STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. JOSE SUAREZ-DIAZ, M.D., Respondent.	)	Case No. 07-0096PL DOH Case No. 2003-28432

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, on January 14, 2008, by video teleconference between Miami and Tallahassee, Florida.

APPEARANCES

For Petitioner: Irving Levine
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For Respondent: Sean Ellsworth, Esquire
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STATEMENT OF THE ISSUES

The issues in this case for determination are whether Respondent Jose Suarez-Diaz, M.D., violated Section

458.331(1)(m) and (t), Florida Statutes (2003), as alleged in an Amended Administrative Complaint filed by the Department of Health before the Board of Medicine on November 29, 2006; and, if so, what disciplinary action should be taken against his license to practice medicine in the State of Florida.

PRELIMINARY STATEMENT

This case began with the filing by the Department of Health before the Board of Medicine of an Administrative Complaint, DOH Case Number 2003-28432, against Respondent Jose Suarez-Diaz, M.D., an individual licensed to practice medicine in Florida. On August 28, 2006, Dr. Suarez-Diaz, through counsel, filed a Petition for Formal Administrative Hearing and Request for Complete Investigative File and Exhibits and an Election of Rights form signed by Dr. Suarez-Diaz, disputing the allegations of fact contained in the Administrative Complaint and requesting a formal administrative hearing pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes (2006).

On November 29, 2006, the Department of Health filed a two-count Amended Administrative Complaint against Dr. Suarez-Diaz, in which it alleged that Dr. Suarez-Diaz had violated Section 458.331(1)(m), Florida Statutes (Count II), and Section 458.331(1)(t), Florida Statutes (Count I).

On January 9, 2007, the matter was filed with the Division of Administrative Hearings with a request that an administrative

law judge be assigned to conduct proceedings pursuant to Section 120.57(1), Florida Statutes (2006). The matter was designated DOAH Case Number 07-0096PL and was assigned to the undersigned.

The final hearing was scheduled to be held in Miami, Florida, on March 19 and 20, 2007, by Notice of Hearing entered January 18, 2007. On March 3, 2007, an Amended Notice of Hearing by Video Teleconference was entered shortening the hearing to one day, March 19th, and scheduling the hearing to be conducted by video teleconferencing between Miami and Tallahassee, Florida.

On March 16, 2007, Petitioner filed a Motion to Relinquish Jurisdiction, in which it was represented that the parties had entered into a Settlement Agreement which they planned to submit to the Board of Medicine for consideration. The same day, an Order Closing File was issued, canceling the final hearing and closing the file of the Division of Administrative Hearings with leave of either party to request that the file be re-opened should the Board of Medicine not approve the Settlement Agreement.

On October 3, 2007, Petitioner filed a Motion to Reopen DOAH Case, Maintain the Original DOAH Case Number and Schedule a Hearing. Petitioner explained in the Motion that Dr. Suarez-Diaz had withdrawn his support of the Settlement Agreement at a June 1, 2007, meeting of the Board of Medicine.

On October 12, 2007, the file of this case was reopened by the issuance of an Initial Order. By Notice of Hearing by Video Teleconference issued October 17, 2007, an evidentiary hearing was scheduled for January 14, 2008, to be conducted by video teleconferencing between Miami, and Tallahassee, Florida.

On December 28, 2007, the parties filed a Revised Joint Prehearing Stipulation, in which they identified certain facts and issues of law they agreed on.

During the final hearing, Petitioner presented the expert testimony of Joan Christie, M.D., by deposition transcript. The deposition transcript and the curriculum vitae of Dr. Christie were marked as Petitioner's Exhibits 1 and 2, respectively, and were admitted.

Dr. Suarez-Diaz testified on his own behalf and offered four exhibits, identified as Respondent, Dr. Suarez-Diaz's Exhibits A, B, C, and D. Those exhibits were admitted.

Pertinent medical records were admitted as Joint Exhibit 1.

The one-volume Transcript of the final hearing was filed on February 6, 2008. By Notice of Filing Transcript entered February 6, 2008, the parties were informed that the Transcript had been filed and that their proposed recommended orders were to be filed on or by February 15, 2008.

Petitioner's Proposed Recommended Order and Respondent, Jose Suarez-Diaz, M.D.'s Proposed Recommended Order were filed

on February 15, 2008. The post-hearing proposals of both parties have been fully considered in rendering this Recommended Order.

All references to Florida Statutes in this Recommended Order are to the 2003 version unless otherwise noted.

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. § 20.43 and Chs. 456 and 458, Fla. Stat. (Admitted facts).

2. Respondent, Jose Suarez-Diaz, 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 14791. (Admitted facts).

3. Dr. Suarez-Diaz is board-certified in Anesthesiology. (Admitted facts).

4. Dr. Suarez-Diaz's mailing address of record at all times relevant to this matter is 8340 S.W. 62nd Avenue, Miami, Florida 33143. (Admitted Facts).

5. The Department conceded that Dr. Suarez-Diaz has not previously been the subject of a license disciplinary proceeding.

B. Patient J.C.

6. On October 28, 2003, J.C. was admitted to Mercy Hospital in Miami, Florida, with a diagnosis of possible appendicitis.

7. J.C., a 49-year-old male, had a history of heart attack, which occurred in 1998, five years prior to his admission; pneumonia which occurred two months prior to his admission; and chronic obstructive pulmonary disease.

8. After admission, J.C. underwent a chest x-ray, which showed moderate cardiomegaly, and an EKG, which showed left ventricular hypertrophy.

9. J.C. was scheduled for an immediate laparoscopic appendectomy, with Dr. Suarez-Diaz in charge of anesthesiology.

10. Prior to surgery Dr. Suarez-Diaz completed a pre-anesthesia evaluation, documenting J.C.'s history of a 1998 heart attack, pneumonia two months prior to admission, and chronic obstructive pulmonary disease. He did not, however, document the results of the chest x-ray.

11. At approximately 2330 hours (11:30 p.m.), Dr. Suarez-Diaz began anesthesia. J.C. was, from the start of surgery, connected to the following monitors: pulse oximoetry (which

measured the level of oxygen in J.C.’s blood); electrocardiogram (which measures heart activity); and NCO2 monitor (which measured the level of CO2 in J.C.’s blood); and a blood pressure monitor (hereinafter these monitors are collectively referred to as the “Monitors”). Dr. Suarez-Diaz documented the connection of all of the Monitors, except the NCO2 monitor, in J.C.’s medical records.

12. The Monitors, consistent with insurance requirements, remained connected to J.C. throughout the surgery, and, based upon Dr. Suarez-Diaz’s uncontroverted and convincing testimony, were monitored throughout J.C.’s surgery.

13. Surgery commenced at approximately 2345 hours (11:45 p.m.).

14. Almost immediately after anesthesia was first administered, J.C. experienced bronchospasm (the constriction of his airway). In response, Dr. Suarez-Diaz appropriately increased the volume of gas into J.C.’s lungs.

15. In addition to constriction of J.C.’s airways, the few oxygen level recordings made by Dr. Suarez-Diaz indicate that J.C.’s blood oxygen levels were below normal, especially considering the amount of oxygen J.C. was being provided.

16. Due to the emergency nature of the surgery, surgery commenced after J.C.’s bronchospasm was controlled.

17. What took place during surgery, from the standpoint of Dr. Suarez-Diaz's responsibilities, cannot be determined from Dr. Suarez-Diaz's medical record, which is essentially illegible and grossly incomplete:

a. Systolic and diastolic blood pressure readings should have been recorded often, but were not. Of the 15 diastolic readings which should have been recorded, only five readings were;

b. Vital signs were not recorded until after 0045 hours (12:25 a.m.);

c. Pulse oximoetry readings ended at 0015 hours (12:15 a.m.);

d. EKG readings were not recorded after 2400 hours (midnight); and

e. End-tidal CO2 readings ended at 0015 hours (12:15 a.m.).

18. Surgery ended on October 29, 2003, at between 0015 and 0030 hours (12:15 and 12:30 a.m.).

19. Due to impacts on J.C.'s diaphragm during the surgery, ventilation became so difficult that it became necessary for Dr. Suarez-Diaz to "bag" J.C. in order to maintain better control over oxygen levels in J.C.'s blood. When a patient is "bagged" ventilated is provided manually with a gas bag.

Bagging allows a physician to control the rate of ventilation in a way which a ventilator machine cannot.

20. Because Dr. Suarez-Diaz was engaged in bagging J.C., and at the same time closely monitoring J.C.'s oxygen levels, Dr. Suarez-Diaz was unable to record his observations in J.C.'s medical records. According to Dr. Suarez-Diaz's uncontroverted and persuasive testimony, J.C. was one of the three most difficult patients he had dealt with in his 50 years of experience.

21. When surgery ended, J.C. was kept in the operating room with all monitors connected. Dr. Suarez-Diaz still failed to record vital signs and oxygen saturation levels.

22. At some time between 0035 and 0045 hours (12:35 to 12:45 a.m.), J.C. was extubated (the removal of tubes used to breath for the patient) and was breathing on his own. While Dr. Suarez-Diaz noted in his records that J.C. had been extubated, he did not record whether the monitors remained connected between the time he was extubated and then moved to a stretcher. According to his own uncontroverted testimony, he did not maintain the monitors when J.C. was transferred to the stretcher because, in Dr. Suarez-Diaz's opinion, J.C. was breathing on his own.

23. Shortly after extubation, J.C. experienced respiratory difficulty and became dusky and pulseless. At approximately

0045 hours (12:45 a.m.), J.C. was reintubated and a code was called for cardiac arrest; CPR and defibrillation were performed. Dr. Suarez-Diaz remained until approximately 0100 hours (1:00 a.m.), when J.C.'s blood pressure was reestablished.

24. Electoencephalograms were performed on J.C. on October 29 and 31, 2003. Both tests indicated reduced activity consistent with a lack of oxygen to the brain.

25. On November 10, 2003, J.C. was extubated with "do-not-resuscitate" orders. J.C. died on November 18, 2003.

E. The Standard of Care.

26. The Department obtained opinions of two expert witnesses concerning Dr. Suarez-Diaz's treatment of J.C.: Joan Christie, M.D., who testified by deposition (Petitioner's Exhibit 1); and Les King, M.D., whose opinion letter to the Department was admitted without objection as Respondent, Dr. Suarez-Diaz's Exhibit B. Dr. King's opinion letter was not given as much weight as it may have if he had testified, but his opinions do raise significant questions about Dr. Christie's opinions.

27. Both of the Department's experts relied upon essentially the same information to formulate their options. Both reached contrary opinions concerning whether Dr. Suarez-Diaz failed to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to

health care licensure in violation of Section 458.331(1)(t), Florida Statutes (hereinafter referred to as the "Standard of Care"), in his treatment of J.C.

28. Dr. King offered the following general, summary opinion:

> This patient had coronary artery disease of advanced stages HTW and COPD. This is not always information available prior to emergent surgery. Management of the anesthetic, ACLS and post code care are seemingly appropriate for the events. The subject met the standard of care.

29. Dr. Christie, on the other hand, testified generally that Dr. Suarez-Diaz violated the Standard of Care by failing to adequately monitor J.C. “prior to” extubation. The difficulty with Dr. Christie’s testimony in this regard is that she relied completely on the medical records for J.C., without any consideration of Dr. Suarez-Diaz’s uncontroverted and convincing testimony that he indeed did monitor J.C. prior to extubation.

30. Dr. Christie’s testimony does not, therefore, support a finding or conclusion that Dr. Suarez-Diaz violated the Standard of Care “[b]y failing to maintain adequate monitoring . . . after extubation despite intra-operative indications of oxygenation difficulty . . . .”

31. Dr. Christie also offered the following opinion, which apparently was intended to apply to the question of whether

Dr. Suarez-Diaz violated the Standard of Care "after" extubation:

> I think that the lack of monitoring, particularly in the last – lack of monitoring of end-tidal CO2 and oxygenation in the last half an hour and at the time of extubation are not the standard of care. . . .

Petitioner's Exhibit 1, Page 33, Lines 21 through 25.

32. There are several problems with Dr. Christie's opinion. First, she again relied completely on the medical records, without any consideration of Dr. Suarez-Diaz's uncontroverted and convincing testimony as to why he did disconnected the monitors prior to placing J.C. on the stretcher. Secondly, Dr. Christie's opinion is not very precise as to what period of time she is talking about. She clearly rendered her opinion as to the care provided at the time of extubation, but the Amended Administrative Complaint charges a lack of monitoring "after extubation." Thirdly, Dr. King reached contrary conclusions on this matter.

33. Dr. King precisely addressed the question of whether J.C. should have been monitored upon transport to the stretcher:

> 3. It is difficult to determine exactly what transpired at the end of anesthesia and in the moving to the stretcher piror to transport to Recovery. Charting is exceptionally incomplete. As far as meeting the standard of care, it seems to have been appropriate patient management. Standard of care de facto

> is for patients to be transported from the operating room to recovery without monitoring. Appropriate care seems to have been rendered.
>
> . . . .
>
> 13. For stable patients following surgery and anesthetics, general transport to recovery is un-monitored other than direct observation. Generally, if the patient is stable, there is not an issue in moving the patient to the stretcher unmonitored.

Respondent, Dr. Suarez-Diaz's Exhibit B.

34. While Dr. King's opinions may not be adequate, given the manner in which they were entered into evidence, to find that Dr. Suarez-Diaz "met the Standard of Care," his statements, coupled with the lack of precision in Dr. Christie's opinion and Dr. Suarez-Diaz's testimony, are adequate to find that Dr. Christie's opinion does not support a finding or conclusion that Dr. Suarez-Diaz violated the Standard of Care "[b]y failing to maintain adequate monitoring prior to . . . extubation despite intra-operative indications of oxygenation difficulty . . . ."

35. Finally, Dr. Christie opined, in relevant part, as follows concerning the issue of whether Dr. Suarez-Diaz violated the Standard of Care by simply "failing to maintain adequate medical records":

> In my view the practitioner did not meet the standards with respect to documentation and – in the medical records. . . .

Petitioner's Exhibit 1, Page 10, Lines 7 through 9.

Dr. Christie goes on to describe in some detail the significant shortcomings in Dr. Suarez-Diaz's medical records for J.C.

36. Dr. Christie's opinion as to whether inadequate medical records along constitutes a violation of the Standard of Care, again, is contrary to Dr. King's opinion, and, more importantly, the definition of the Standard of Care. Clearly, Dr. Suarez-Diaz kept medical records which were inadequate as to whether he monitored J.C. The evidence, however, proved that, despite the inadequate records, he did monitor J.C. and provided the care he was required to provide. The Standard of Care requires a physician to use adequate "care, skill, and treatment" of in the physician's care of a patient. As poor as Dr. Suarez-Diaz's records for J.C. were, the mere inadequate records do not support a finding that he did not provide adequate "care, skill, and treatment" to J.C.

37. The evidence failed to prove that Dr. Suarez-Diaz violated the Standard of Care as alleged in the Amended Administrative Complaint in his care of J.C.

CONCLUSIONS OF LAW

A. Jurisdiction.

38. 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 (2007).

B. The Burden and Standard of Proof.

39. The Department seeks to impose penalties against Dr. Suarez-Diaz's license through the Amended 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. Suarez-Diaz violated Sections 458.331(1)(m) and (t), Florida Statutes, 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); Nair v. Department of Business and Professional Regulation, 654 So. 2d 205 (Fla. 1st DCA 1995); and § 120.57(1)(j), Fla. Stat. (2007)("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.").

40. 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).

C. The Charges of the Administrative Complaint.

41. Section 458.331(1), Florida Statutes, authorizes the Board of Medicine (hereinafter referred to as the "Board"), to impose penalties ranging from the issuance of a letter of concern to revocation of a physician's license to practice medicine in Florida if a physician commits one or more acts specified therein.

42. The Amended Administrative Complaint alleges in Count I that Dr. Suarez-Diaz violated Section 458.331(1)(t), Florida Statutes, in his treatment of J.C. In Count II it is

alleged that Dr. Suarez-Diaz violated Section 458.331(1)(m), Florida Statutes, in his treatment of J.C.

D. Counts I: Violation of Section 458.331(1)(t), Florida Statutes; The Standard of Care.

43. Section 458.331(1)(t), Florida Statutes, defines the following disciplinable offense:

> 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 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 $50,000 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. 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.

44. In paragraph 20 of the Amended Administrative Complaint, it is alleged that Dr. Suarez-Diaz violated the Standard of Care in his treatment of J.C. in one or more of the following ways:

> (a) By failing to maintain adequate monitoring prior to and immediately after extubation despite intraoperative indications of oxygen difficulty; (b) By failing to maintain adequate medical records in that much of his records for Patient J.C. are illegible, dosages of paralytic and reversal medication are not appropriately recorded, and oxygen saturations and vital signs are not recorded frequently enough.

The Department has essentially alleged that Dr. Suarez-Diaz violated the Standard of Care for three reasons:

a. The failure to monitor J.C. prior to extubation;

b. The failure to monitor J.C. after extubation; and

c. The failure to keep adequate medical records.

The evidence failed to prove any of these charges.

45. When the expert opinion of Dr. Christie is weighed against the totality of the evidence in this case, including the uncontroverted and persuasive testimony of Dr. Suarez-Diaz and the opinion of Dr. King, it cannot be said that the Department proved clearly and convincingly that Dr. Suarez-Diaz violated

the Standard of Care as alleged in the Amended Administrative Complaint.

46. As to whether Dr. Suarez-Diaz violated the Standard of Care simply because of his failure to keep adequate medical records, this allegation is inadequate as a matter of law to support a Standard of Care violation. See Barr v. Department of Health, Board of Dentistry, 954 So. 2d 668 (Fla. 1st DCA 2007). In Barr the Dr. Barr, a dentist, was charged with failing to meet the standard of care for dentists for his actual treatment of a patient and by failing to maintain adequate records associated with the treatment. An Administrative Law Judge found that Dr. Barr had met or exceeded the standard as to his actual treatment, but, that his medical records were so inadequate, that his medical records were below the standard of care. The Board of Dentistry issued a final order accepting the Administrative Law Judge's findings.

47. In reversing the Board of Dentistry, the court, while recognizing that the Board of Dentistry's interpretation of a statute it was charged with administering was entitled to great weight, went on to reach the following conclusion about the Board of Dentistry's interpretation of its standard of care statute:

> The Board argues that particularly egregious recordkeeping violations could rise to the level of a "standard of care" violation.

> Because this interpretation renders subsection (m) [the equivalent of Section 458.331(m)] useless, it is clearly erroneous. We believe there is a significant difference between improperly diagnosing a patient, which constitutes a subsection (x) violation [the equivalent of Section 458.331(t)], and properly diagnosing a patient, yet failing to properly document the actions taken on the patient's chart, which constitutes a subsection (m) violation. . . .

Barr at 669.

48. The rationale of the Barr decision applies equally to this case, to the extent that the Department has alleged that Dr. Suarez-Diaz violated the Standard of Care based solely on his inadequate record keeping. Neither the law, nor the facts, support this allegation.

49. The Department has failed to clearly and convincingly proved that Dr. Suarez-Diaz violated the Standard of Care as alleged in Count I of the Amended Administrative Complaint.

E. Count II; Violation of Section 458.331(1)(m), Florida Statutes; Medical Records.

50. Section 458.331(1)(m), Florida Statutes, defines the following disciplinable offense:

> Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment

procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

51. Florida Administrative Code Rule 64B8-9.003(2) describes the type of medical records a physician must maintain in order to avoid discipline under Section 458.331(1)(m), Florida Statutes:

. . . .

(2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.

(3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

(4) All entries made into the medical records shall be accurately dated and timed. Late entries are permitted, but must be clearly and accurately noted as last entries and dated and timed accurately when they are entered into the record. However, office records do not need to be timed, just dated.

. . . .

52. In paragraph 24, of the Amended Administrative Complaint, it is alleged that Dr. Suarez-Diaz failed to keep legible medical records justifying his course of treatment of J.C. in one or more of the following ways:

> (a) by preparing illegible records; (b) by failing to adequately document the dosages of medications prescribed to Patient J.C., including neuromuscular reversal agents; (c) by not recording the oxygen saturations, neuromuscular monitoring, and vital signs frequently enough.

53. Based upon Dr. Christie's testimony, a review of pertinent parts of Joint Exhibit 1, and Dr. Suarez-Diaz's admission at the final hearing, Dr. Suarez-Diaz's medical records are largely illegible.

54. The same evidence proved that Dr. Suarez-Diaz failed to adequately document dosages of medications he prescribed for J.C., including neuromuscular reversal agents, which were identified on page 231 of Joint Exhibit 1, in his surgery records.

55. Finally, the evidence proved clearly and convincingly, and Dr. Suarez-Diaz admitted at hearing, that he failed to record oxygen saturations, neuromuscular monitoring results, and J.C.'s vital signs frequently enough.

56. The evidence proved clearly and convincingly that Dr. Suarez-Diaz failed to keep legible medical records

justifying his course of treatment of J.C. by preparing illegible records; (b) by failing to adequately document the dosages of medications prescribed to Patient J.C., including neuromuscular reversal agents; and (c) by not recording the oxygen saturations, neuromuscular monitoring, and vital signs frequently enough in violation of Section 458.331(1)(m), Florida Statutes.

F. The Appropriate Penalty.

57. 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 under Section 458.331, Florida Statutes. See Parrot Heads, Inc. v. Department of Business and Professional Regulation, 741 So. 2d 1231 (Fla. 5th DCA 1999).

58. 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.

59. Florida Administrative Code Rule 64B8-8.001(2)(m) provides, in pertinent part, for a penalty for a violation of Section 458.331(1)(m), Florida Statutes, of a reprimand to denial of licensure or two years' suspension, followed by probation, and an administrative fine of from $1,000.00 to $10,000.00.

60. Florida Administrative Code Rule 64B8-8.001(2)(t)3. provides, in pertinent part, for a penalty for a violation of

Section 458.331(1)(t), Florida Statutes, of from two years' probation to revocation, and an administrative fine of $1,000.00 to $10,000.00.

61. Florida Administrative Code Rule 64B8-8.001(3) provides that, in applying the penalty guidelines, 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.

62. In Petitioner's Proposed Recommended Order, the Department has suggested that the following are mitigating and aggravating circumstances in this case: "Respondent is under no legal constraints; the patient died; this is a two count complaint; Respondent had not previously been disciplined; there are no other incidents." The Department has requested that it be recommended that Dr. Suarez-Diaz receive a reprimand; be required to pay an administrative fine of $10,000.00; attend no less than ten hours of continuing medical education to be specified by the Board; and perform 100 hours of community service. These suggested penalties are excessive in that the Department failed to prove the allegations of Count I of the Amended Administrative Complaint and because the Board's statutory authority and adopted rules do not provide for community service.

63. In Respondent, Jose Suarez-Diaz, M.D.'s Proposed Recommended Order, Dr. Suarez-Diaz has suggested that the Board issue a Letter of Guidance and require that he pay an administrative fine of $1,000.00. The Letter of Guidance is less than the guideline of the Board's rules of a reprimand to denial of licensure or two years' suspension, followed by probation, and an administrative fine of from $1,000.00 to $10,000.00.

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 dismissing Count I of the Amended Administrative Complaint; finding that Jose Suarez-Diaz, M.D., has violated Section 458.331(1)(m), Florida Statutes, as alleged in Count II of the Amended Administrative Complaint; issuing a reprimand; requiring that he pay an administrative fine of $2,500; and requiring that he attend ten hours of continuing medical education related to appropriate record keeping.

DONE AND ENTERED this 13th day of March, 2008, 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 13th day of March, 2008.

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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 these cases.