STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 03-2537PL
ANDREW LOGAN, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case before Larry J. Sartin, an Administrative Law Judge of the Division of Administrative Hearings, in Fort Lauderdale, Florida, on December 1, 2003.

APPEARANCES

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For Respondent: James S. Haliczer, Esquire
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STATEMENT OF THE ISSUE

The issue in this case is whether Respondent, Andrew Logan, M.D., committed a violation of Section 458.331(1)(t), Florida

Statutes, as alleged in an Administrative Complaint filed by Petitioner, the Department of Health, on April 30, 2003, and, if so, what disciplinary action should be taken against him.

PRELIMINARY STATEMENT

On or about April 30, 2003, the Department of Health filed an Administrative Complaint against Andrew Logan, M.D., a Florida-licensed medical doctor, before the Board of Medicine. On or about July 7, 2003,[1] Dr. Logan, by letter from counsel, disputed the allegations of fact contained in the Administrative Complaint and requested a formal administrative hearing pursuant to Section 120.569(2)(a), Florida Statutes. On July 14, 2003, the matter was filed with the Division of Administrative Hearings, with a request that an administrative law judge be assigned the case. The matter was designated DOAH Case Number 03-2537PL and was assigned to the undersigned.

The final hearing was scheduled by Notice of Hearing entered July 23, 2003, for September 17, 2003. The hearing was continued several times and ultimately scheduled for December 1 and 2, 2003.

On November 26, 2003, a Joint Prehearing Stipulation was filed by the parties.

At the final hearing, Petitioner offered and had admitted ten exhibits. Petitioner called no witnesses during the final hearing, but offered the deposition testimony of William Cobb,

M.D. (Petitioner's Exhibit 5), Joel Kramer, M.D. (Petitioner's Exhibit 7), Ann Tuza, R.N. (Petitioner's Exhibit 8), and Lowell Sherris, M.D. (Petitioner's Exhibit 9).

Respondent testified on his own behalf and presented the testimony of Harry Hamburger, M.D. Respondent offered and had admitted two exhibits.

A Notice of Filing of Transcript issued January 15, 2004, informed the parties that the Transcript of the final hearing had been filed that same day and that they had until January 26, 2004, to file proposed recommended orders. Both parties timely filed proposed orders, which have been fully considered in rendering this Recommended Order.

FINDINGS OF FACT

A. The Parties.

1. Petitioner, the Department of Health (hereinafter referred to as the "Department"), is the agency of the State of Florida charged with the responsibility for the investigation and prosecution of complaints involving physicians licensed to practice medicine in Florida.

2. Respondent, Andrew Logan, M.D., is, and was at the times material to this matter, a physician licensed to practice medicine in Florida, having been issued license number ME 0058658. Dr. Logan's last known business address is 8551 West Sunrise Boulevard, Suite 105, Plantation, Florida 33322.

3. At the times material to this matter, Dr. Logan was certified in ophthalmology. He specializes in medical and surgical ophthalmology.

4. Dr. Logan received a bachelor of arts degree in biology in 1982 from Brown University. He received his medical degree in 1986 from the University of California, San Francisco.[2]

5. Dr. Logan completed a residency in ophthalmology.

6. Dr. Logan has practiced medicine in Florida since 1990. At the times relevant to this matter, Dr. Logan worked in a group practice in Plantation, Florida. Most of his practice consisted of an office practice, seeing patients. He also performed some laser and minor surgeries in the office. Approximately once a week, for half a day, he performed surgery out of the office at "three hospitals and surgical centers."

7. Dr. Logan's license to practice medicine has not been previously disciplined.

B. The Department's Administrative Complaint and Dr. Logan's Request for Hearing.

8. On April 30, 2003, the Department filed an Administrative Complaint against Dr. Logan before the Board of Medicine (hereinafter referred to as the "Board"), alleging that his treatment of one patient, identified in the Administrative Complaint as C. S., constituted gross or repeated malpractice or the failure to practice medicine with that level of care, skill,

and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances (the recognized acceptable treatment will hereinafter be referred to as the "Standard of Care"), a violation of Section 458.331(1)(t), Florida Statutes.

9. In particular, it is alleged in the Administrative Complaint that Dr. Logan violated the Standard of Care in "one or more of the following ways":

> a. Respondent failed to identify the correct patient for the implantation of the 23 diopter lens;
>
> b. Respondent failed to verify that the lens he implanted into Patient C.S. was the power of lens that he had previously ordered;
>
> c. Respondent implanted the wrong lens into the left eye of Patient C.S.

The factual allegations of the Administrative Complaint, although stated differently, essentially allege that Dr. Logan operated on the wrong patient.

10. Dr. Logan filed a request for a formal administrative hearing with the Department, which was filed by the Department with the Division of Administrative hearings.

C. Treatment of Patient C.S.

11. C.S., who was 70 years of age at the time of the incident involved in this matter, began seeing Dr. Logan for eye care in approximately February 1997.

12. C.S. developed cataracts in both eyes, for which Dr. Logan diagnosed and suggested surgical treatment.[3]

13. Dr. Logan explained the procedure he believed necessary to remove C.S.'s cataracts to her and obtained her approval thereof. The procedure to be performed on C.S., known as phacoemulisification, consisted of making an very small incision in her eye, breaking up her natural, or intraocular, lens with ultrasound, irrigating the eye, and then suctioning out the destroyed lens and irrigation material. Once the intraocular lens is removed, it is replaced with an artificial lens, the power and model of which is selected by the physician.

14. Dr. Logan determined that the lens needed to restore C.S.'s vision in her left eye after removal of her intraocular lens was a 15-diopter lens. The "diopter" of a lens relates to the corrective power of the lens.

15. C.S. was scheduled for the planned cataract surgery on her left eye at the Surgery Center of Coral Springs (hereinafter referred to as the "Surgery Center") for the morning of September 5, 2000.[4] C.S. was one of at least two patients scheduled for surgery by Dr. Logan that morning.

16. The Surgery Center is a free-standing center where various types of surgery are performed. Dr. Logan was not an owner or employee of the Surgery Center. He did not hire, nor

could her fire, any employee of the Surgery Center, and none of the equipment utilized in the Surgery Center was owned by him.[5]

17. Consistent with established procedures, the Surgery Center was faxed information concerning C.S.'s scheduled surgery. In particular, the facsimile identified C.S. by name, which eye was to be operated on (her left eye), and the power (15-diopter) and model number of the replacement lens Dr. Logan had determined was necessary to restore C.S.'s vision after the surgery.

18. The day before C.S.'s scheduled surgery, Dr. Logan was provided with C.S.'s patient records and the records of the other patient scheduled for surgery on September 5, 2000. He reviewed those records either that afternoon or that night. He also took the records with him to the Surgery Center where he reviewed them again.

19. On or around the morning of September 5, 2000, the Surgery Center's nurse manager took the facsimiles that had previously been sent to the Surgery Center by Dr. Logan's office and retrieved the lens for each patient scheduled for surgery that day. When the nurse manager retrieved the lens, she was expected to ensure that the ordered lens, both as to power and model, were available, and that they were within their expiration date. She then bundled the lens and the facsimile. Three lens per patient were routinely retrieved. The bundles

were then placed on a table in the operating room in the order they were supposed to be used.

20. The order of surgery for September 5, 2000, had been prearranged and that information was available on a list prepared by the Surgery Center to all of those involved in the surgery that morning, including Dr. Logan and his surgery team. C.S. had been scheduled to be the second patient seen that morning.

21. When C.S. arrived at the Surgery Center she was eventually taken to a pre-operation room (hereinafter referred to as "pre-op") to be readied for surgery.

22. The patient who had been scheduled for the first surgery of the morning (hereinafter referred to as the "First Scheduled Patient"), had been late arriving on September 5, 2000. C.S. had come early. Therefore, C.S. was taken to pre-op in place of the First Scheduled Patient. What exactly transpired after C.S. was taken to pre-op was not explained. The nurse manager, who had overall responsibility for getting patients ready for surgery did not testify during this proceeding and the circulating nurse, Ann Tuza, was unable to recall what took place in any detail. What was proved is that Dr. Logan was not informed of the switch and the records and lens, which had been placed in the order of the scheduled surgeries for that day, were not changed to reflect that C.S.

would be taken to surgery in place of the First Scheduled Patient. Therefore, although C.S. was the first patient into surgery, the records and lenses of the First Scheduled Patient were not replaced with C.S.'s records or lens.

23. As was his practice, before going into the operating room, Dr. Logan went to pre-op to administer a local anesthesia. Dr. Logan, who had not been informed that the second scheduled patient, C.S., had been substituted for the First Scheduled Patient, administered the anesthesia to C.S. Dr. Logan found C.S. asleep. Dr. Logan did not recognize C.S. and he did not speak to her, as would have been his practice had she been awake, or otherwise identify her. Dr. Logan injected a local anesthesia by needle under and behind C.S.'s left eye,[6] a procedure referred to as a "block" or "retrobulbar block."[7]

24. After the block had time to take effect, which normally took approximately five to ten minutes, Nurse Tuza went to retrieve C.S. from pre-op and bring her to the operating room.

25. C.S. was brought into the operating room by Nurse Tuza and prepared for surgery. She was covered completely except for her feet and her left eye, which had an "X" placed over it to identify the eye to be operated on. Nurse Tuza remained in the operating room, along with a scrub technician, who assisted Dr. Logan, and a nurse anesthetist. None of these individuals

apparently checked to ensure that they were correct in their assumption that the patient was the First Scheduled Patient.

26. Dr. Logan, who did not recall what he did between seeing C.S. in pre-op and arriving at the operating room, completed scrubbing and entered the operating room where C.S. awaited. He had placed his charts in the operating room. His routine after arriving in the operating room was to go to the head of the patient and adjust a microscope used during the surgery. It is inferred that he did so on the morning of September 5, 2000.

27. Although C.S. was awake when she was taken into the operating room and during the surgery, no one, including Dr. Logan, asked her her name. Nor did anyone, including Dr. Logan, check to see if she was wearing a wrist-band which identified her. Instead everyone, including Dr. Logan, assumed that they were operating on the First Scheduled Patient.

28. Not actually knowing who he was operating on,[8] Dr. Logan performed the surgery scheduled for the First Scheduled Patient on C.S. Although the procedure her performed on C.S., fortunately, was the same one scheduled for C.S., the diopter of the replacement lens was not.[9] The First Scheduled Patient was to receive a 23-diopter lens, rather than C.S.'s 15-diopter lens. Dr. Logan placed the 23-diopter lens in C.S.'s eye, completed the procedure, and C.S. was taken to recovery.

29. When Nurse Tuza went to get the next patient for surgery, who she expected to be C.S., she discovered for the first time that C.S. had been substituted for the First Scheduled Patient. She immediately informed Dr. Logan of the error.

30. Dr. Logan went to the recovery room and, after ensuring that C.S. was alert enough to comprehend what he was saying, informed C.S. of the error. She consented to Dr. Logan's suggestion the he take her back into the operating room, remove the 23-diopter lens, and replace it with the correct, 15-diopter lens, which he immediately did.

31. The replacement procedure required no additional trip to the Surgery Center, anesthesia, or incisions.

32. C.S. recovered from the procedures without problem or direct harm. She continued to see Dr. Logan as her eye care until a change in insurance prevented her from doing so.

D. Standard of Care.

33. There was little dispute that Dr. Logan "failed to identify the correct patient for the implantation of the 23 diopter lens"; "failed to verify that the lens he implanted into Patient C.S. was the power of lens that he had previously ordered [for her]"; and "implanted the wrong lens into the left eye of Patient C.S." These facts, which form the factual basis

for the Department's allegation that Dr. Logan violated the Standard of Care, have been proved.

34. Including Dr. Logan, five physicians gave opinions in this proceeding as to whether Dr. Logan's actions violated the Standard of Care: Drs. William Cobb, Harry Hamburger, Joel Kramer, and Lowell Sherris. The testimony of Drs. Cobb and Kramer, primarily, and, to a lesser degree, the testimony of the Dr. Logan and the other two physicians, support a finding that Dr. Logan's actions, as alleged in the Administrative Complaint, constitute a violation of the Standard of Care.

35. The testimony of Drs. Cobb, Kramer, and Sherris, which was credible and persuasive, have been summarized in the Department's proposed recommended order, and will not, in light of recent changes in Section 456.073(5), Florida Statutes, be summarized in any detail here.

36. All of the physicians who testified, including Dr. Logan, agreed that a physician must know on whom he or she is operating and that operating on the wrong patient or inserting the wrong lens in a patient's eye is inappropriate.

37. Dr. Logan, with Dr. Hamburger's support, attempted to prove that Dr. Logan did not violate the Standard of Care, despite the fact that he "failed to identify the correct patient for the implantation of the 23 diopter lens"; "failed to verify that the lens he implanted into Patient C.S. was the power of

lens that he had previously ordered [for her]"; and "implanted the wrong lens into the left eye of Patient C.S.," by suggesting the following:

> 78. It is reasonable and common practice in the South Florida community for a physician to rely on the staff of a surgical center to identify a patient prior to surgery and bring the patients [sic] back in the order originally anticipated.
>
> 79. Dr. Logan had several safeguards in place to avoid the error that occurred in this case.
>
> 80. The standard of care does not require that physician act as a supervisor who is responsible for every act of the healthcare provided team.
>
> 81. This incident occurred due to an error of the staff at the Surgical Center at Coral Springs.
>
> . . . .

Respondent's Proposed Final [sic] Order, paragraph 78.

38. The proposed findings quoted in paragraph 37 are based primarily on Dr. Hamburger's, and to a lesser extent, Dr. Logan's, assertion that the surgery was a team effort, that the team had established procedures to identify the patient, and that the team failed in this instance to properly identify the patient. This testimony, and the proposed findings quoted in paragraph 37 are rejected. Nothing in the procedures followed in this instance alleviated Dr. Logan's responsibility to ensure

that he actually established for himself who he was about to perform surgery on, a task which would have taken little effort.

CONCLUSIONS OF LAW

A. Jurisdiction.

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

B. The Charges of the Administrative Complaint.

40. In its Administrative Complaint, the Department has alleged that Dr. Logan has violated Section 458.331(1)(t), Florida Statutes (2000), which provides in pertinent part, that the following constitutes grounds for discipline of a physician's license to practice medicine in Florida:

> . . . . [T]he 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. . . .

41. The Department has asserted that Dr. Logan violated Section 458.331(1)(t), Florida Statutes (2000), or the Standard of Care" when he "failed to identify the correct patient for the implantation of the 23 diopter lens"; "failed to verify that the lens he implanted into Patient C.S. was the power of lens that

he had previously ordered [for her]"; and "implanted the wrong lens into the left eye of Patient C.S."

C. The Burden and Standard of Proof.

42. The Department seeks to impose penalties against Dr. Logan through the Administrative Complaint that include suspension or revocation of his license and/or the imposition of an administrative fine. Therefore, the Department has the burden of proving the specific allegations of fact that support its charge that Dr. Logan violated Section 458.331(1)(t), Florida Statutes (2000), by clear and convincing evidence. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Pou v. Department of Insurance and Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998); and Section 120.57(1)(h), Florida Statutes ("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.").

43. What constitutes "clear and convincing" evidence was described by the court in Evans Packing Co. v. Department of Agriculture and Consumer Services, 550 So. 2d 112, 116, n. 5 (Fla. 1st DCA 1989), as follows:

> . . . [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 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 or 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).

See also In re Graziano, 696 So. 2d 744 (Fla. 1997); In re Davey, 645 So. 2d 398 (Fla. 1994); and Walker v. Florida Department of Business and Professional Regulation, 705 So. 2d 652 (Fla. 5th DCA 1998)(Sharp, J., dissenting).

D. The Department's Proof.

44. The proof presented by the Department in this case was clear and convincing as to the specific factual allegations of the Administrative Complaint. The only real dispute between the parties is whether those actions constitute a violation of the Standard of Care.

45. It is no longer clear whether the determination of whether a physician has violated the Standard of Care, which previously clearly required both a finding of fact to be made by this forum, is a question of law solely within the province of the Board to decide. By operation of new legislation enacted during the 2003 session of the Florida Legislature, effective September 15, 2003, prior the formal hearing in this case, "[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 2003, Ch. 2003-416, at § 20 (amending Section 456.073(5), Florida Statutes (2002)).

46. The foregoing legislative change suggests that there is no longer any need for an administrative law judge to decide the factual question of whether a physician violated the Standard of Care. The following change in Section 458.331(1)(t), Florida Statutes, however, suggests that such findings are to be made:

> . . . . 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 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 must so specify.

This language specifically requires an administrative law judge to decide the issue despite the language quoted in paragraph 45.

47. Despite the confusion over the role of the administrative law judge in a case such as this, where the ultimate issue to be decided is whether a physician has violated the Standard of Care, the parties in this case agreed at the outset of the hearing that they did not believe that change in the law quoted in paragraph 45 required any change in the manner in which they presented their evidence, the manner in which the hearing should be conducted, or the appropriate content of this Recommended Order. By their statements and actions at hearing, and in their proposed orders, both parties have agreed that the nature of the evidence to be offered and considered in this case, and the findings to be based thereon, should not be limited by the above-quoted changes to the determination of whether the Standard of Care has been violated. Both parties requested, and, therefore, were granted, the opportunity to offer expert witness testimony on the subject matter of whether Dr. Logan violated the Standard of Care. The proposed orders submitted by the parties also do address the issue of whether Dr. Logan violated the Standard of Care in essentially the same manner that was addressed in proposed orders and recommended orders prior to the adoption of the above-quoted statutory language.

48. It is concluded, based upon the Findings of Fact made in this Recommended Order and the arguments of the parties in

their proposed orders, that there is clear and convincing evidence in the record of this case that Dr. Logan committed the factual allegations of the Administrative Complaint and that by those actions, in failing to properly identify whom he was performing surgery on the morning of September 5, 2000, constituted a violation of the Standard of Care.

E. The Appropriate Penalty

49. In determining the appropriate punitive action to recommend to the Board in this case, it is necessary to consult the Board's "disciplinary guidelines," which impose restrictions and limitations on the exercise of the Board's disciplinary authority. See Parrot Heads, Inc. v. Department of Business and Professional Regulation, 741 So. 2d 1231 (Fla. 5th DCA 1999).

50. The Board's guidelines are set out in Florida Administrative Code Rule 64B8-8.001, which provides the following "purpose" and instruction on the application of the penalty ranges provided in the Rule:

> (1) Purpose. Pursuant to Section 456.079, F.S., the Board provides within this rule disciplinary guidelines which shall be imposed upon applicants or licensees whom it regulates under Chapter 458, F.S. The purpose of this rule is to notify applicants and licensees of the ranges of penalties which will routinely be imposed unless the Board finds it necessary to deviate from the guidelines for the stated reasons given within this rule. The ranges of penalties provided below are based upon a single count violation of each

> provision listed; multiple counts of the violated provisions or a combination of the violations may result in a higher penalty than that for a single, isolated violation. Each range includes the lowest and highest penalty and all penalties falling between. The purposes of the imposition of discipline are to punish the applicants or licensees for violations and to deter them from future violations; to offer opportunities for rehabilitation, when appropriate; and to deter other applicants or licensees from violations.
>
> (2) Violations and Range of Penalties. In imposing discipline upon applicants and licensees, in proceedings pursuant to Section 120.57(1) and 120.57(2), F.S., the Board shall act in accordance with the following disciplinary guidelines and shall impose a penalty within the range corresponding to the violations set forth below. The verbal identification of offenses are descriptive only; the full language of each statutory provision cited must be consulted in order to determine the conduct included.

51. Florida Administrative Code Rule 64B8-8.001(2)(t), goes on to provide, in pertinent part, the following range of penalties for a first offense of violating Section 458.331(1)(t), Florida Statutes: "From two (2) years probation to revocation . . . and an administrative fine from $1,000.00 to $10,000.00."

52. Florida Administrative Code Rule 64B8-8.001(3), provides that, in determining the appropriate penalty, the following aggravating and mitigating circumstances are to be taken into account:

(3) Aggravating and Mitigating Circumstances. Based upon consideration of aggravating and mitigating factors present in an individual case, the Board may deviate from the penalties recommended above. The Board shall consider as aggravating or mitigating factors the following:

(a) Exposure of patient or public to injury or potential injury, physical or otherwise: none, slight, severe, or death;

(b) Legal status at the time of the offense: no restraints, or legal constraints;

(c) The number of counts or separate offenses established;

(d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;

(e) The disciplinary history of the applicant or licensee in any jurisdiction and the length of practice;

(f) Pecuniary benefit or self-gain inuring to the applicant or licensee;

(g) The involvement in any violation of Section 458.331, Florida Statutes, of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure;

(h) Any other relevant mitigating factors.

53. In its Proposed Recommended Order, the Department has requested that it be recommended that the following penalties be imposed on Dr. Logan: an "administrative fine of $10,000.00,

the completion of four hours of continuing medical education in risk management, a one hour lecture on wrong patient surgery and how to avoid it, and a letter of concern from the Board of Medicine."

54. Having carefully considered the facts of this matter in light of the provisions of Florida Administrative Code Rule 64B8-8.001, it is concluded that the Department's suggested penalty, with an administrative fine of $5,000.00 rather than $10,000.00, is reasonable. A single offense was proved in this case, this is Dr. Logan's first disciplinary action, there was no proof of any pecuniary gain to Dr. Logan or financial loss to C.S., the problem was discovered and correctly shortly after the error occurred, and the exposure of C.S. and the public to injury or potential injury, physical or otherwise was slight and none, respectively.

RECOMMENDATION

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

RECOMMENDED that the a final order be entered by the Board of Medicine finding that Andrew Logan, M.D., has violated Section 458.331(1)(t), Florida Statutes (2000), as alleged in the Administrative Complaint, requiring the payment of an administrative fine of $5,000.00, completion of four hours of continuing medical education in risk management, and attendance

at a one hour lecture on wrong patient surgery and how to avoid it, and issuing Dr. Logan a letter of concern from the Board of Medicine.

DONE AND ENTERED this 19th day of February, 2004, in Tallahassee, Leon County, Florida.

LARRY J. SARTIN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of February, 2004.

ENDNOTES

[1]/ No explanation was given as to why an Election of Rights form was not filed by Dr. Logan or why more than two months lapsed before he requested a hearing.

[2]/ A number of proposed findings of fact have been included in Dr. Logan's proposed order concerning his credentials and training. No citation to the record has been made to support these proposed findings and no record support has been found.

[3]/ There is no dispute as to the appropriateness of Dr. Logan's diagnosis, recommended course of treatment, or his treatment of C.S. other than his treatment of her on April 5, 2000.

[4]/ Cataract surgery had previously been performed by Dr. Logan on C.S.'s right eye.

[5]/ Dr. Logan was, however, responsible for any surgical procedure he performed and the staff assisting him in any surgical procedure were subject to his direction. More importantly, he was responsible for his patient's well-being.

[6]/ Anesthesia was administered to C.S. by I.V. while she was asleep and before Dr. Logan inserted the needle.

[7]/ In its proposed order, the Department has suggested findings of fact that administering the block was an invasive procedure, which Dr. Logan performed without making any effort to verify who the patient was other than to look at the medical chart. While true, the Administrative Complaint does not allege this to be a fact which supports the Department's allegation that Dr. Logan violated the Standard of Care in his treatment of C.S. The Department's suggested facts are, therefore, irrelevant because the grounds proven in support of the Department's assertion that Dr. Logan license should be disciplined are limited to those specifically alleged in the Amended Administrative Complaint. See, e.g., Cottrill v. Department of Insurance, 685 So. 2d 1371 (Fla. 1st DCA 1996); Kinney v. Department of State, 501 So. 2d 129 (Fla. 5th DCA 1987); and Hunter v. Department of Professional Regulation, 458 So. 2d 842 (Fla. 2nd DCA 1984).

[8]/ Although Dr. Logan at first testified that he had been told that the patient was the First Scheduled Patient by name, he later admitted that he could not recall if anyone in the operating room had named the patient.

[9]/ Consistent with established procedures, prior to inserting the intraocular lens into C.S.'s eye, the circulating nurse read aloud the model and power of the lens from the lens box. Dr. Logan verified this information by looking at a copy of the faxed order that was taped to the microscope. Unfortunately, in this instance the box contained the lens for the First Scheduled Patient and the fax order taped to the microscope was also for the First Scheduled Patient.

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.