STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 07-0659PL
STEPHEN W. THOMPSON, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on July 27, 2007, in Naples, Florida, before Susan B. Harrell, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Matthew Casey, Esquire
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For Respondent: Bruce McLaren Stanley, Esquire
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent violated Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes (2003),[1] and, if so, what discipline should be imposed.

PRELIMINARY STATEMENT

On November 2, 2006, the Department of Health (Department) filed with the Board of Medicine, an Administrative Complaint against Respondent, Stephen W. Thompson, M.D. (Dr. Thompson), alleging that Dr. Thompson violated Subsection 458.331(1)(t), Florida Statutes, relating to Patient T.C. by failing 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. Dr. Thompson requested an administrative hearing, and the case was forwarded to the Division of Administrative Hearings on February 8, 2007, for assignment to an Administrative Law Judge to conduct a final hearing.

The final hearing was scheduled for March 29, 2007. Dr. Thompson filed a motion to continue the final hearing, and the motion was granted. The final hearing was rescheduled for June 19, 2007. The Department filed a motion to continue, and the case was rescheduled for July 27, 2007.

On July 10, 2007, the Department filed a motion to amend the Administrative Complaint, which was granted by Order dated July 13, 2007. The Amended Administrative Complaint added a count relating to a violation of Subsection 458.331(1)(m), Florida Statutes.

The parties filed a Joint Pre-hearing Stipulation and stipulated to certain facts contained in Section E of the Joint Pre-hearing Stipulation. Those facts have been incorporated in this Recommended Order to the extent relevant.

At the final hearing, the Department requested official recognition of Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes, and Florida Administrative Code Rule 64B8-8.001. Official recognition was taken of those statutes and that rule.

At the final hearing, the Department called Jose Cortes, M.D., as its witness. Petitioner's Exhibits 1, 2, and 3 were admitted in evidence.

At the final hearing, Dr. Thompson testified in his own behalf and called Lawrence Antonucci, M.D., as his witness. Respondent's Exhibits D, E, F, G, H, I, J, and K were admitted in evidence.

The one-volume Transcript was filed on August 27, 2007. Dr. Thompson filed a Motion for Extension of Time to File Proposed Recommended Order, which was granted. The time for filing proposed recommended orders was extended to September 12, 2007. The parties timely filed their Proposed Recommended Orders, which have been considered in the rendering of this Recommended Order.

FINDINGS OF FACT

1. The Department is the state agency in Florida charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes, and Chapters 456 and 458, Florida Statutes.

2. At all times material to the Amended Administrative Complaint, Dr. Thompson has been a licensed physician in the State of Florida, having been issued license number ME 44112. Dr. Thompson is board-certified by the American Board of Obstetrics and Gynecology with a General Certificate in Obstetrics and Gynecology.

3. On July 18, 2003, T.C., a 41-year-old female, presented to Dr. Thompson with complaints of very heavy menstrual bleeding with clots lasting four days. She was requesting a hysterectomy. T.C. had been a patient of Dr. Thompson for 17 years. She had been complaining of heavy menstrual bleeding for two years, and Dr. Thompson had prescribed birth control pills, which seemed to help at first, but by July 18, 2003, were no longer relieving the symptoms of heavy bleeding.

4. Dr. Thompson ordered a vaginal ultrasound, which revealed two uterine fibroids that were submucous in location. The fibroids were the likely cause of T.C.'s heavy bleeding.

5. On August 12, 2003, T.C. returned to Dr. Thompson's office for a surgical consult. Dr. Thompson discussed the

alternative of a laparoscopic hysterectomy rather than an abdominal hysterectomy. Dr. Thompson also discussed alternatives to a hysterectomy to resolve T.C.'s problems, including a hysteroscopy, a dilation and curettage (D&C), a thermal ablation, a myomectomy, an Essure procedure, and a bilateral tubal ligation with laparoscopy. The thermal ablation involves the injection of a liquid material into the uterus and the heating of the liquid to cauterize the lining of the uterus. A myomectomy is the removal of the fibroids. The Essure procedure was to provide permanent birth control. T.C. chose to have the hysteroscopy, the D&C, the ablation, the myomectomy, and the Essure procedure.

6. The procedures were scheduled for September 11, 2003, at the Naples Day Surgery, which is a freestanding surgical ambulatory center. T.C. went to see Dr. Thompson on September 9, 2003, to fill out the paperwork for the surgical procedures and to again discuss the options available to her. Dr. Thompson did discuss the options available to her and signed the consent form in the presence of T.C., indicating that he had discussed the reasonable alternatives with T.C. and that she had been informed about the foreseeable risks and benefits of the procedures that she had chosen.

7. Around 8:00 a.m. and 9:00 a.m. on September 11, 2003, Dr. Thompson was informed that one of his obstetrical patients

(obstetrical patient) was in labor with her first child at The Birth Place at North Collier Hospital, which is across the street from the Naples Day Surgery. Dr. Thompson examined the obstetrical patient.

8. Dr. Thompson had arranged for Dr. Beckett to provide coverage for his patients, including the obstetrical patient, while Dr. Thompson was performing surgery on T.C. at the Naples Day Surgery.

9. At approximately 11:40 a.m., on September 11, 2003, T.C. presented at the Naples Day Surgery for the procedures. Again, Dr. Thompson reviewed the procedures with T.C. and discussed alternatives and the risks and benefits of the procedures that were to be done.

10. Prior to beginning surgery on T.C., Dr. Thompson was notified by the nurses at The Birth Place that the obstetrical patient's labor was progressing. Dr. Thompson prescribed some pain medication for the obstetrical patient and advised the nurses that he was going into surgery and that Dr. Beckett would be covering for him with the obstetrical patient.

11. Dr. Thompson began surgery on T.C. and performed the hysteroscopy and D&C. During the hysteroscopy, it was noticed that there was a problem with the hysteroscope being used and that it would not fit the Essure device that would be used later.

12. Prior to Dr. Thompson beginning the thermal ablation procedure, he was informed by telephone that the obstetrical patient was making rapid progress and that Dr. Beckett was stuck in traffic and probably would not get to The Birth Place in time to deliver the baby. Dr. Thompson instructed the nurse at The Birth Place to find any available physician because he was in surgery.

13. Dr. Thompson performed the thermal ablation. At the end of the procedure, it was determined that the instrument necessary to perform the Essure procedure was not in the operating room and that the instruments needed for the myomectomy were not sterile. It was necessary that the instrument needed for the Essure procedure be located and that the instruments for the myomectomy be flash sterilized, which would take about 15 minutes.

14. While in the operating room, Dr. Thompson received another telephone call from The Birth Place. The nurse advised Dr. Thompson that no physician was available in-house to deliver the baby and that no other physician could be located quickly enough to get to The Birth Place in time to deliver the baby. The essence of the telephone call to Dr. Thompson was that if a physician did not get to The Birth Place quickly that the baby would be delivered without an attending physician.

15. At the time Dr. Thompson received the last telephone call from The Birth Place, T.C. was in stable condition and nothing further could be done until the instruments for the myomectomy were sterilized and an appropriate scope was located for the Essure procedure. Dr. Thompson made the decision to leave T.C. with the anesthetist and go across the street to deliver the baby. He informed the surgical team that he was going to deliver the baby and would be back as quickly as possible.

16. Since The Birth Place is directly across the street from the Naples Day Surgery, it took Dr. Thompson about one or two minutes to get to the delivery room at The Birth Place. He left the operating room at the Naples Day Surgery at 13:35. He delivered the baby without complications and returned to the operating room at the Naples Day Surgery by 13:50. At that time, the instruments were sterilized for the myomectomy, and the proper scope had been located for the Essure procedure. Dr. Thompson performed the myomectomy and the Essure procedure without complications.

17. The head nurse at the Naples Day Surgery advised Dr. Thompson that she would prepare a variance report that noted his absence from the operating room from 13:35 to 13:50. Dr. Thompson’s physical presence during the delivery was noted in the records of The Birth Place.

18. It is not uncommon for a physician to leave the operating room during a procedure to use the restroom or get a drink of water. It also is not uncommon during an operation for a physician to have to wait for the results of a frozen section biopsy, which can take 30 minutes, or to have to wait during a procedure while a new instrument is obtained to replace a broken instrument.

19. While Dr. Thompson was at The Birth Place, the operating room personnel at the Naples Day Surgery knew where Dr. Thompson was, what he was doing, and how to reach him. There were multiple means of communications between both locations including cell telephones, cordless telephones, and hard-wired telephones.

20. Dr. Thompson did not notify T.C. that he left the operating room and the building between performing surgical procedures on her.

21. Jose H. Cortes, M.D., testified as an expert witness on behalf of the Department. Dr. Cortes has been licensed to practice in Florida since 1979. He is board-certified by the American Board of Obstetrics and Gynecology. Dr. Cortes currently specializes in gynecology with the Cleveland Clinic in Weston, Florida. From 2001 to 2006, he served as an assistant professor of Clinical Obstetrics and Gynecology for the University of Miami.

22. It is Dr. Cortes' opinion that Dr. Thompson fell below the standard of care when he left T.C. in the operating room to go to another building to deliver a baby. His opinion is based on Dr. Thompson's having no way of knowing when he left T.C. if the delivery would be complicated and would delay his return to the operating room. Dr. Cortes opined that Dr. Thompson should have cancelled the remaining procedures for T.C. and gone to deliver the baby.

23. Dr. Cortes also opined that Dr. Thompson fell below the standard of care by not documenting in his medical notes his absence during the delivery of the baby and by not telling T.C. that he had left the building to deliver a baby while T.C. was in the operating room. It was his opinion that T.C. should have been made aware of the delay between her procedures because the increased time under anesthesia could result in possible complications at a later time.

24. During his practice of medicine, Dr. Cortes has had to wait for the results of a frozen section during an operation and the delay has been as long as 20 to 30 minutes. Dr. Cortes opined that as long as the patient was stable it was within the standard of care for the physician to leave the operating room during this delay. He did not indicate whether in the case of waiting for the results of a frozen section, the physician was

required to note in the medical records the delay and tell the patient of the delay after the operation.

25. Lawrence R. Antonucci, M.D., testified as an expert witness for Dr. Thompson. Dr. Antonucci has been practicing as a physician since 1983 and is board-certified in obstetrics and gynecology. It is Dr. Antonucci's opinion that Dr. Thompson was faced with very unusual circumstances because he had to make a decision on which patient needed him the most. Based on the circumstances, Dr. Antonnuci opined that Dr. Thompson met the standard of care when he left the operating room to deliver the baby. The operation with T.C. was delayed while the instruments were being sterilized and a scope was being located. T.C. would have remained under anesthesia during the delay regardless if Dr. Thompson had left the operating room or stayed. Once Dr. Thompson got to The Birth Place he could assess the situation, and, if necessary, he could call the Naples Day Surgery and cancel the additional procedures for T.C.

26. Dr. Antonucci also opined that Dr. Thompson did not depart from the standard of care when he did not put in his medical notes that he had left the operating room to go across the street to deliver a baby. He was of the opinion that the medical records were adequate to advise future health care providers of the procedures that were done. It was also his

practice not to put in the medical notes when there was a delay due to waiting for the results of a frozen section.

27. Dr. Antonucci opined that Dr. Thompson's failure to tell T.C. that he had been absent from the operating room for 15 minutes did not fall below the standard of care.

CONCLUSIONS OF LAW

28. 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. (2007).

29. The Department must establish the allegations in the Amended Administrative Complaint by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern Company, 670 So. 2d 932 (Fla. 1996). The clear and convincing standard has been described by the courts 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 testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

30. The Department has alleged that Dr. Thompson violated Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes, which provide:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072:
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> * * *
>
> (m) 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.
>
> * * *
>
> (t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. . . . 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 to require that a physician be incompetent

to practice medicine in order to be disciplined pursuant to this paragraph.

31. In Count I of the Amended Administrative Complaint, the Department alleged that Dr. Thompson violated Subsection 458.331(1)(t), Florida Statutes, in one or more of the following ways:

a. By leaving T.C. for several minutes in the middle of surgery and in between procedures, while T.C. was under general anesthesia;

b. By failing to notify the patient that Respondent had left the building in the middle of the surgery;

c. By failing to note in the medical records that Respondent had left the building during surgery.

32. The Department has failed to establish by clear and convincing evidence that Dr. Thompson violated Subsection 458.331(t), Florida Statutes. Dr. Thompson was faced with an unusual situation and had to make a decision about which patient needed him the most. The procedures for T.C. were delayed because instruments were not sterile and a particular scope was not available. She was going to be under anesthesia during that delay regardless of Dr. Thompson's presence or absence. She was stable during the delay. Dr. Thompson made the operating staff aware of where he was going, and they knew how to reach him if needed. The Birth Place was located across the street from the Naples Day Surgery and could be reached within two minutes.

There was communication between The Birth Place and the Naples Day Surgery such that Dr. Thompson could be immediately reached. After Dr. Thompson assessed the obstetrical patient, he could have cancelled T.C.'s procedures, if he felt that he could not get back to the operating room because of complications with the delivery. Based on these circumstances, Dr. Thompson did not fall below the standard of care.

33. The Department did not establish that Dr. Thompson's failure to notify T.C. that he had left the operating room for 15 minutes fell below the standard of care. T.C. was going to have to wait for the instruments to be sterilized and for the scope to be located, and she would have remained under anesthesia during those circumstances. No expert testified that when there is any delay in a surgical procedure the patient has to be told. It is a common occurrence for physicians to wait for the results of a frozen section, and such delay can be as much as 30 minutes. No expert testified that in those circumstances the patient had to be told of the delay, and, in fact, Dr. Antonucci testified that it was his practice not to advise the patient when there had been a delay waiting for the results of a frozen section. Dr. Cortes' rationale for advising T.C. that there had been a delay was that she needed to be alert to any possible effects from the additional anesthesia time. His rationale does not make sense unless the standard of care

would require that every time there is a delay in surgery due to unforeseen circumstances that the patient must be advised of the circumstances.

34. The Department has failed to establish that Dr. Thompson fell below the standard of care by failing to document in his medical notes that he left the operation room for 15 minutes. The delay to the procedures was caused by instruments not being sterilized and the unavailability of a scope, not by Dr. Thompson's leaving to deliver a baby. Dr. Thompson took advantage of the delay to deal with another patient who needed him. Additionally, the head nurse had advised Dr. Thompson that she would note his absence in a variance report.

35. In Count II of the Amended Administrative Complaint, the Department alleged that Dr. Thompson violated Subsection 458.331(1)(m), Florida Statutes, in the following ways:

> [B]y failing to document in T.C.'s medical records that he left the building during the procedures he performed on T.C. on or about September 11, 2003, and/or by failing to document any discussion with T.C. about alternative treatment options such as discontinuing oral contraceptives, a formal dilation and curettage, and/or the use of a Mirena IUD to address T.C.'s problems or concerns.

36. The Department has failed to establish by clear and convincing evidence that Dr. Thompson violated Subsection

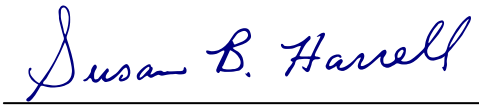
458.331(1)(m), Florida Statutes. The standard of care did not require him to document that he left the building, and Subsection 458.331(1)(m), Florida Statutes, does not require him to document his absence.

37. The Department has failed to establish that Dr. Thompson did not discuss any alternative treatment options with T.C. The evidence did establish that he discussed treatment options with her on more than one occasion.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a final order be entered finding that Dr. Thompson did not violate Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes, and dismissing the Amended Administrative Complaint.

DONE AND ENTERED this 31st day of October, 2007, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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this 31st day of October, 2007.

ENDNOTE

[1/] Unless otherwise stated, all references to the Florida Statutes are to the 2003 version.

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.