STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs.

Case No. 07-0503PL

SAMUEL COX, 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, on April 11 and 12, 2007, by video teleconference between Lauderdale Lakes and Tallahassee, Florida.

APPEARANCES

For Petitioner: Patricia Nelson
Assistant General Counsel
Prosecution Services Unit
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For Respondent: Jonathon Lynn, Esquire
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STATEMENT OF THE ISSUES

The issues in this case for determination are whether Respondent Samuel Cox, M.D., committed the violations of Chapter 458, Florida Statutes, as alleged in an Administrative Complaint filed by the Department of Health on November 18, 2006; and, if so, what disciplinary action should be taken against his license to practice medicine in Florida.

PRELIMINARY STATEMENT

On or about November 18, 2006, the Department of Health filed before the Board of Medicine a three-count Administrative Complaint, Case Number 2005-67168, against Respondent Samuel Cox, M.D., an individual licensed to practice medicine in Florida. In particular, it is alleged in the Administrative Complaint that Dr. Cox committed violations of Sections 458.331(1)(m) and (t), Florida Statutes (2005)(All references to Florida Statutes and the Florida Administrative Code are to the 2005 versions, unless otherwise indicated). Dr. Cox, through counsel, disputed the allegations of fact contained in the Administrative Complaint and requested a formal administrative hearing pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes (2006).

On January 29, 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 07-0503PL and was assigned to the undersigned.

The final hearing was scheduled to be held in Fort Lauderdale, Florida, April 11 through 13, 2007, by Notice of Hearing entered February 13, 2007. On April 6, 2007, an Amended Notice of Hearing By Video Teleconference was entered scheduling the hearing to be conducted by video teleconferencing between Lauderdale Lakes and Tallahassee, Florida.

On April 10, 2007, Dr. Cox filed a Motion to Limine to Preclude Evidence of Prior Acts. Argument on this Motion was heard at the commencement of the final hearing. Reserving ruling on the Motion, Dr. Cox was told to raise the issue of the Motion as "each situation" arose during the final hearing so that his arguments could be dealt with based on a specific situation. No objection was raised by Dr. Cox during the hearing. Therefore, the Motion was effectively denied.

On April 11, 2007, Petitioner filed a Motion to Take Official Recognition. The Motion was granted.

During the final hearing, Petitioner presented the testimony of Christian Birkedal, M.D. Petitioner's Exhibits A through H were admitted. Dr. Cox objected to the admission of Petitioner's Exhibit I, a transcript of the deposition testimony of Robert T. Marema, M.D. A ruling on the admissibility of the deposition was reserved to give the parties an opportunity to

address fully the basis for the objection. As discussed in the Conclusions of Law section of this Recommended Order, the deposition is admitted.

Dr. Cox testified on his own behalf and presented the testimony of Samuel Ross Fox, M.D., and Samuel Szomstein, M.D. Respondent's Exhibits 1 through 3 were also admitted.

The two-volume Transcript of the final hearing was filed on May 2, 2007. By Notice of Filing Transcript entered May 2, 2007, the parties were informed that the Transcript had been filed and that their proposed recommended orders were to be filed on or by May 22, 2007. The date for filing proposed recommended orders was extended to May 29, 2007, at the unopposed request of Petitioner. Dr. Cox filed Proposed Findings of Fact on May 25, 2007 and Petitioner filed Petitioner's Proposed Recommended Order on May 29, 2007. The post-hearing proposals of both parties 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. § 20.43 and Chs. 456 and 458, Fla. Stat.

2. Respondent, Samuel Cox, 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 77851 on April 22, 1999.

3. Dr. Cox's mailing address of record at all times relevant to this matter is 2438 East Commercial Boulevard, Fort Lauderdale, Florida 33308.

4. Dr. Cox is a board-certified general surgeon who has specialized his practice to bariatric surgery. He has performed bariatric surgery since 1985, performing approximately 3,000 such surgeries since that time. Dr. Cox has performed approximately 214 Roux-en Y procedures in Florida.

5. No evidence that Dr. Cox has previously been the subject of a license disciplinary proceeding was offered.

B. Bariatric Surgery.

6. Bariatric surgery, also known as gastro-bypass surgery, is a type of surgery performed on morbidly obese patients to assist them in losing weight. In order to be found to be morbidly obese and, therefore, to be considered a candidate for the procedure, a patient must be found to have a Body Mass Index greater than 40. Body Mass Index is a measure of body fat based on height and weight (weight in kilograms divided by the square

of height in meters). For example, a six-foot-tall individual weighing 296 pounds would have a Body Mass Index of 40.1. See http://www.nhlbisupport.com/bmi/. A patient with a Body Mass Index of 35 may also be considered a candidate for the surgery if they present with certain comorbidities associated with obesity. Comorbidities are physical problems associated with obesity and include diabetes, lung problems, heart problems, and high blood pressure. The more comorbidities a patient has, the higher the risk is to that patient from bariatric surgery.

7. While there is more than one type of bariatric surgery, at issue in this case is a procedure known as Roux-en-Y gastric-bypass surgery (hereinafter referred to as "RNY Surgery"). RNY Surgery is a surgical method of creating a reduced-sized stomach. This reduced-sized stomach is created by removing a small portion of the stomach, where the esophagus (which brings food from the mouth to the stomach) attaches to the stomach, from the larger remaining portion of the stomach. The small portion of the stomach attached to the esophagus is then formed into a pouch, creating a much smaller stomach. The remaining larger portion of the stomach is completely by-passed. Often a device called a silastic ring is used at the bottom of the newly created stomach to help the pouch maintain the desired size and prevent it from stretching into a larger pouch. A portion of the small intestine is attached to the bottom of the newly

created stomach. Approximately 150 centimeters down the small intestine, the excluded or removed portion of the stomach, the liver, and the pancreas are connected back to the intestine. This allows digestion of food to continue, but reduces the amount of digestion that previously occurred in the 150 centimeters of the intestine which are bypassed.

8. RNY Surgery allows a patient to lose weight in two ways: first, by limiting the amount of food the patient can eat; and secondly, by reducing the absorption of nutrients by bypassing part of the intestine.

9. The most common and serious complication of RNY Surgery is a leak at the gastrojejunal anastomosis, or the point where the newly created stomach pouch (the gastro) is connected to the intestine (the jejunal)(a gastrojejunal anastomosis leak will hereinafter be referred to simply as a "Leak"). This complication may be evidenced by several symptoms exhibited by a patient. Surgeons performing bariatric surgery must look for these symptoms. The typical symptoms of a Leak include left shoulder pain (caused by pooling of the leakage under the diaphragm which causes irritation which manifests as left shoulder pain), decreased urine output, fever, shortness of breath, and high heart rate. Some manifestations of a Leak, such as atrial fibrillation, are indirect signs of a Leak in

that they are associated with the stress on the body caused by the Leak.

C. Dr. Cox's Treatment of Patient W.T.

10. Patient W.T. presented to Dr. Cox for bariatric surgery. W.T., a male, was 47 years of age at the time and was morbidly obese.

11. W.T. weighed 458 pounds and had a Body Mass Index of 62. Because his Body Mass Index exceeded 50, he was considered "super" morbidly obese. He also had the following comorbidities: high blood pressure, sleep apnea, congestive heart failure, thrombophlebitis, pulmonary eboli, diabetes, and gatroesophageal reflux disease.

12. There is no dispute that W.T. was an appropriate candidate for bariatric surgery.

13. W.T. underwent RNY Surgery on August 31, 2005. During the surgery, Dr. Cox experienced difficulty seeing, due to the size of W.T.'s liver, the staples which he used to connect the intestine to the bottom of the newly formed stomach. Instead of confirming the placement of the staples, he was required to assess the staples with his fingers. This should have made him more sensitive to the possibility of a Leak.

14. Before ending the surgery, Dr. Cox performed a test called a methylene blue test. To perform this test, an anesthesiologist puts medicine down a tube which passes through

the patient's nose and into the new stomach. The physician then looks for any sign of a leak where the physician has sewn or stapled the small intestine to the stomach. With W.T., the methylene blue test did not disclose any leaks.

15. The day after W.T.'s bariatric surgery, September 1, 2005, W.T. began to complain of pain in his left shoulder which is an important symptom of a Leak. W.T. also experienced decreased urine output during the night (he had, however, "responded well to fluid increases and diuretics"), and a low-grade fever, which are also indicators of a Leak.

16. Although pain is a normal response to any operation, pain in the shoulder for the type of non-laparoscropic bariatric surgery performed by Dr. Cox should have made Dr. Cox more concerned than he apparently was as to the cause. The normal pain response to the type of operation Dr. Cox performed would be expected where the incision was made, but not in the shoulder.

17. Dr. Cox treated W.T.'s shoulder pain with narcotic analgesia by a patient-controlled analgesia pump. He treated the decreased urine output with increased fluids and a diuretic (Mannitol). The fever was treated with Tylenol.

18. Although the left shoulder pain, decrease in urine output, and low-grade fever could have been indicative of a Leak, Dr. Cox made no note in the patient records that he had

considered the possibility that W.T. had a Leak, prematurely ruling out the possibility of a Leak.

19. Dr. Cox suggested that the left shoulder pain was related to a diaphragmatic irritation caused by the use of surgical instruments on the diaphragm and that the urine output decline could have been attributable to the impact on W.T.'s kidneys by his diabetes. While these might have been appropriate considerations at the time, Dr. Cox could have not known for sure what was causing W.T.'s symptoms and, therefore, should have considered all the possible causes of these symptoms, especially the possibility of a Leak.

20. On the second post-operative day, September 2, 2005, W.T. exhibited an abnormal heart rhythm, called atrial fibrillation. With a normal heart rhythm, the atrial (the first two of the four heart chambers) contracts, followed by contraction of the ventricles (the other two heart chambers). Atrial fibrillation is an abnormal heart rhythm characterized by a failure of the atria to completely contract. The fact that W.T., who had no prior history of atrial fibrillation, was evidencing atrial fibrillation on post-operative day two should have raised a concern about what was happening to W.T., including, but not limited to, the possibility of a Leak.

21. W.T. was also experiencing an abnormally high heart rate of 148, which could have also been indicative of a Leak.

22. Dr. Cox continued to treat W.T.'s shoulder pain with narcotic analgesia and the decreased urine output with increased fluids and Mannitol. He treated the elevated heart rate with Cardizem, a medicine used to slow the heart. W.T.'s shoulder pain appeared to decrease, which was to be expected given the course of treatment ordered by Dr. Cox. Dr. Cox had not, however, appropriately determined the cause of the pain.

23. Again, nothing in Dr. Cox's medical records indicates that he considered the possibility that W.T.'s various symptoms might be indicative of a Leak. Nor did he take any action, such as an upper gastrointestinal test, to rule out the possibility of a Leak.

24. To perform a gastrointestinal test, a patient drinks a water-soluble contrast called Gastrografin and a radiologists takes serial pictures of the patient, which show the contrast as it moves down the esophagus and then crosses through the anastomosis of the pouch and intestine. From these pictures, it can be determined whether the anastomosis is open and functioning properly and whether any of the contrast leaks outside of the new stomach-intestine path. The test is not fool-proof, but it is an appropriate diagnostic tool for Leaks.

25. Dr. Cox suggests that the atrial fibrillation and high heart rate could have simply been a recognized complication of any stress W.T., with his borderline cardiac status, was

experiencing. Again, while these might have been appropriate considerations at the time, Dr. Cox could have not known for sure what was causing W.T.'s symptoms and, therefore, should have considered all the possible causes of these symptoms, especially the possibility of a Leak.

26. On the third post-operative day, September 3, 2005, air and serosanguinous fluid were observed seeping from W.T.'s abdominal incision. The existence of air may be evidence of a Leak. Although some air gets into the abdominal cavity during surgery, it is usually absorbed by the body very, very quickly. Air coming from an incision on post-operative day three suggests a hole in the intestine.

27. Dr. Cox responded to the finding of air coming from the abdominal incision by ordering a methylene blue swallow, where W.T. swallowed a small amount of blue dye. Blue dye was then seen either coming out of the incision or drains placed in W.T.'s abdomen. Either way, the test was "positive" indicating a leak in W.T.'s intestine.

28. Dr. Cox correctly took W.T. back into surgery. He discovered and corrected a Leak which had been caused by failure of the staples used in W.T.'s surgery.

29. Although much was made as to when the staples failed, that evidence was not conclusive nor is it necessary to resolve the dispute. Whether the staples failed immediately after

surgery or at some later time does not excuse Dr. Cox's failure to appropriately react to signs exhibited by W.T. which could have indicated that W.T. had a Leak. This case does not turn on whether a Leak actually existed. It turns on whether Dr. Cox appropriately considered the possibility of a Leak and took the steps medically necessary. With W.T., he did not.

30. Dr. Cox's error was not in failing to find the Leak earlier; it was in failing to properly consider the possibility of a Leak when W.T. exhibited signs that should have prevented Dr. Cox from, with reasonable medical certainty, ruling out the possibility that a Leak was present. For this reason, the fact that a Leak was ultimately found is of little importance in deciding whether the charges leveled against him in the Administrative Complaint are accurate. Even if no Leak had ultimately been found, Dr. Cox's failure to properly respond to the potential of a Leak evidenced by W.T.'s symptoms was inconsistent with the standard of care.

D. Dr. Cox's Treatment of Patient J.L.

31. Patient J.L. presented to Dr. Cox for bariatric surgery. J.L., a male, was 35 years of age at the time and was morbidly obese.

32. J.L. weighed 417 pounds and had a Body Mass Index of 58. Because his Body Mass Index exceeded 50, he was considered "super" morbidly obese. He also had the following

comorbidities: high cholesterol, stress incontinence, depression, anxiety, high blood pressure, gastroesophageal reflux disease, and shortness of breath on exertion associated with asthma.

33. There is no dispute that J.L. was an appropriate candidate for bariatric surgery.

34. J.L. underwent RNY Surgery on August 4, 2005. Dr. Cox also removed J.L.'s gallbladder. Before ending the surgery, Dr. Cox performed a methylene blue test. The methylene blue test performed on J.L. did not disclose any leaks.

35. On the first post-operative day, August 4, 2005, J.L.'s heart rate was as high as 155 (anything over 120 is problematic), was experiencing decreased oxygen saturation of 89 percent (95 percent to 98 percent are considered normal saturation levels), had increased BUN and creatinine levels, and his urine output was borderline low. The increased BUN and creatinine, indicative of a problem with the kidneys, were are not being perfused well. J.L. was also complaining of right shoulder pain. Dr. Cox's note concerning the right shoulder pain specifically notes that it was not the "left" shoulder, which suggests that Dr. Cox was aware of the significance of left shoulder pain.

36. J.L.'s high heart rate and low oxygen saturation level were considered significant enough to return him to the intensive care unit.

37. On the second post-operative day, August 5, 2005, J.L.'s BUN and creatinine levels rose higher. That evening J.L. had a high heart rate. His urine output level, which Dr. Cox had treated with a diuretic and increased fluids, had improved.

38. J.L. also became agitated and restless. He began to constantly request water. Dr. Cox eventually ordered, however, that J.L. not be given water.

39. Dr. Cox failed to note in his records that he considered the possibility that J.L. had a Leak. Instead, Dr. Cox focused on the possibility that J.L. was suffering from rhabdomyolysis, a malfunction of the kidneys caused by the breakdown, as a result of surgery, of muscle tissue into cells too large in size for the kidneys to process. Dr. Cox ordered a CK test which found elevated creatine phosphor kinase or CPK, a marker of muscle death. Dr. Cox then consulted with a nephrologists.

40. While the symptoms evidenced by J.L. could have very well been a result of rhadbodmyolysis, they also could have been symptomatic of a Leak. Dr. Cox did not have adequate information on August 5, 2005, to conclusively find that J.L.

was suffering from rhadbodmyolysis and, more importantly, not from a Leak.

41. As of the second post-operative day, J.L. was exhibiting a high heart rate, low urine output, pain in his right shoulder, a worsening oxygen saturation level and hunger for air, and a changed mental status (anxiety and combativeness). Due to these symptoms, Dr. Cox should have considered the possibility of a Leak, rather than merely concluding that J.L. was suffering from rhabdomyolysis and treating J.L.'s individual symptoms.

42. On the third post-operative day, August 6, 2005, J.L.'s condition worsened. His agitation and combativeness due to his thirst and air hunger worsened. J.L. was treated with Haldol, a psychiatric medication.

43. Dr. Cox continued to suspect rhadbdomyolysis and to ignore the possibility of a Leak.

44. On the fourth post-operative day, August 7, 2005, at approximately 15:30, pink-tinged fluid was seen draining from J.L.'s incision.

45. A pulmonologist consulting on J.L.'s case was the first to suggest the possibility of a Leak, questioning whether the entire clinical picture pointed to intra-abdominal sepsis due to a Leak.

46. It was not until the drainage from J.L.'s incision that Dr. Cox first considered the possibility of a Leak. Even then, Dr. Cox did not return J.L. to surgery until August 7, 2005, where a Leak was found and repaired.

47. Dr. Cox's error in his treatment of J.L., like his error in his treatment of W.T., was not in failing to find the Leak earlier, but in failing to properly consider the possibility of a Leak when J.L. exhibited signs which should have prevented Dr. Cox from, with reasonable medical certainty, ruling out the possibility that a Leak was present. For this reason, the fact that a Leak was ultimately found is of little importance in deciding whether the charges leveled against him in the Administrative Complaint are accurate. Even if no Leak had ultimately been found, Dr. Cox's failure to properly respond to the potential of a Leak, evidenced by J.L.'s symptoms, was inconsistent with the standard of care.

48. Dr. Cox's explanation at hearing as to why he waited from August 5, 2005, when it was apparent that J.L. had a Leak, until August 7, 2005, to repair the Leak, is not contained in Dr. Cox's medical records.

E. The Standard of Care.

49. The Department's expert, Christian Birkedal, M.D., credibly opined that Dr. Cox 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 W.T. and J.L.

50. In particular, it was Dr. Birkedal's opinion that Dr. Cox violated the Standard of Care as to W.T. by failing to recognize W.T.'s signs and symptoms of a Leak and by failing to perform a post-operative upper gastrointestinal test on W.T. once he evidenced those signs. Dr. Birkedal's opinion is credited and accepted.

51. As to J.L., Dr. Birkedal's opinion that Dr. Cox violated the Standard of Care by failing to recognize the signs and symptoms of a Leak for two days post-operatively is credited and accepted.

52. The opinions to the contrary offered by Dr. Cox and his witnesses as to W.T. and J.L. are rejected as not convincing and as not addressing the issue precisely enough. The opinions offered by Dr. Cox and his witnesses with regard to both patients were essentially that the various symptoms pointed to by Dr. Birkedal were not "evidence" of a Leak. Those opinions do not specifically address the issue in this case. Dr. Cox and his witnesses based their opinions on whether Dr. Cox should have "known" there was a Leak at the times in issue. That is not the charge of the Administrative Complaint or the basis for

Dr. Birkedal's opinion. The question was, not whether Dr. Cox should have known there was a Leak, but whether he should have considered a Leak as a possible cause for the symptoms exhibited by W.T. and J.L. Additionally, and finally, Dr. Birkedal based his opinions, not by looking at the record as a whole, as did Dr. Cox and his experts, but by looking at only those records in existence at the times relevant to this matter. In this way, Dr. Birkedal limited himself to a consideration of what Dr. Cox knew about his patients at the times relevant in the Administrative Complaint.

CONCLUSIONS OF LAW

A. Jurisdiction.

53. 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 (2006).

B. The Charges of the Administrative Complaint.

54. 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.

55. In its Administrative Complaint the Department has alleged that Dr. Cox has violated Section 458.331(1)(m) and (t), Florida Statutes. The Administrative Complaint alleges in Count I that Dr. Cox violated Section 458.331(1)(t), Florida Statutes, in his treatment of W.T. In Count II it is alleged that Dr. Cox violated Sections 458.331(1)(m) and (t), Florida Statutes, in his treatment of J.L.

C. The Burden and Standard of Proof.

56. The Department seeks to impose penalties against Dr. Cox's license 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. Cox 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); and Section 120.57(1)(j), Florida Statutes (2005)("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.").

57. 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. Counts I and II: Violation of Section 458.331(1)(t), Florida Statutes, The Standard of Care.

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

> . . . .
>
> 1. Committing medical malpractice as defined in s. 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed to

require more than one instance, event, or act.

2. Committing gross medical malpractice.

3. Committing repeated medical malpractice as defined in s. 456.50. A person found by the board to have committed repeated medical malpractice based on s. 456.50 may not be licensed or continue to be licensed by this state to provide health care services as a medical doctor in this state.

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 medical malpractice," "repeated medical malpractice," or "medical malpractice," or any combination thereof, and any publication by the board must so specify.

59. The terms "Medical malpractice" are defined in Section 456.50(1)(g), Florida Statutes, in pertinent part, as follows:

> (g) "Medical malpractice" means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. . . .

"Repeated medical malpractice" is defined as three or more incidents of medical malpractice committed by a physician. § 56.50(1)(h), Fla. Stat. While "gross medical malpractice" is not defined in Section 456.50, Florida Statutes, the Department has not suggested that Dr. Cox committed gross medical malpractice.

60. In paragraph 18 of the Administrative Complaint, it is alleged that Dr. Cox violated the Standard of Care in his treatment of W.T. by:

> a. failing to recognize the signs and symptoms of a post-operative leak in the bowel, once Patient WT exhibited symptoms of a bowel leak;
>
> b. failing to perform a post-operative upper gastrointestinal test on Patient WT showed symptoms of a bowel leak.

61. In paragraph 35 of the Administrative Complaint, it is alleged that Dr. Cox violated the Standard of Care in his treatment of J.L. "by failing to recognize the signs and symptoms of a post-operative leak in the bowel at the onset of leak symptoms."

62. The evidence has clearly and convincingly proved that Dr. Cox violated the Standard of Care as alleged in paragraphs 18 and 35 as described in the Findings of Fact. Clearly, there were signs exhibited by both W.T. and J.L. that are typical signs associated with a Leak. No expert who testified in this proceeding disagreed with this finding. Dr. Cox should have taken steps to rule out or substantiate the existence of a Leak in both patients sooner than he did.

63. Any physician must consider all possible causes for a the symptoms evidenced by a patient and systematically and appropriately rule out or confirm the various possible causes of

those symptoms. Both W.T. and J.L. evidenced symptoms that all the experts agreed are typical symptoms of a Leak. Dr. Cox failed to consider one of the most logical causes of the symptoms evidenced by W.T. and J.L., a Leak, until some time after both patients had exhibited those signs. He did so without any reasonable medical justification.

64. The Department has clearly and convincingly proved that Dr. Cox violated the Standard of Care as alleged in Counts I and II of the Administrative Complaint.

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

65. 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.

66. 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.
>
> . . . .

67. The evidence proved clearly and convincingly that Dr. Cox failed to document why he waited from August 5, 2005, until August 7, 2005, to repair J.L.'s Leak, which was inconsistent with Florida Administrative Code Rule 64B8-9.003, and in violation of Section 458.331(1)(m), Florida Statutes.

F. The Appropriate Penalty.

68. 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).

69. 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.

70. 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.

71. 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.

72. 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.

73. In Petitioner's Proposed Recommended Order, the Department has suggested that there are two aggravating circumstances. The Department has requested that it be recommended that Dr. Cox receive a reprimand, be placed on probation for two years, with terms to be set by the Board, and be required to pay a fine of $15,000.00.

74. 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 is reasonable.

G. <u>The Admissibility of Dr. Marema's Deposition Testimony</u>.

75. Dr. Cox objected to the admission of Dr. Marema's deposition testimony, arguing that he had rendered no opinions relevant to this matter and because of his participation in the peer review process at the hospital where W.T. and J.L. were treated. Both arguments are rejected.

76. Dr. Cox's first argument goes to the weight to be afforded Dr. Marema's testimony, not to whether it is admissible.

77. As to his second argument, Section 395.0193(8), Florida Statutes (2006), govern the admissibility of, among other things, the testimony of individuals who testify during peer review investigations and proceedings:

> (8) The investigations, proceedings, and records of the peer review panel, a committee of a hospital, a disciplinary board, or a governing board, or agent thereof with whom there is a specific written contract for that purpose, as described in this section shall not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such group or its agent, and a person who was in attendance at a meeting of such group or its agent may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the proceedings of such group or its agent or as to any findings, recommendations, evaluations, opinions, or other actions of

> such group or its agent or any members thereof. <u>However</u>, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented during proceedings of such group, and <u>any person who testifies before such group or who is a member of such group may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her testimony before such a group or opinions formed by him or her as a result of such group hearings</u>. [Emphasis added].

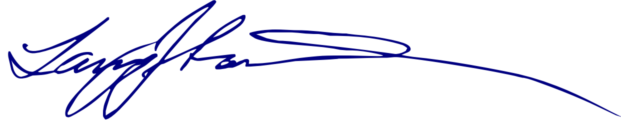
78. Having cited no other authority for the exclusion of Dr. Marema's testimony, it is concluded that Dr. Marema's testimony comes within the exception to the prohibition of Section 395.0193(8), Florida Statutes (2006). Nothing in his testimony related any testimony "before such a group or opinions formed by him . . . as a result of such group hearings."

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 Samuel Cox, M.D., has violated Section 458.331(1)(m) and (t), Florida Statutes, as alleged in Counts I, II, and III of the Administrative Complaint; issuing a reprimand; placing his license on probation for two years, with terms to be established by the Board; and imposing a fine of $15,000.

DONE AND ENTERED this 19th day of June, 2007, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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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.