STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 08-4197PL

JAMES S. PENDERGRAFT, IV, M.D.,

Respondent.

RECOMMENDED ORDER

A formal administrative hearing in this case was held on May 20 and 21, 2009, in Orlando, Florida, and on July 10, 2009, by video teleconference between Tallahassee and Orlando, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Greg S. Marr, Esquire
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

For Respondent: Kenneth J. Metzger, Esquire
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STATEMENT OF THE ISSUES

The issues in this case are whether the allegations of the Administrative Complaint are correct, and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaint dated April 11, 2008, the Department of Health (Petitioner) alleged that James S. Pendergraft, IV, M.D. (Respondent), violated Subsections 458.331(1)(m), 458.331(1)(t)1., and 458.331(1)(q), Florida Statutes (2005).

The Respondent disputed the allegations and requested a formal administrative hearing. By letter dated August 25, 2008, the Petitioner forwarded the matter to the Division of Administrative Hearings. The hearing was initially scheduled to commence on December 16, 2008; was twice continued at the request of the parties; and, thereafter, was scheduled for May 20 through 22, 2009. Inclement weather prevented the travel to Orlando of an out-of-state witness planned for May 22, 2009, and the hearing recessed and was completed by video teleconference on July 10, 2009.

At the hearing, the Petitioner presented the testimony of five witnesses and had Exhibits numbered 1 and 3 admitted into evidence. The Respondent testified on his own behalf, presented the testimony of two additional witnesses, and had Exhibits

numbered 1 through 3 admitted into evidence. Joint Exhibits 1 through 5 were admitted into evidence.

On May 18, 2009, the Respondent filed a Motion to Dismiss related to certain allegations contained in the Administrative Complaint. No response to the motion has been filed. The motion has been granted as specifically addressed herein.

The Transcript of the proceedings held on May 20 and 21 was filed on June 26, 2009. The Transcript of the July 10, 2009, proceedings was filed on August 17, 2009. Both parties filed Proposed Recommended Orders that have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. The Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43 and Chapters 456 and 458, Florida Statutes (2005).

2. At all times material to this case, the Respondent was a physician licensed by the State of Florida, holding license number 59702 and was board-certified in obstetrics and gynecology. The Respondent owned, and practiced medicine at, EPOC Clinic, 609 Virginia Drive, Orlando, Florida.

3. On December 19, 2005, Patient S.B. presented to the EPOC Clinic to inquire about terminating a pregnancy, but elected not to proceed with the termination at that time.

4. On February 3, 2006, S.B. returned to the EPOC Clinic, having decided to terminate the pregnancy. A sonogram was performed, and S.B. was determined to be approximately 18 to 19 weeks gestation. At that time, she executed consent forms for pregnancy termination by medication, and dilation and extraction (D&E).

5. Patient S.B. had been pregnant three times previously and had birthed three children, each delivered live by cesarean section.

6. The patient's pregnancy termination was scheduled to commence on February 4, 2006, but S.B. was late in arriving at the clinic, and the procedure was rescheduled for February 6, 2006. The patient returned to the EPOC Clinic as rescheduled.

7. While at the EPOC Clinic on February 6 and 7, 2006, S.B. received medical care and treatment primarily from the Respondent and from Carmita Etienne, a medical assistant working at the clinic.

8. The termination was initiated with the use of "Cytotec," a drug that causes cervical dilation and uterine contractions, and which generally results in passage of the fetus into the vaginal vault.

9. Cytotec is commonly used in medication-based pregnancy termination. It is known to increase the potential for uterine

rupture during labor and delivery, the risk for which is noted within the relevant consent documents executed by the patient.

10. Cytotec tablets, in 200 microgram dosages, were administered orally to the patient by the Respondent's medical assistant.

11. S.B. received 200 micrograms of Cytotec at 10:00 a.m. on February 6, 2006, and received the same dosage at four-hour intervals through 10:00 a.m. on February 7, 2006, at which time the patient's cervix remained undilated.

12. The Respondent thereafter escalated the frequency of the Cytotec to every two hours, and the drug was administered two additional times on February 7, 2006, at noon and 2:00 p.m.

13. According to progress notes contained in the medical records, S.B. complained of discomfort on February 6, 2006, at 7:45 p.m. and on February 7, 2006, at 3:00 a.m.

14. Discomfort or pain is a typical element of labor, and S.B.'s discomfort was not unexpected.

15. Demerol, a controlled substance, is routinely used to relieve pain during medical procedures, including pregnancy terminations.

16. The medical assistant relayed S.B.'s reports of discomfort to the Respondent.

17. The Respondent ordered Demerol on both occasions to relieve S.B.'s pain.

18. A physician must be properly registered with the U.S. Drug Enforcement Administration (DEA) to order the administration of Demerol to a patient.

19. The Respondent was not properly registered with the DEA on February 6 or 7, 2006.

20. At the hearing, the Respondent denied that he ordered the Demerol. He testified that he was serving as a conduit between his medical assistant and another physician, Dr. Harry Perper, who also worked at the clinic and who was apparently properly registered with the DEA. The Respondent's testimony on this issue was not persuasive and has been rejected.

21. The evidence failed to establish that Dr. Perper ordered the administration of Demerol to the patient or that the Respondent merely relayed such orders from Dr. Perper to the medical assistant.

22. The Respondent asserted that he had not been registered with the DEA since 2002 and that everyone at the clinic knew he could not order controlled substances.

23. The patient's progress notes, created contemporaneously with the patient's treatment at the clinic, explicitly state that the orders for Demerol came from the Respondent.

24. The medical assistant who created the progress notes testified that she preferred talking to the Respondent rather

than Dr. Perper and that the directions she received for the patient's Demerol came from the Respondent.

25. The Respondent's assertion that he did not order the Demerol was not credible and has been rejected.

26. The Demerol was administered by the medical assistant through injection of the medication into S.B.'s buttocks, and the patient's pain was reduced.

27. The medical assistant denied that she personally administered the Demerol to the patient. Her denial was not credible and has been rejected.

28. The progress notes also state that the patient complained of "right side" pain at 3:00 p.m. on February 7, 2006.

29. At approximately 3:45 p.m. on February 7, 2006, the patient was apparently examined by Dr. Perper, who wrote "SROM" in the progress notes, signifying that a "spontaneous rupture of membranes" had occurred and indicating that the patient's "water had broken." He also documented his observation that a fetal part was protruding from the cervix into the vagina.

30. By that evening, the patient's termination was not completed. At approximately 7:00 p.m. on February 7, 2006, the medical assistant moved the patient into a procedure room at the Respondent's direction.

31. The instruments to perform a D&E were present in the procedure room. The Respondent began to perform an examination of S.B. to assess the situation and determine whether the termination procedure should be completed by D&E.

32. The Respondent utilized a speculum to open the patient's vagina and performed a sonogram on the patient's abdomen to identify the location of the fetus. The fetus was observed to be within S.B.'s uterus.

33. The Respondent observed a fetal part protruding through the cervical os into the vagina. In order to examine the extent of cervical dilation, he detached the part from the fetus by grasping the part with a "Hearn" instrument and twisting the instrument. After he detached the part, he withdrew the instrument and the part from the patient.

34. The Petitioner alleged that the Respondent "apparently" attempted a D&E. The evidence failed to support the allegation. The evidence failed to establish that the Respondent pulled on the exposed fetal part in an attempt to extract the fetus from the uterus.

35. The evidence failed to establish that the Respondent inserted the Hearn or any other instrument into the patient's cervix or uterus.

36. After removing the fetal part from the vagina, the Respondent placed the part on a tray. Almost immediately

thereafter, the Respondent's reviewed the ultrasound image and observed that the image indicated the fetus was no longer fully contained within the uterus.

37. The Respondent understood that the ultrasound image indicated a potential uterine perforation or rupture and, appropriately, concluded that the situation could be life-threatening for the patient.

38. He quickly contacted the Arnold Palmer Hospital to arrange for emergency transfer of S.B. to the hospital. The Respondent also spoke to two practitioners at the hospital.

39. Initially, he spoke by telephone to Dr. Pamela Cates, a resident physician at the hospital. Dr. Cates did not have the authority to admit the patient to the hospital and directed the Respondent to talk to Dr. Norman Lamberty, the "Ob/Gyn" physician on call and present at the hospital.

40. The Respondent spoke by telephone to Dr. Lamberty, who agreed to accept the transfer of the patient from the clinic to the hospital.

41. The Respondent failed to inform either Dr. Cates or Dr. Lamberty that he had removed a portion of the fetus from the patient at the clinic.

42. While waiting for an ambulance to arrive to transport the patient, the Respondent wrote a note to be transported to the hospital with the patient. Although in the note he

documented the treatment provided to the patient at the clinic, he failed to include the removal of the fetal part in the note.

43. The Respondent testified that he did not document his removal of the fetal part because he did not believe it was significant to the medical care the patient would receive at the hospital.

44. S.B. was transported to the hospital along with some of her medical records from the clinic and the Respondent's handwritten note. None of the documentation indicated that a part of the fetus had been removed at the clinic.

45. After S.B. arrived at the hospital, Dr. Lamberty removed the fetus and completed the abortion procedure.

46. Dr. Lamberty also repaired a cervical laceration and performed a hysterectomy. He noted that the uterine rupture occurred on the patient's right side and that the fetus was located not "floating" in the abdomen but "between two layers of tissue on the right side of the pelvis."

47. The evidence failed to establish that the cervical laceration occurred while the patient was at the clinic or that it was caused by treatment the patient received at the clinic.

48. Upon removing the fetus, Dr. Lamberty observed that the fetus was incomplete and that a portion of the fetal leg was missing. Dr. Lamberty began efforts to locate the missing part, which he reasonably presumed remained in the patient.

49. Dr. Lamberty's concern regarding the missing part was that potential exposure of the part to the patient's vagina would have contaminated the part with bacteria and that a risk of infection would be presented by leaving the part within the patient's pelvis or abdomen.

50. Dr. Lamberty was unable to locate the missing part, and, thereafter, radiological studies, including X-rays and a CT scan, were performed in an unsuccessful attempt to locate the part.

51. The patient remained hospitalized and on February 10, 2006, a second surgical procedure was performed on the patient, this time to remove a "Jackson-Pratt" drain that had been improperly sutured into the patient's abdomen at the time of the hysterectomy. The second surgery was unrelated to the search for the missing part.

52. Also on February 10, 2006, the hospital contacted the clinic to inquire as to the missing part and was advised that the part had been removed by the Respondent at the clinic.

CONCLUSIONS OF LAW

53. 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. (2009).

54. The Respondent is the state agency charged with regulating the practice of medicine. § 20.43 and Chapters 456 and 458, Fla. Stat. (2005).

55. The Administrative Complaint charged the Respondent with violations of Subsection 458.331(1), Florida Statutes (2005), which provides in relevant part as follows:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
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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.
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> * * *
>
> (q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best

> interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.
>
> * * *
>
> (t) Notwithstanding s. 456.072(2) but as specified in s. 456.50(2):
>
> 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.
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> * * *
>
> 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.

56. Subsection 456.50(1)(g), Florida Statutes (2005), defines medical malpractice as follows:

> "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. Only for the purpose of finding repeated medical malpractice pursuant to this section, any similar wrongful act, neglect, or default committed in another state or country which, if

> committed in this state, would have been considered medical malpractice as defined in this paragraph, shall be considered medical malpractice if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.

57. Subsection 458.305(3), Florida Statutes (2005), defines the "practice of medicine" as "the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition."

58. The Petitioner has the burden of proving by clear and convincing evidence the allegations set forth in the Administrative Complaint against the Respondent. Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932, 935 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

59. Clear and convincing evidence is that which is credible, precise, explicit, and lacking confusion as to the facts at issue. The evidence must be of such weight that it produces in the mind of the trier of fact the firm belief of conviction, without hesitancy, as to the truth of the allegations. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

60. Count I of the Administrative Complaint alleged various violations of Subsection 458.331(1)(m), Florida Statutes

(2005), which essentially requires a physician to keep medical records documenting and justifying the course of treatment.

61. The evidence established that, by failing to document the removal of a portion of a fetal limb, the Respondent clearly failed to keep legible medical records justifying the course of treatment in violation of Subsection 458.331(1)(m), Florida Statutes (2005).

62. The Administrative Complaint alleged that the Respondent's failure to document a D&E constitutes a violation of Subsection 458.331(1)(m), Florida Statutes (2005). The evidence failed to establish that the Respondent attempted to perform a D&E; accordingly, the Respondent had no obligation to document such a procedure.

63. The Administrative Complaint alleged that the medical records were insufficient to set forth a rationale and justification for the increased frequency of Cytotec administration thereby violating Subsection 458.331(1)(m), Florida Statutes (2005). The evidence establishes that the patient's medical records sufficiently indicated that the increased frequency of administration was based on a lack of cervical dilation 24 hours after initial commencement of drug therapy.

64. Count II of the Administrative Complaint alleged that the Respondent committed medical malpractice in violation of

Subsection 458.331(1)(t)1., Florida Statutes (2005), by failing to practice medicine in accordance with the level of care, skill, and treatment that, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. Specifically, the Petitioner alleged that the Respondent committed medical malpractice in violation of Subsection 458.331(1)(t)1., Florida Statutes (2005), as follows:

> A. By having prescribed, ordered or administered controlled substances to patient S.B. when he did not possess a current, valid DEA number;
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> B. By ordering or administering one additional dosage of Cytotec two hours after a prior dosage;
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> C. By ordering or administering an excessive amount of Cytotec;
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> D. By apparently attempting a D&E without sufficient dilation of the cervix;
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> E. By causing a cervical laceration that may have lead to a uterine rupture;
>
> F. By removal of a portion of the fetal limb;
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> G. By not advising the hospital that part of the fetus' lower limb had been removed causing unnecessary delays during surgery trying to find the missing extremity and the taking of an additional x-ray to confirm that it was not inside the abdomen;
>
> H. By the lack of adequate documentation of the removal of a portion of the fetal limb.

65. The federal Controlled Substances Act obligates practitioners engaged in prescribing, ordering, administering or dispensing controlled substances to be registered with the DEA. The Respondent was not registered with the DEA on February 6 or 7, 2006.

66. The Respondent offered the testimony of Pharmacist Jose Rey, who asserted that there was no proper order issued for Demerol in this case. The evidence established that the Respondent ordered the Demerol that was administered to the patient and that the Respondent was not properly registered with the DEA to order the medication. Mr. Rey's testimony has been rejected.

67. The Petitioner presented the expert testimony of Dr. Jorge Gomez, who opined that a physician who was not properly registered with the DEA would breach the standard of care and commit medical malpractice by ordering the administration of a controlled substance in violation of Subsection 458.331(1)(t)1., Florida Statutes (2005).

68. The Respondent asserted that such a practice would not constitute medical malpractice and offered the expert testimony of Dr. Steven Warsof, who opined that a physician who failed to provide pain-relieving medication to a patient in need would have breached the standard of care.

69. As referenced in the Preliminary Statement to this Recommended Order, the Respondent filed a Motion to Dismiss immediately prior to commencement of the hearing, wherein the Respondent asserted that the charge of medical malpractice under Subsection 458.331(1)(t)1., Florida Statutes (2005), was improper. The Respondent observed that the Petitioner did not charge the Respondent with a violation of Subsection 458.331(1)(g), Florida Statutes (2005), which provides that a failure "to perform any statutory or legal obligation placed upon a licensed physician" is grounds for discipline. The argument was further addressed in the Respondent's Proposed Recommended Order.

70. As noted by the Respondent, in Barr v. Dep't of Health, Bd. of Dentistry, 954 So. 2d 668 (Fla. Dist. Ct. App. 1st Dist. 2007), the court rejected the Department of Health position that a "particularly egregious" recordkeeping violation could also constitute a breach of a standard of care for purposes of disciplinary proceedings, stating that to do so would render the statutory recordkeeping requirement "useless" as grounds for discipline. The same reasoning would suggest that an allegation that a licensee's failure to comply with a legal obligation (in this case, the Respondent's lack of DEA registration) could constitute medical malpractice.

71. The Petitioner has filed no response to the Motion to Dismiss and did not directly address the matter in its Proposed Recommended Order.

72. The Motion to Dismiss is hereby granted, as to the allegation that the Respondent's ordering Demerol for the patient without proper DEA registration constituted a violation of Subsection 458.331(1)(t), Florida Statutes (2005).

73. The Petitioner alleged that the Respondent's use of Cytotec was a breach of the applicable standard of care. Dr. Gomez opined that the administration of Cytotec every two hours, as occurred twice in this case, was excessive and a breach of the standard of care for this patient. Dr. Gomez also uses Cytotec but prescribes a dosage of 400 micrograms at six-hour intervals administered vaginally. Dr. Warsof testified that the progress of labor was very slow in this case and that it was not inappropriate to increase the frequency of Cytotec to induce labor. Dr. Warsof's testimony has been credited.

74. The evidence failed to establish that the Respondent's use of Cytotec in this case, either by dosage or frequency, was inappropriate or was a breach of the standard of care.

75. The evidence failed to establish that the Respondent attempted to terminate the pregnancy through a D&E.

76. The evidence failed to establish that the Respondent caused a cervical laceration.

77. The evidence failed to establish that the Respondent's removal of the portion of the fetal limb constituted medical malpractice.

78. As charged in the Administrative Complaint, the Respondent's failure to advise the hospital's physicians during the telephone conversations that a portion of the patient's fetus had been removed at the Respondent's clinic breached the standard of care and constituted medical malpractice.

79. The Respondent asserted that the missing part did not pose a serious risk to the patient. Dr. Warsof opined that the risk of infection would have been addressed through the use of antibiotics that would have been administered to the patient. He testified that the hospital's inability to locate the missing part was of little consequence and should not have impacted the management of the patient in the hospital. Dr. Gomez opined that the Respondent's failure to inform the receiving hospital to which the patient was transferred that a fetal part had been removed at the clinic was a breach of the standard of care as set forth herein. Dr. Gomez's testimony was persuasive and has been credited. Dr. Warsof's testimony was not persuasive and has been rejected.

80. The evidence established that the medical care provided to the patient at the hospital was directly affected by the Respondent's failure to advise the hospital that the missing

part had been removed at the clinic. Had the hospital been advised that a fetal part had been removed at the clinic, the radiological tests performed during the attempt to locate the part would have been unnecessary, although other tests directly related to the sutured drain and second surgery would have been required.

81. The hospital eventually discovered that the Respondent had removed the fetal part at the clinic when the hospital contacted the clinic on February 10, 2006. The Respondent asserted that, had the hospital inquired of the clinic at an earlier time, the hospital would have learned that the missing part had been removed from the patient's vagina while she was at the clinic.

82. It was the Respondent's obligation to advise the hospital of the events occurring at the clinic, and the implication that the hospital should have contacted the clinic to track down the missing part has been rejected. There is no credible evidence that the hospital personnel erred in their attempt to locate the missing fetal part.

83. In the Motion to Dismiss, the Respondent asserted that the alleged failure to adequately document the removal of the portion of the fetal limb, charged as a recordkeeping violation under Subsection 458.331(1)(m), Florida Statutes (2005), was inappropriately charged as medical malpractice under Subsection

458.331(1)(t), Florida Statutes (2005). The assertion was re-addressed in the Respondent's Proposed Recommended Order.

84. As stated previously, in the Barr decision, the court rejected the position that the "particularly egregious" recordkeeping violation could also constitute a breach of a standard of care in a disciplinary proceeding. This was specifically what was charged in the Administrative Complaint in this case. The Petitioner filed no response to the Motion to Dismiss and did not directly address the matter in its Proposed Recommended Order. The Motion to Dismiss is hereby granted as to the allegation that the Respondent's recordkeeping constituted a violation of Subsection 458.331(1)(t), Florida Statutes (2005).

85. Count III of the Administrative Complaint alleged that the Respondent committed medical malpractice in violation of Subsection 458.331(1)(q), Florida Statutes (2005), by "prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice." Specifically, the Petitioner alleged that the Respondent violated Subsection 458.331(1)(q), Florida Statutes (2005), by ordering Demerol without proper DEA registration and through the administration of "excessive" Cytotec.

86. The evidence failed to establish that the Respondent's use of Cytotec and Demerol occurred "other than in the course of" the Respondent's professional practice, or that such use otherwise constituted medical malpractice under Subsection 458.331(1)(q), Florida Statutes (2005).

87. Florida Administrative Code Rule 64B8-8.001 sets forth the disciplinary guidelines applicable to the statutory violations relevant to this proceeding.

88. Florida Administrative Code Rule 64B8-8.001(2) provides that the penalty for a first offense of Subsection 458.331(1)(m), Florida Statutes, ranges from a reprimand to denial or two years' suspension followed by probation, and an administrative fine from $1,000.00 to $10,000.00.

89. Florida Administrative Code Rule 64B8-8.001(2) provides that the penalty for a first offense of Subsection 458.331(1)(t), Florida Statutes, ranges from a two-year probation to revocation or denial and an administrative fine from $1,000.00 to $10,000.00.

90. Florida Administrative Code Rule 64B8-8.001(3) provides as follows:

> 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, F.S., 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) Where a licensee has been charged with violating the standard of care pursuant to Section 458.331(1)(t), F.S., but the licensee, who is also the records owner pursuant to Section 456.057(1), F.S., fails to keep and/or produce the medical records.

(i) Any other relevant mitigating factors. (Emphasis supplied)

91. The failure to notify hospital personnel that a fetal part was removed while the patient was at the clinic adversely

impacted the medical care the patient received at the hospital and has been considered as an aggravating factor.

92. The Respondent was the subject of a prior disciplinary proceeding which resulted in an imposition of discipline against the Respondent's license; however, the Final Order entered in that case has been appealed and is not yet final. The prior disciplinary case has not been considered in rendering the recommended penalty set forth herein.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health enter a final order finding James S. Pendergraft IV, M.D., in violation of Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes (2005), and imposing a penalty as follows: a two-year period of suspension followed by a three-year period of probation and an administrative fine of $20,000.00.

DONE AND ENTERED this 21st day of September, 2009, in Tallahassee, Leon County, Florida.

William F. Quattlebaum

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of September, 2009.

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.