STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 05-0840PL

MELODY M. JOHNSON, P.A.,

Respondent.

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on May 13, 2005, in Sebring, Florida, before Susan B. Harrell, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Robert E. Fricke, Esquire
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STATEMENT OF THE ISSUES

Whether Respondent violated Subsection 458.331(1)(t), Florida Statutes (1999),[1] and, if so, what discipline should be imposed.

PRELIMINARY STATEMENT

On January 26, 2005, Petitioner, Department of Health, Board of Medicine (Department), filed an Administrative Complaint against Respondent, Melody M. Johnson, P.A. (Ms. Johnson),[2] alleging that she violated Subsection 458.331(1)(t), Florida Statutes (2001).[3] Ms. Johnson requested an administrative hearing, and the case was forwarded to the Division of Administrative Hearings on March 4, 2005, for assignment to an administrative law judge. The case was assigned to Administrative Law Judge Larry J. Sartin, but was later transferred to the undersigned to conduct the final hearing.

On April 29, 2005, the Department filed Petitioner's Motion to Amend Administrative Complaint, which was granted by order dated May 5, 2005.

Prior to the final hearing, the parties submitted a Joint Prehearing Stipulation, which contained facts to which the parties agreed. Those facts which are contained in Section E of the Joint Prehearing Stipulation are incorporated into this Recommended Order to the extent relevant.

At the final hearing, Respondent advised that she had married, and her legal name was Melody M. Johnson. The caption of the case was changed to reflect Ms. Johnson's married name. At the final hearing, the Department called Philip T. Nix as its witness and proffered the testimony of Dr. Lawrence Kaplan. Petitioner's Exhibits 1 through 4, and 6 were admitted in evidence. Petitioner's Exhibit 9 was proffered. Official recognition was taken of Sections 458.337 and 458.331, Florida Statutes (2000), and Florida Administrative Code Rule 64B8-30.015.

At the final hearing, Ms. Johnson testified in her own behalf and called the following witnesses: Iqbal Ahmed, M.D.; Ernest Benjamin Walton; and Don Milton Harvey, M.D. Respondent's Exhibits 1 through 4 were admitted in evidence.

The two-volume Transcript was filed on June 3, 2005. The parties filed their Proposed Recommended Orders on June 13, 2005. The parties' Proposed Recommended Orders have been considered in rendering this Recommended Order.

FINDINGS OF FACT

1. The Department is the state agency charged with the regulation of medicine pursuant to Chapters 20, 456, and 458, Florida Statutes.

2. Ms. Johnson, is and was at all times material to this proceeding, a licensed physician assistant in the State of Florida, having been issued license number PA3320.

3. In February 2000, Ms. Johnson was asked to help start a program to evaluate the benefit of having physician assistants in the Emergency Department at Highlands Regional Medical Center (Medical Center) in Sebring, Florida. She was the only full-time physician assistant in the program. There were a few other physician assistants, who worked part-time. In the trial program, the emergency physician would work directly and closely with the physician assistant. The physician assistant would assess a patient and report any abnormal findings to the physician. The physician would see the patient and repeat the assessment. Because this trial program was also a teaching experience, the physician would advise the physician assistant of any abnormal findings. The physician would tell the physician assistant what to order and the physician assistant would order it.

4. On April 15, 2000, Ms. Johnson was working as a physician assistant in the Emergency Department at the Medical Center when J.W. arrived at the Emergency Department via Highlands Emergency Medical Services (EMS) at about 9:40 a.m. A copy of the EMS report was made available to the Emergency Department staff.

5. According to the EMS report, when the EMS personnel arrived at J.W.'s home, J.W.'s chief complaint was nausea and vomiting. J.W. had not had adequate fluid intake in two days. She was alert and oriented to time, place, and person, and denied having lost consciousness. She was taken to the Medical Center.

6. On arrival at the Medical Center, J.W. was complaining of nausea and dry heaves, dizziness, and neck pain, and that she could not raise her head. J.W. was seen by Ms. Johnson, who examined J.W. and took a medical history. In assessing J.W., Ms. Johnson used a T-sheet for nausea, vomiting and diarrhea. A T-sheet is a form which has questions which would be germane to the complaints of the patient. In the instant case, a T-sheet for nausea and vomiting was appropriate based on J.W.'s primary complaint of nausea and vomiting.

7. Using the T-sheet, Ms. Johnson found that J.W. had nausea, had been vomiting, had muscle aches, had a headache on the top of her head, had blurred vision, had dizziness, and had back pain. It was noted that J.W. had a history of high blood pressure and was a smoker. Ms. Johnson's examination indicated that J.W.'s neck was supple, meaning that J.W. could freely move her neck and Ms. Johnson was able to bring J.W.'s neck from her chin to her chest. Ms. Johnson circled on the form that J.W. had "passed out," but this notation was in error. Ms. Johnson

should have circled "dizziness" which appeared in front of "passed out" on the T-sheet.

8. J.W. was alert and oriented to person, place, and time during the entire time she was in the Emergency Department of the Medical Center. None of J.W.'s relatives were available in the Emergency Department during the entire time that she was in the Emergency Department.

9. Iqbal Ahmed, M.D., Ms. Johnson's supervising physician in the Emergency Department on April 15, 2000, also examined J.W. and made an assessment. When he saw that Ms. Johnson had indicated on the T-sheet that J.W. had passed out, he specifically asked J.W. if she had passed out, and J.W. stated that she had not, but that she was dizzy. Dr. Ahmed asked J.W. about her headache, and she indicated that the headache was not a sudden onset and that she did not remember when it started. J.W. denied any injury or trauma to the head and indicated that she had a mild headache on the top of her head. He viewed the headache as a secondary complaint.

10. While J.W. was in the Emergency Department, she was given Toradol for the body aches and pain, and Antivert for the nausea and lightheadedness.

11. X-rays were taken of J.W.'s lungs and cervical spine. The X-rays of the lungs indicated that there was a small patch

infiltrate in the right lower lobe. The X-rays of the cervical spine showed normal findings.

12. Ms. Johnson diagnosed J.W. with lower lobe pneumonia, labyrinthitis, intractable neck pain, and nausea. After conducting his own examination and reviewing J.W.'s X-rays, Dr. Ahmed concurred with the diagnosis. Both Ms. Johnson and Dr. Ahmed felt that J.W. should be admitted to the Medical Center.

13. J.W.'s primary care physician, Dr. Jackson, was contacted at 1:00 p.m. on April 15, 2000. He gave orders at 1:20 for J.W. to be admitted to the Medical Center and further ordered laboratory tests and medications for J.W. The patient's primary care physician indicated that he would be in to see J.W. on the day of her admission.

14. At 6:00 p.m. on April 15, 2000, the nurses' notes indicate that after J.W. was admitted to the Medical Center, she was complaining of neck pain and a pounding headache from her forehead over the top of her head and back down to her neck. J.W. was still complaining of a headache and neck pain at 9:30 p.m. At 10:00 p.m., Dr. Jackson gave verbal orders for additional pain medication.

15. On April 16, 2000, Dr. Jackson, assessed J.W. for the first time and wrote a progress note that J.W. was more comfortable, but still had some neck discomfort. On the evening

of April 16, 2000, the nurses' notes indicate that a family member had expressed concern about J.W.'s mental status, stating that prior to going to the Medical Center, J.W. had acted differently than normal, leaving clothing on the floor of her home, not answering her telephone, failing to follow her normal routine of talking on the telephone to her friend every morning, and walking around the house in front of her granddaughter with nothing but a blouse on. Dr. Jackson spoke to the family member about J.W.'s unusual behavior.

16. A CT scan was ordered of J.W.'s head. The laboratory report that the indication for the procedure was a "Change in mental status." The CT scan revealed that J.W. had a subarachnoid hemorrhage. She was later transferred to another hospital. The evidence did not establish when J.W. actually suffered the subarachnoid hemorrhage.

17. A subarachnoid hemorrhage is a rupture of a blood vessel in the brain. Normally, when a patient has had a subarachnoid hemorrhage, the primary complaint of the patient will be the headache. The headache is usually described as the worst headache of the patient's life, and the headache usually starts as a sudden onset like a thunder clap.

18. Ben Walton, a physician assistant with over 20 years' experience, testified as an expert witness on Ms. Johnson's behalf. It was his opinion that her evaluation

and diagnosis of J.W. met the standard of care. Mr. Walton came to this conclusion prior to his finding out that the CT scan taken after J.W. was admitted to hospital showed that J.W. had a subarachnoid hemorrhage.

19. Dr. Don Harvey, an emergency room physician with over 24 years' experience, also testified on Ms. Johnson's behalf. Dr. Harvey is board-certified in internal medicine and in emergency medicine. He supervises physician assistants in the Emergency Department at Manatee Memorial Hospital and evaluates the performance of physician assistants. It is Dr. Harvey's opinion that based on J.W.'s primary complaint of nausea and vomiting that Ms. Johnson did not fall below the standard of care by failing to order a CT scan and failing to diagnose a cerebrovascular or neurologic abnormality.

20. Phillip Nix, a physician assistant with over 20 years' experience in emergency medicine, testified as an expert on behalf of the Department. Mr. Nix was of the opinion that Ms. Johnson's performance fell below the standard of care. His opinion is based, in part, on an incorrect assumption that J.W. had lost consciousness at some point. Mr. Nix could not tell when the subarachnoid hemorrhage occurred.

CONCLUSIONS OF LAW

21. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat. (2004).

22. The Department has the burden to establish by clear and convincing evidence the allegations in the Amended Administrative Complaint. Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996). The Department has alleged that Ms. Johnson violated Subsection 458.331(1)(t), Florida Statutes, which provides that the following acts constitute grounds for disciplinary action:

> 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 circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $25,000 each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross 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," 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.

23. The Department alleged that Ms. Johnson violated Subsection 458.331(1)(t), Florida Statutes, by "fail[ing] to identify and record symptoms of cerebrovascular and neurologic abnormality in Patient J.W." The Department has failed to establish this allegation by clear and convincing evidence. J.W.'s primary complaint was nausea and vomiting. Her headache was a secondary complaint. Additionally, the symptoms of the headache were not symptoms that would normally be found with a subarachnoid hemorrhage. J.W. did not know when her headache started, and she denied passing out. J.W. complained of neck pain, and a cervical spine X-ray was taken. The X-ray did not reveal any abnormalities. Additionally, Ms. Johnson's supervising physician, who also examined and talked with J.W., came to the same diagnosis that Ms. Johnson did.

24. The Department alleged that Ms. Johnson violated Subsection 458.331(1)(t), Florida Statutes, by "fail[ing] to recommend adequate diagnostic procedures such as a CT scan, testing such as a lumbar puncture, or to obtain a timely neurology consult to evaluate and treat the cause of Patient J.W.'s abnormal symptoms." The Department has failed to establish this allegation by clear and convincing evidence. The headache as described by the patient did not warrant the

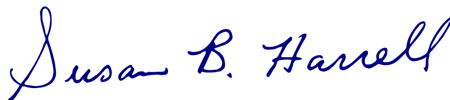
ordering of a CT scan or other diagnostic procedures. Additionally, Dr. Ahmed did not order a CT scan, and Dr. Jackson did not order a CT scan until two days after J.W.'s admission to the Medical Center.

RECOMMENDATION

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

RECOMMENDED that a final order be entered finding that Melody M. Johnson did not violate Subsection 458.331(1)(t), Florida Statutes, and dismissing the Administrative Complaint.

DONE AND ENTERED this 17th day of August, 2005, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of August, 2005.

ENDNOTES

1/ Unless otherwise indicated, all references to the Florida Statutes shall be to the 1999 version.

2/ At the time of the incident in question and at the time of the filing of the Administrative Complaint, Ms. Johnson was known as Melody McSorley. She will be referred to in this Recommended Order by her new married name Melody M. Johnson.

3/ The Administrative Complaint was amended, and the date of the statute was corrected to 1999.

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.