STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. LUCIEN ARMAND, M.D., Respondent.	)	Case Nos. 08-4285PL DOH Case No. 2006-38439

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 6, 2009, by video teleconference between Lauderdale Lakes and Tallahassee, Florida.

APPEARANCES

For Petitioner: Diane K. Kiesling
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STATEMENT OF THE ISSUES

The issues for determination are whether Respondent Lucien Armand, M.D., violated Section 458.331(1)(v), Florida Statutes (2006); Section 458.331(1)(nn), Florida Statutes (2006), by violating Florida Administrative Code Rule 64B8-9.009(2) and (4), and Section 458.351, Florida Statutes (2006); Section 458.331(1)(m), Florida Statutes (2006); and Section 458.331(1)(t), Florida Statutes (2006), as alleged in an Amended Administrative Complaint filed by the Department of Health before the Board of Medicine on June 20, 2008; and, if so, what disciplinary action should be taken against his license to practice medicine in the State of Florida.

PRELIMINARY STATEMENT

This case began with the filing by the Department of Health before the Board of Medicine of a four-count Amended Administrative Complaint, DOH Case Number 2006-38439, against Respondent Lucien Armand, M.D., an individual licensed to practice medicine in Florida. On or about July 20, 2008, Respondent, through counsel, filed a Petition for Formal Administrative Hearing and an Election of Rights form signed by Respondent, disputing the allegations of fact contained in the Amended Administrative Complaint and requesting a formal administrative hearing pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes (2008).

On August 29, 2008, 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 (2008). The matter was designated DOAH Case Number 08-4285PL and was assigned to the undersigned.

This case was consolidated with another case involving the parties, DOAH Case No. 08-4403PL, DOH Case No. 2005-63004, by Order of Consolidation entered September 12, 2008. The two cases were consolidated for purposes of hearing only. A separate Recommended Order is being entered in DOAH Case No. 08-4403PL.

The final hearing was scheduled to be held on November 7, 2008, by video teleconference between sites in Miami and Tallahassee, Florida, by Notice of Hearing by Video Teleconference entered September 12, 2008. The hearing was re-scheduled twice at the request of Respondent.

On March 20, 2009, the parties filed a Joint Pre-Hearing Stipulation, in which they identified certain facts and issues of law they agreed on. To the extent relevant, those agreed upon facts and issues of law have been included in this Recommended Order.

On March 31, 2009, an Order Granting Petitioner’s Motion for Official Recognition was entered.

During the final hearing, Petitioner presented the testimony of Melinda Gray, Patient W.C., Christian Birkedal, M.D., and Angela Potter. Petitioner's Exhibits 1 through 3, 6, and 8 through 14 were admitted. Respondent testified on his own behalf and had one exhibit admitted.

The two-volume Transcript of the final hearing was filed on April 24, 2009. By Notice of Filing Transcript entered the same day, the parties were informed that the Transcript had been filed and that their proposed recommended orders were to be filed on or by May 25, 2009. May 25, 2009, was a holiday, so proposed orders were actually required to be filed on or before May 26, 2009.

Petitioner's Proposed Recommended Order and Dr. Armand's Memorandum in Support of a Recommended Order Dismissing Administrative Complaints were filed on May 26, 2009. The post-hearing proposals of both parties have been fully considered in rendering this Recommended Order.

All references to Florida Statutes in this Recommended Order are to the 2006 version unless otherwise noted.

FINDINGS OF FACT

A. The Parties.

1. Petitioner, the Department of Health (hereinafter referred to as the "Department"), is the agency of the State of Florida charged with the responsibility for the investigation

and prosecution of complaints involving physicians licensed to practice medicine in Florida. § 20.43 and Chs. 456 and 458, Fla. Stat.

2. Respondent, Lucien Armand, 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 33997.

3. Dr. Armand is board-certified in general surgery by the American Board of Surgery.

4. Dr. Armand's mailing address of record at all times relevant to this matter was 2071 Southwest 52nd Way, Plantation, Florida 33317. At the times relevant, Dr. Armand practiced medicine at 4100 South Hospital Drive, Suite 108, Plantation, Florida 33317. The office at which Dr. Armand practiced medicine was located very close to Plantation General Hospital (hereinafter referred to as "Plantation").

5. Dr. Armand has been the subject of three prior disciplinary matters arising out of five separate cases. Penalties were imposed in those three disciplinary matters. The Department summarized those disciplinary matters in paragraph 37 of its Proposed Recommended Order:

> In DPR Case Numbers 0019222, 0019123 and 0091224, Respondent was fined, received a reprimand, and was required to complete 30 hours of Continuing Medical Education (CME) in general vascular surgery and risk management within the surgical practice. In Case Number 94-10100, Respondent was

> required to submit to and comply with an evaluation at the University of Florida, to pay a fine, was reprimanded, was required to complete twenty hours of CME in general surgery in performing Laparoscopic Cholecystectomy, and was placed on Probation for two (2) years. In Case Number 1999-58474, Respondent was restricted from performing Level II or above office surgery as defined in Rule 64B8-9.009(1)(d), Florida Administrative Code, until the Respondent demonstrated to the Board that he had successfully completed the University of Florida Comprehensive Assessment and Remedial Education Service (UF C.A.R.E.S.) course and complied with all recommendations, was reprimanded, was placed on probation for two (2) years, was required to attend the Florida Medical Association "Quality Medical Record Keeping for Health Care Practitioners" course, was required to perform 100 hours of community service, and was required to reimburse the Department for costs.

6. Dr. Armand, who is 70 years of age, has been practicing medicine for 46 years. He has practiced medicine in Florida since 1979. During the eight months prior to the final hearing of this matter, Dr. Armand was working in South Sudan pursuant to contract with the United States State Department.

B. October 6, 2006, Surgery on Patient W.C.

7. On September 14, 2006, Patient W.C. presented to Dr. Armand and was diagnosed as having a slow-growing left inguinal hernia.

8. Dr. Armand scheduled Patient W.C. for surgical repair of the inguinal hernia. The surgery was scheduled for

October 6, 2006, at Dr. Armand's office and, at the request of Patient W.C., under local sedation.

9. At approximately 9:30 a.m., October 6, 2006, Patient W.C. arrived as scheduled at Dr. Armand's office, accompanied by his wife and child. Patient W.C., who was not asked to execute any paperwork concerning the operation, was taken into a room where he was directed to lie down. There were two nurses in the room.

10. Patient W.C. was given one shot of some form near the site of the procedure. This shot is the only medication he remembers receiving. He denied any recollection of having received medication intravenously, intramuscularly, or rectally.

11. According to Dr. Armand, Patient W.C. was given "local anesthesia, Xylocaine 1% and ½% during the procedure and I gave some oral sedation, 10mg. of Valium, by mouth." Page 171, Lines 19-21, Vol. II, Transcript of Final Hearing.

12. At some point during the surgery, Patient W.C.'s intestines eviscerated, pushed themselves out through the hernia, making the hernia impossible to repair in the office.

13. Due to the evisceration of Patient W.C.'s intestines, Dr. Armand eventually closed the incision and decided to transport Patient W.C. to Plantation to complete the procedure. Dr. Armand's testimony that he closed and took patient W.C. to

Plantation because Patient W.C. began “fidgeting” is not credited.

14. While Patient W.C. did not have any clear recollection of the surgery while at Dr. Armand’s office, he did recall that “I was shaking myself and one of the nurses put something on my head and I went to sleep.” Page 40, Lines 20-22, Vol. I, Transcript of Final Hearing. Patient W.C. later indicated that “[o]ne of the ladies sprayed something on my face,” at which point Patient W.C. “went to sleep.” Page 41, Lines 23-24, and Page 42, Line 8, Vol. I, Transcript of Final Hearing. Patient W.C. did not remember anything else from this point in the surgery until he awoke at approximately 2:00 p.m., October 6, 2006, in a room at Plantation.

15. Patient W.C. was transported to Plantation after he “fell asleep” by Dr. Armand.

16. When Patient W.C. arrived at the Plantation emergency room, he was noted to be “sleepy” and, based upon Dr. Armand’s representation to the emergency room physician, Cornell Calinescu, M.D., was described as “somewhat sedated secondary to Valium and Clonidine.” Patient W. C. was also described by Dr. Calinescu and an emergency room nurse as able to speak.

17. Upon admission to Plantation, Dr. Armand performed emergency surgery on Patient W.C. under general anesthesia,

completing the procedure he had begun in his office. The surgery was completed without further complication.

18. As noted above, Patient W.C. has no recollection of arriving at the Plantation emergency room, how he got to the hospital, or anything else that took place after falling asleep in Dr. Armand's office, until he awoke in a hospital room later in the afternoon.

C. Dr. Armand's Medical Records for the October 6, 2006, Surgery.

19. Dr. Armand's office notes for Patient W.C. lack any documentation as to what took place in his office on October 6, 2006. Dr. Armand did not record the date of the procedure; the type of procedure performed; pre-operative care; any drugs that were prescribed, dispensed, and/or administered; the type and dosage of anesthetic sedation used; or post-operative care.

20. Dr. Armand's medical records for Patient W.C. also failed to include any informed consent for the procedure performed on October 6, 2006.

21. As noted above, Dr. Armand did complete an operative report after the emergency surgery performed on Patient W.C. at Plantation.

D. Office Surgery; Level of Anesthesia.

22. Florida Administrative Code Rule 64B8-9.009 (hereinafter referred to as the "Office Surgery Rule")

prescribes standards for the performance of office surgery. In providing those standards, the Office Surgery Rule defines three levels of sedation and the conditions under which each level may be achieved and must be performed. Level II and Level III office surgery require registration of the physician's office to perform. Dr. Armand's office was not registered to perform Level II or Level III office surgery at the times relevant to this proceeding. Only the first and second levels of office surgery are relevant to this case.

23. Florida Administrative Code Rule 64B8-9.009(3) describes the types of procedures appropriate for "Level I" office surgery, which Dr. Armand has argued he performed on Patient W.C., as follows:

> 1. Minor procedures such as excision of skin lesions, moles, warts, cysts, lipomas and repair of lacerations or surgery limited to the skin and subcutaneous tissue performed under topical or local anesthesia not involving drug-inducted alteration of consciousness other than minimal pre-operative tranquilization of the patient.
>
> 2. Liposuction involving the removal of less than 4000cc supernatant fat is permitted.
>
> 3. Incision and drainage of superficial abscesses, limited endoscopies such as proctoscopes, skin biopsies, arthrocentesis, thoracentesis, paracentesis, dilation of urethra, cysto-scopic procedures, and closed reduction of simple fractures or small joint dislocations (i.e., finger and toe joints).

. . . .

5. Chances of complication requiring hospitalization are remote.

24. Florida Administrative Code Rule 64B8-9.009(4) describes the types of procedures appropriate for "Level II" office surgery, which the Department argues Dr. Armand utilized on Patient W.C., as follows:

> 1. Level II Office Surgery is that in which peri-operative medication and sedation are used intravenously, intramuscularly, or rectally, thus making intra and post-operative monitoring necessary. Such procedures shall include, but not be limited to: hemorrhoidectomy, hernia repair, reduction of simple fractures, large joint dislocations, breast biopsies, colonoscopy, and liposuction involving the removal of up to 4000cc supernatant fat.
>
> 2. Level II Office surgery includes any surgery in which the patient is placed in a state which allows the patient to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal command and/or tactile stimulation. Patients whose only response is reflex withdrawal from a painful stimulus are sedated to a greater degree than encompassed by this definition. [Emphasis added].

25. While the Department relies in part upon the language of Florida Administrative Code Rule 64B8-9.009(4) that "[s]uch procedures shall include, but not be limited to . . . hernia repair . . ." to support its argument that the procedure performed by Dr. Armand on Patient W.C. was in fact performed as

Level II surgery, this reliance is misplaced. Regardless of the proper interpretation of this language of the Rule (whether it clearly puts physicians on notice that all hernia repair surgery must be conducted as Level II surgery or not), at best it establishes a proscription. Such a proscription, cannot, however, be relied upon to establish the "fact" that Level II surgery was performed or not. The question of whether Dr. Armand performed the procedure defined as "Level II" office surgery is *the* disputed issue of fact in this case. Resolving this factual dispute requires an ultimate factual determination, which involves the application of a legal standard (the Rule) to the historical facts (what Dr. Armand actually did) as found by the trier-of-fact based upon the evidence. The Rule is not evidence of what Dr. Armand did; rather it is the yardstick against which Dr. Armand's conduct must be measured and, ultimately, judged.

26. The evidence either way concerning the level of surgery performed by Dr. Armand consisted of his testimony denying that Level II surgery was performed, the testimony of Patient W.C. concerning his condition, the description of Patient W.C.'s condition by emergency room personnel, and the opinion of the Department's expert witness, Christian Brikedal, M.D., as to the level of surgery.

27. Dr. Armand's denial that he performed Level II surgery was not convincing because it was inconsistent with the patient's description of his condition on October 6, 2006, and the description of his condition by emergency room staff when arrived at Plantation. Patient W.C. had no recollection of going to the hospital or anything that transpired there until he awoke at about 2:00 p.m. the afternoon of October 6, 2006. Emergency room staff noted that Patient W.C. was able to talk when he arrived. These facts, convincingly proved, are more consistent with what constitutes Level II surgery: "the patient is placed in a state which allows the patient to tolerate unpleasant procedures while maintaining . . . the ability to respond purposefully to verbal command and/or tactile stimulation." This finding is further supported by Dr. Brikedal opinion that Patient W.C.'s condition was consistent with having undergone Level II sedatopm.

28. Dr. Brikedal, whose testimony was convincing and uncontroverted, was asked the following question and gave the following answer at Page 22, Lines 7-14, Vol. I, Transcript of Final Hearing:

> Q Assuming W.C. is going to testify that as soon as the complication occurred that he was put to sleep and didn't wake up until he was in the hospital, are you able to reach any conclusions about the level of sedation that occurred?

A He would have to have been given a sedative I.V. or I.M. to be that sleepy.

This opinion, as to Patient W.C.'s condition on October 6, 2006, supports a finding that Patient W.C. was under Level II anesthesia while surgery was being performed in Dr. Armand's office. Having found that Patient W.C. was under the level of sedation described in the definition of "Level II" office surgery, leads inescapably to the finding that Dr. Armand administered Level II sedation to Patient W.C.

29. The foregoing finding is further supported by the portion of the Office Surgery Rule quoted, supra, in finding of fact 24. Dr. Brikedal explained during the hearing why it is "appropriate and necessary to do an inguinal hernia repair" as Level II surgery: "Sedation to the point that the patient's comfortable so they're able to or they're not pushing against you, inhibiting you from performing this very safely." Page 24, Lines 20-22, Vol. I, Transcript of Final Hearing. As a board-certified general surgeon who has previously registered and had his office accredited as an office at which Level II surgery could be performed, Dr. Armand must have been aware of why it is prudent to perform hernia repairs as Level II surgery. While Dr. Armand may have begun the surgery as Level I, when Patient W.C.'s intestines eviscerated, Dr. Armand must have realized that taking Patient W.C. to Level II sedation would give him a

better opportunity to correct the problem. Unfortunately for Dr. Armand, it was too late.

E. Office Surgery Rule Procedures.

30. Florida Administrative Code Rule 64B8-9.009(2) prescribes requirements for conducting "office surgery," taking into account of the level of sedation utilized during a procedure.

31. The hernia repair performed by Dr. Armand on Patient W.C. constituted "surgery" as defined in Florida Administrative Code Rule 64B8-9.009(1). Performance of the surgery in Dr. Armand's office constituted "office surgery" as those terms are defined in Florida Administrative Code Rule 64B8-9.009(1)(d).

32. The "office surgery" performed by Dr. Armand on Patient W.C. failed to comply, as required, with all the requirements of Florida Administrative Code Rule 64B8-9.009(2), applicable to conducting Level II office surgery and, in some instances, Level I office surgery:

a. Dr. Armand failed to "maintain complete records" of the surgical procedure as required by Florida Administrative Code Rule 64B8-9.003, or a written informed consent from the patient as required by Florida Administrative Code Rule 64B8-9.009(2)(a)(applicable in part to Level I and Level II surgery);

b. No log of Level II surgery was kept as required by Florida Administrative Code Rule 64B8-9.009(2)(c);

c. No adverse incident report was filed as required by Florida Administrative Code Rule 64B8-9.009(2)(k). This portion of the rule requires that "[t]he surgeon shall report to the Department of Health any adverse incidents that occur within the office surgical setting. . . ." (Emphasis added). This requirement is separate from any requirement that a hospital report adverse incidents and the burden of reporting is put directly on the surgeon; and

d. Dr. Armand did not have an established risk management program as required by Florida Administrative Code Rule 64B8-9.009(2)(j).

F. The Standard of Care.

33. Dr. Birkedal provided an opinion to the Department and testified at the final hearing as to whether Dr. Armand's treatment of Patient W.C. met the "level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers . . . ." (Hereinafter referred to as the "Standard of Care").

34. In his original opinion dated December 22, 2007, Dr. Birkedal indicated that he did not believe that Dr. Armand's care of Patient W.C. violated the Standard of Care. There were caveats or assumptions, however, which Dr. Birkedal recognized in his written opinion could change his opinion if not correct.

In particular, at the time of his original opinion, Dr. Birkedalk had incorrectly assumed that the procedure performed on Patient W.C. was a Level I procedure. Dr. Birkedal recognized in his original opinion that, if his assumption were incorrect, that his opinion would change: "[i]f he did give an IV sedative, then he may have violated the standard of care if his office is not licensed to give IV sedatives."

35. At hearing, Dr. Birkedal was of the opinion that Dr. Armand had not simply performed Level I surgery and, therefore, opined that he had violated the Standard of Care because his office was not a properly licensed office surgery suite.

36. Dr. Birkedal also offered other opinions at hearing concerning what he perceived were violations of the Standard of Care, but those "violations" were not alleged by the Department in the Amended Administrative Complaint.

CONCLUSIONS OF LAW

A. Jurisdiction.

37. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2008).

B. The Burden and Standard of Proof.

38. The Department seeks to impose penalties against Dr. Armand's license through the Amended Administrative Complaint that include suspension or revocation of his license and/or the imposition of an administrative fine. Therefore, the Department has the burden of proving the specific allegations of fact that support its charge that Dr. Armand committed the statutory and rule violations alleged in the Amended Administrative Complaint by clear and convincing evidence. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Pou v. Department of Insurance and Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998); Nair v. Department of Business and Professional Regulation, 654 So. 2d 205 (Fla. 1st DCA 1995); and § 120.57(1)(j), Fla. Stat. (2008)("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.").

39. What constitutes "clear and convincing" evidence was described by the court in Evans Packing Co. v. Department of Agriculture and Consumer Services, 550 So. 2d 112, 116, n. 5 (Fla. 1st DCA 1989), as follows:

> . . . [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the evidence must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact the firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

See also In re Graziano, 696 So. 2d 744 (Fla. 1997); In re Davey, 645 So. 2d 398 (Fla. 1994); and Walker v. Florida Department of Business and Professional Regulation, 705 So. 2d 652 (Fla. 5th DCA 1998)(Sharp, J., dissenting).

C. The Charges of the Amended Administrative Complaint.

40. 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.

41. The four-count Amended Administrative Complaint alleges that Dr. Armand violated the following provisions of Section 458.331(1), Florida Statutes, in his treatment of Patient W.C.:

a. Count One: Section 458.331(1)(v), Florida Statutes;

b. Count Two: Section 458.331(1)(nn), Florida Statutes (2006), by violating Florida Administrative Code Rule 64B8-9.009(2) and (4), and Section 458.351, Florida Statutes;

c. Count Three: Section 458.331(1)(m), Florida Statutes; and

d. Count Four: Section 458.331(1)(t), Florida Statutes, the Standard of Care.

42. In determining whether Dr. Armand committed the alleged statutory violations, only those specific factual grounds alleged by the Department in the Amended Administrative Complaint can form the basis of a finding of violation. See Trevisani v. Department of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005); Cottrill v. Department of Insurance, 685 So. 2d 1371 (Fla. 1st DCA 1996). As the Department acknowledged in its Proposed Recommended Order, "[d]ue process prohibits the Department from taking disciplinary action against a licensee based on matters not specifically alleged in the charging instrument, unless those matters have been tried by consent. See Shore Village Property Owners' Association, Inc . v. Department of Environmental Protection, 824 So. 2d 208, 210 (Fla. 4th DCA 2002); and Delk v. Department of Professional Regulation, 595 So. 2d 966, 967 (Fla. 5th DCA 1992)."

D. Count One: Section 458.331(1)(v), Florida Statutes.

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

> (v) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform. The board may establish by rule standards of practice and standards of care for particular practice settings, including, but not limited to, education and training, equipment and supplies, medications including anesthetics, assistance of and delegation to other personnel, transfer agreements, sterilization, records, performance of complex or multiple procedures, informed consent, and policy and procedure manuals.

44. In particular, the Amended Administrative Complaint alleges that Dr. Armand violated this prohibition because he "performed Level II office surgery on Patient W.C. by attempting to perform a hernia repair in his office" in violation of the Office Surgery Rule.

45. The evidence proved clearly and convincingly that Dr. Armand performed Level II surgery on Patient W.C. on October 6, 2006, when he knew or should have known that such surgery was beyond the scope of what he was authorized to do under the Officer Surgery Rule because he was not licensed at the time to perform Level II surgery in his office.

E. Count Two: Section 458.331(1)(nn), Florida Statutes.

46. Section 458.331(1)(nn), Florida Statutes, defines the following disciplinable offense:

> (nn) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

47. In particular, Count Two of the Amended Administrative Complaint goes on to allege that Dr. Armand violated Florida Administrative Code Rule 64B8-9.009(2) and (4), "by performing Level II office surgery on Patient W.C. in Respondent's office without complying with the requirements of Rule 64B8-9.009 as to informed consent, staffing, equipment, crash cart, medications, and assistance of other personnel."

48. While the Department admits that it failed to prove whether Dr. Armand violated the standards of the Office Surgery Rule concerning staffing, equipment, crash cart, medications, and assistance of other personnel on October 6, 2006, it did prove that Dr. Armand failed to obtain an informed consent from Patient W.C.

49. The Department's suggestion that Dr. Armand's failure to file an adverse incident report as required by the Office Surgery Rule in violation of Section 458.331(nn), Florida Statutes, is rejected as a basis for discipline because the Department did not specifically make this allegation in the Amended Administrative Complaint. The only allegation in Count

Two of the Amended Administrative Complaint concerning Dr. Armand's failure to file an adverse incident report was based upon Section 458.351, Florida Statutes.

50. It is alleged that Dr. Armand violated Section 458.331(nn), Florida Statutes, by having violated Section 458.351, Florida Statutes, "by failing to file an adverse incident report regarding the incident involving Patient W.C." Section 458.351, Florida Statutes, provides, in pertinent part, the following:

> (1) Any adverse incident that occurs on or after January 1, 2000, in any office maintained by a physician for the practice of medicine which is not licensed under chapter 395 must be reported to the department in accordance with the provisions of this section.
>
> (2) Any physician or other licensee under this chapter practicing in this state must notify the department if the physician or licensee was involved in an adverse incident that occurred on or after January 1, 2000, in any office maintained by a physician for the practice of medicine which is not licensed under chapter 395.
>
> (3) The required notification to the department must be submitted in writing by certified mail and postmarked within 15 days after the occurrence of the adverse incident.
>
> . . . .

51. While not excusing his failure, the evidence did prove that Dr. Armand's failure to file an adverse incident report is somewhat mitigated by the fact that the hospital filed one.

52. The evidence proved clearly and convincingly that Dr. Armand failed to file an adverse incident report as required by Section 458.351, Florida Statutes.

F. Count Three; Violation of Section 458.331(1)(m), Florida Statutes.

53. 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.

54. In the Amended Administrative Complaint it is alleged that Dr. Armand failed to keep adequate medical records in violation of Section 458.331(m), Florida Statutes, in that he failed to document one or more of the following:

a. A record of the procedure performed;
b. The date the procedure was performed;

c. A record of the drugs prescribed, dispensed or administered;
d. The type and dosage of anesthetic sedation used during the procedure;
e. The pre-operative and post-operative care provided;
f. The informed consent;
g. The adverse incident report.

The Department proved clearly and convincingly that Dr. Armand failed to keep medical records documenting these matters as alleged in the Amended Administrative Complaint.

55. The evidence proved clearly and convincingly that Dr. Armand failed to keep medical records as alleged in the Amended Administrative Complaint in violation of Section 458.331(1)(m), Florida Statutes.

G. Count Four: Violation of Section 458.331(1)(t), Florida Statutes.

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

> 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.

57. Section 456.50(1)(g), Florida Statutes, defines medical malpractice as follows:

> . . . 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.

58. Section 456.50(1)(e), Florida Statutes, defines "level of care, skill, and treatment recognized in general law related to health care licensure" as the "standard of care" by referring to Section 766.102, Florida Statutes, which defines the Standard of Care as "[t]he prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."

59. In paragraph 39 of the Amended Administrative Complaint, it is alleged that Dr. Armand violated the Standard of Care in his treatment of Patient W.C. in one or more of the following ways:

> a. By performing inguinal hernia surgery in his office in violation of Rule 64B8-[9].009, FAC;
> b. By violating Rule 64B8-9.009, FAC, by performing invasive office surgery in an office;
> c. By administering sedation that prevented the patient from signing the necessary consent to the emergency surgery;

d. By failing to document his preoperative, post operative, or operative actions or anesthetic;
e. By failing to file an adverse incident report as required by Section 458.351, Florida Statutes (2006);
f. By failing to meet the Standards of Practice and Care established by the Board of Medicine in Rule 64B8-9.009, FAC.

60. The alleged Standard of Care violations of paragraphs 39a. and b. are essentially the same: Dr. Armand performed surgery in his office in violation of the Office Surgery Rule. The allegations of paragraphs 39c. and d. are more specific failures on the part of Dr. Armand to follow the requirements of the Office Surgery Rule. The allegation of paragraph 39f. simply summarizes the allegations of paragraphs 39 a., b., c. and d. The allegation of paragraph 39e. is the only allegation that does not specifically turn on adherence to the Office Surgery Rule.

61. The Department has pointed out in its Proposed Recommended Order that the Office Surgery Rule itself establishes the Standard of Care. The Office Surgery Rule is titled “Standard of Care for Office Surgery” and it prescribes what the Board considers the prevailing professional standard of care for any health care provider performing office surgery. The Department’s interpretation of its own rule is persuasive and is accepted.

62. The Department next argues that Dr. Armand violated the Standard of Care by failing to comply with the Office Surgery Rule. Clearly and convincingly, Dr. Armand performed "surgery" on Patient W.C. as defined in the Office Surgery Rule. Whether the surgery was performed at Level I or Level II, it was performed in his office and he was required to comply with all relevant portions of the Office Surgery Rule. His failure to do so constituted a violation of the Office Surgery Rule and, consequently, a violation of the Standard of Care.

63. Again, regardless of the level of the surgery performed, it was proved clearly and convincingly that he performed "inguinal hernia surgery in his office in violation of Rule 64B8-[9].009, FAC" and that he violated "Rule 64B8-9.009, FAC, by performing invasive office surgery in an office" as alleged in the Amended Administrative Complaint.

64. The Department also proved, again without regard to the level of the surgery performed, that Dr. Armand failed to document his preoperative, post-operative, or operative actions or anesthetic as required by the Office Surgery Rule.

65. The Department failed to prove, however, that failure to comply with Section 458.351, Florida Statutes, while a violation of Section 456.331(nn), Florida Statutes, constitutes a violation of the Standard of Care. The Office Surgery Rule, while also requiring that adverse incident reports be filed,

does not refer to Section 358.351, Florida Statutes, and the Department did not specifically allege in support of the charged violation of the Standard of Care that Dr. Armand's failure to file the report violated any provision other than Section 458.351, Florida Statutes.

66. In addition to alleging that Dr. Armand violated the Standard of Care by failing to adhere to the requirements of the Office Surgery Rule, the Department has argued in its Proposed Recommended Order that Dr. Brikedal's opinions at hearing support a finding that the Standard of Care was violated independent of the Office Surgery Rule. While Dr. Brikedal's testimony does support such a finding, the allegations of the Amended Administrative Complaint concerning the Standard of Care did not put Dr. Armand on notice that he was being charged with any violation of the Standard of Care other than his failure to comply with the Office Surgery Standard.

67. The Department has proved clearly and convincingly that Dr. Armand violated the Standard of Care as alleged in Count Four of the Amended Administrative Complaint as more specifically alleged in paragraph 39.a., b., c., d., and f. of the Amended Administrative Complaint.

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(2), which provides for the following range of penalties:

a. For a violation of Section 458.331(1)(v), Florida Statutes: from two years' suspension to revocation and an administrative fine from $1,000.00 to $10,000.00;

b. For a violation of Section 458.331(1)(nn), Florida Statutes, second offense: from probation to revocation and an administrative fine from $5,000.00 to $10,000.00;

c. For a violation of Section 458.331(1)(m), Florida Statutes, second offense: from probation to suspension followed by probation and an administrative fine of from $5,000.00 to $10,000.00; and

d. For a violation of Section 458.331(1)(t), Florida Statutes, second offense: from two years' probation to revocation and an administrative fine from $5,000.00 to $10,000.00

70. 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.

71. In its Proposed Recommended Order, the Department has suggested that there are no mitigating circumstances and the following aggravating circumstances in this case:

> Based on the previous serious disciplinary history of the Respondent, including multiple violations of the standard of care, the fact that W.C. was exposed to potential

> harm, the fact that this is a four count complaint, and because Respondent has been disciplined in three previous cases for the violation of Section 458.331(1)(m), Florida Statutes, and on five previous occasions (in seven cases) for violation of Section 458.331(1)(t), Florida Statutes, the level of aggravating factors is high. . . .

This summary of aggravating circumstances is accurate.

72. The Department overlooks, however, that, while there was "potential" for harm to Patient W.C., in fact the surgery ultimately was concluded without any actual physical harm to Patient W.C. The Department also has failed to acknowledge the fact that the violations concerning Dr. Armand's failure to file an adverse incident report are mitigated by the fact that the hospital filed one. Finally, consideration should be given to the fact that Dr. Armand has ceased performing Level II and Level III surgery in an office setting and that he has effectively closed his office practice.

73. The Department has requested that it be recommended that Dr. Armand's medical license be revoked. As an alternative, the Board may want to consider suspending Dr. Armand's right to practice medicine in Florida, while allowing him keep his Florida medical license in order for him to continue to practice medicine outside the United States through his relationship with the United States Department of State. Such an arrangement should be conditioned upon full disclosure

to the United States Department of State and should be considered only if his continued licensure is a condition of his employment by the United States Department of State.

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 Lucien Armand M.D., has violated Section 458.331(1)(v), Florida Statutes (2006); Section 458.331(1)(nn), Florida Statutes (2006), by violating Florida Administrative Code Rule 64B8-9.009 and Section 458.351, Florida Statutes (2006); Section 458.331(1)(m), Florida Statutes (2006); and Section 458.331(1)(t), Florida Statutes, to the extent found in this Recommended Order; and indefinitely suspending his license to practice medicine in Florida, but allowing him to continue to practice medicine outside the United States through his relationship with the United States Department of State after full disclosure of the Board's final order to the United States Department of State. Should a medical license not be a condition of employment by the United States Department of State, his license should be revoked.

DONE AND ENTERED this 17th day of June, 2009, in Tallahassee, Leon County, Florida.

LARRY J. SARTIN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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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.