shown by clear and convincing evidence that Respondent committed sexual misconduct with any of his patients.

17/ The findings of fact in this paragraph relating to Patient L.P. and the findings of fact in the following paragraph relating to Patient A.V. are drawn from the factual findings on these issues that were made in Case No. 97-0377 when the same factual issues were litigated by the same parties. Respondent's motion to preclude the relitigation of facts established in the 1997 hearing regarding Patients L.P. and A.V. was argued and granted early in the hearing on September 23-25, 2003. The ruling on the motion, and the reasons for the ruling, are at pages 195-197 of the transcript of the final hearing, which include the following explanation by the ALJ in this case:

> I'm of the view . . . that i[f] paragraph 31 of the findings of fact [in] . . . [J]udge Arrington's recommended order issued in 1997 is read in conjunction with the text of footnotes 5 and 6 in that same document, [t]hat the factual issue of whether the sexual misconduct previously testified to by A.V. [and] previously testified to by L.P. actually occurred, has been resolved in favor of the [d]octor, that the specific conduct to which they testified did not occur. Now [since] I am of the view that because of the identities of the parties and because the Department or Agency in 1997 had the same interest in establishing those facts then as they would have i[n] establishing those facts now, that the Agency is precluded from re-litigating those facts.
>
> So for the purpose of my fact-finding here, I'm going to find as did Judge Arrington in 1997 that the act[s] of misconduct testified to by A.V. and L.P., and the acts of sexual misconduct involving those two persons that are alleged in the administrative complaint that brings us here together today did not occur, or that the evidence is insufficient to show that they did occur. And, stated more specifically, I'm going to conclude that there's no clear and convincing evidence of those facts, and I'm going to preclude the re-litigation of it. I think that those factual issues were settled in the 1997 case.
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> * * *
>
> [A] factual finding that is binding on the parties has already been made to the effect that this Respondent/Doctor did not commit the acts described by L.P. and A.V.

18/ The findings of fact in this paragraph, as well as findings in the three immediately preceding paragraphs, are based in large part on the testimony of Petitioner's expert witnesses Dr. Greenberg and Dr. Glener. Dr. Greenberg's practice, like that

of Respondent, consists primarily of aesthetic plastic surgery, much of which is performed in an office surgery setting. Dr. Greenberg is clearly of the view that, in the normal course of events, the surgeon is not responsible for preparing the post-anesthesia recovery room record. Rather, in Dr. Greenberg's opinion, the preparation of the post-anesthesia recovery room record is the responsibility of the person who is designated to monitor the patient in the recovery room. Dr. Greenberg's conduct is consistent with his opinion. In his entire career as a plastic surgeon, Dr. Greenberg has prepared and kept post-anesthesia recovery room notes on only one occasion. That one occasion was when the circulating nurse, who normally did the recoveries, got called away and the only people left to do the recovery were Dr. Greenberg and the anesthesiologist. (Greenberg deposition transcript, pages 58-59.) Dr. Glener, a board certified anesthesiologist, agreed with Dr. Greenberg's opinion that, in the normal course of events, preparation of the post-anesthesia recovery room records is not the responsibility of the surgeon. Dr. Glener agrees that, in a small facility, it would be acceptable for the nurse anesthetist or a trained nurse to recover the patient and keep the recovery room notes.

19/ Some of my "determinations" as to whether Respondent "has violated the laws and rules regulating the profession" are located in the Findings of Fact portion of this Recommended Order, and other such "determinations" are located in the Conclusions of Law. The ALJ has tried to place such determinations where he believes they belong, taking into consideration both a long history of appellate court guidance on such matters and the new legislative pronouncement which does not appear to have yet been the subject of board, department, or judicial interpretation. In any event, the placement of such determinations in one part of the Recommended Order or the other does not appear to be of any great moment, because it is reasonable to expect that the appellate courts will continue to be of the view that, regardless of where placed and regardless of how characterized, a fact will always be a fact and a conclusion of law will always be a conclusion of law.

20/ At all times material to the alleged violations at issue in this case, Sections 458.329 and 458.331, Florida Statutes (1995), were in effect and are the versions of the statutes which must be applied here. During the 1996 session of the Florida Legislature there were some amendments to other portions of Section 458.331, Florida Statutes, but none of those amendments are relevant to the issues here.

21/ It may well be that, even though not responsible for making a post-anesthesia record tracking the recovery of the patient, a surgeon has some supervisory duty to confirm that those charged with the responsibility of preparing the recovery room record are carrying out their responsibilities. However, no such duty was alleged and no such duty was proved. Absent allegation and proof, no disciplinary action can be predicated upon such a duty, if such a duty exists (or if it existed in 1996 under the circumstances from which this case arises). In this regard it is also worthy of note that it is well-settled that a health care professional cannot be penalized for the improper actions of other employees absent proof that the health care professional had actual knowledge of the improper actions of other employees. Bach v. Florida State Board of Dentistry, 378 So. 2d 34 (Fla. 1st DCA 1980).

22/ See Gross, M.D. v. Department of Health, 819 So. 2d 997 (5th DCA 2002), in which it was held that it was not a violation of Section 458.331(1)(t), Florida Statutes, for a physician to fail to perform a task that was the responsibility of the staff of a hospital's Cardiac Cath Lab.

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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.