STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. JOHN M. LEE, M.D., Respondent.	)	Case No. 11-0922PL

RECOMMENDED ORDER

On June 2, 2011, a duly-noticed hearing was held in Tallahassee, Florida, before Lisa Shearer Nelson, an Administrative Law Judge assigned by the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Elana J. Jones, Esquire
Ian Brown, Esquire
Department of Health
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For Respondent: Brian A. Newman, Esquire
Pennington, Moore, Wilkinson
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STATEMENT OF THE ISSUE

The issue to be presented is whether Respondent violated section 458.331(1)(t), Florida Statutes (2005), and if so, what penalty should be imposed?

PRELIMINARY STATEMENT

On December 6, 2010, Petitioner, Department of Health (Petitioner or the Department), filed a one-count Administrative Complaint against Respondent, charging him with violating section 458.331(1)(t), with respect to the care and treatment of patient R.R. Respondent filed a Request for Formal Hearing which disputed the allegations in the Administrative Complaint and requested a hearing pursuant to section 120.57(1), Florida Statutes. On February 22, 2011, the case was referred to the Division of Administrative Hearings for assignment of an administrative law judge.

On March 8, 2011, a Notice of Hearing was issued scheduling the case for hearing on April 26-27, 2011. At the request of the parties, the case was rescheduled for June 7, 2011, and proceeded as scheduled.

At hearing, Petitioner presented the testimony of R.R., A.R., Respondent John Lee, M.D., and Robert Holloway, M.D. Petitioner's Exhibits numbered 1, 9, 10, 11, 12, and 13 were admitted into evidence. Respondent presented the testimony of John D. Davis, M.D., and Brandi Harper, and Respondent's Exhibits numbered 1-2 were admitted.

The Transcript of the proceeding was filed with the Division on June 28, 2011. At the request of the parties, the deadline for the filing of proposed recommended orders was extended to August 12, 2011. Both parties' Proposed Recommended Orders were

submitted timely and both have been carefully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

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

2. Respondent, John Lee, M.D., is a licensed physician in the State of Florida, having been issued license number ME 50043. Dr. Lee specializes in obstetrics and gynecology, but is not board certified at this time. He has a solo practice.

3. Dr. Lee has had one prior final order imposing discipline against him. On November 7, 1996, the Board of Medicine entered a Final Order approving an amended Consent Agreement entered between the Agency for Health Care Administration (the Department's predecessor with respect to regulation of health care professionals) and Dr. Lee. The Final Order imposed a letter of concern, a fine of $2,000, and 20 hours of continuing medical education.

4. On or about November 2, 2005, patient R.R. first saw Respondent with a complaint of chronic pelvic pain and an inability to function. Based upon his examination of R.R., Respondent recommended that R.R. undergo a bilateral salpingo-oophorectomy (removal of both ovaries and fallopian tubes).

5. R.R. decided to have the recommended surgery and on December 13, 2005, Respondent performed a bilateral salpingo-oophorectomy, as well as an appendectomy, lysis of adhesions and partial omentectomy.

6. There are three layers to the bowel: the serosa is the thin outer protective layer; under the serosa is the muscularis; a third layer below the muscularis called the mucosa. Dr. Lee's surgical notes indicate that there was some serosal denuding of the sigmoid colon, but with no luminal extravasion (no leakage from the bowel). Dr. Lee described the serosal denuding as an irritation of the serosa from removal of adhesions, and not a complication of the surgery. In any event, there are no allegations in the Administrative Complaint claiming that either Dr. Lee's decision to perform the surgery or the performance of the surgery itself deviated from the appropriate standard-of-care, and no findings to that effect are found.

7. R.R. was discharged from the hospital on December 15, 2005. At that time, she was ambulatory, tolerating liquids, had passed flatus and had a small bowel movement. At that time she had no documented fever and a normal white count.

8. The next day, Friday, December 16, 2005, R.R.'s husband called Dr. Lee's office at approximately 3:00 p.m. According to R.R., she spoke to Brandi Melvin, now known as Brandi Harper (Ms. Harper), the medical assistant for Dr. Lee, and told her that she was running a fever of 101.8 degrees, did not feel well

and wanted Dr. Lee to call her. She testified that at that time, she did not feel well, was achy all over, had pain in her abdomen and had chills. R.R. testified that Ms. Harper told her to increase her Dilaudid in accordance with her prescription and to continue rotating Tylenol and Motrin. She denies being told to go to the emergency room if her fever did not go down, and denies being instructed to pick up a prescription for an antibiotic.

9. Brandi Harper is a medical assistant in Dr. Lee's office, and has been since 2004. She is a certified nurse's assistant and has completed a year and a half toward her registered nursing degree.

10. Part of Ms. Harper's duties include screening calls that come in from patients post-surgery. In doing so, she follows a set protocol that has been established in that office. In accordance with Dr. Lee's preferences, she inquires not only about the symptoms the patients report having, but also about symptoms they may not be having. Consistent with that protocol, she testified that, with respect to the call from R.R. and her husband, she asked whether R.R. was having any drainage from the incision; any abdominal pain; or was experiencing any other symptoms. Ms. Harper testified that R.R. did not report having any abdominal pain above expected soreness, and did not report difficulty breathing or shortness of breath; drainage from the incision; vomiting; bloating or distension of the abdomen. Ms. Harper's testimony is credited.

11. After receiving the telephone call from R.R., Ms. Harper wrote a note to Dr. Lee which referenced R.R. and stated, "[t]aking the cephalexin you gave her on discharge. Is running 102 temp, just sore. She has been rotating Tylenol and nothing has brought it down. Informed her to drink plenty of fluids. Do you want to add anything?"

12. Neither Ms. Harper's notes nor her testimony reflect that she told the patient to increase pain medication. Nor does the note reflect that R.R. wanted to speak with Dr. Lee.

13. Because Dr. Lee was seeing patients, Ms. Harper placed the note on his desk for his review. After reviewing the note, Dr. Lee wrote "Levaquin 500mg, #10, 1 a day." Ms. Harper then called the patient to tell her that a prescription was being called in for her and confirmed the pharmacy the patient used. At that time, consistent with the protocol established by Dr. Lee, she told R.R. or her husband that if the fever did not go down after two hours, to go to the emergency room at West Florida Hospital. She did not tell her to call the office back because, at the time of the return phone call, it was approximately 3:30 p.m. on a Friday afternoon, and in two hours the office would be closed.

14. Ms. Harper then called the prescription in to Burklow's Pharmacy, as identified by the patient, and noted the prescription in patient's medication log. She noted the time of the call and the name of the pharmacist with whom she spoke.

15. Ms. Harper did not note in the medical record that she advised the patient to go to the emergency room if her fever did not go down, and did not specifically note the return call to the patient. However, she plausibly explained that she could not call in the prescription to Burklow's without speaking to the patient, because there were two different pharmacies noted in her file previously. She also credibly testified that she always calls the patient back in conjunction with the call to the pharmacy, and gives standard instructions to post-operative patients regarding further action (in this case, going to the West Florida Hospital emergency room) should their condition not change. She does not necessarily document the return call because she does it so many times daily. Dr. Lee also testified that instructions to call back if the office is open or go to the emergency room if symptoms do not improve in a few hours is part of the standard protocol. Ms. Harper's and Dr. Lee's testimony is credited.

16. R.R. did not go to the emergency room over the weekend and there was no evidence that she ever called Dr. Lee's office back after the 3:00 Friday afternoon call. She continued to not feel well, however, and on Monday morning, December 19, 2005, at approximately 5:00 a.m., she woke up in intense pain between her shoulder blades. She went by ambulance to Santa Rosa Medical Center (SRMC). R.R. went to SRMC as opposed to West Florida

Hospital because it was much closer to her home. Dr. Lee does not have privileges at SRMC.

17. Although R.R. went to the emergency room early December 19, 2005, there was no determination that first day that she had a bowel perforation, and she was not admitted to the hospital until approximately 8:30 that evening. At the time of admission, she had a white blood count of 3.3, with a differential count of 12 neutrophil bands. The history and physical taken at the hospital and signed by Dr. Michael Barber, M.D., states in part:

> HISTORY OF PRESENT ILLNESS: [R.R.] is a 33-year-old, . . . who underwent abdominal surgery six days ago by Dr. John Lee at West Florida Hospital. She had bilateral salpingo-oophorectomy, partial omentectomy, appendectomy, and extensive adhesiolysis. . . . She states that although this surgery was prolonged and reportedly difficulty (sic), she tolerated the surgery well and by the second postoperative day was ambulating and voiding freely, tolerating a regular diet with a bowel movement and positive flatus. She stated her pain was well managed with 4 mg of Dilaudid q4h as needed. She was sent home on Cephalexin 500 mg q6h, Phenergan 25 mg q6h and Dilaudid 4 mg q6h. She was also on Hydrochlorothiazide for chronic hypertension, Klonopin and Effexor for anxiety and depression. She states that after going home she had some anorexia that was doing well until the morning of admission. She was awakened from her sleep at approximately 6 a.m. with remarkable abdominal distention and severe diffuse abdominal pain. She developed nausea as the pain progressed but has had no vomiting. She states that other than the bowel movement immediately post surgery, she had not had any bowel activity since discharge in six days. After several hours and worsening of pain,

> she presented to the emergency room at Santa Rosa Medical Center. On admission, a CT scan of the abdomen was accomplished and revealed a moderate volume loss infiltrate in the left lung base, apparent present to a lesser extent on the right. There was free air noted within the abdomen and also noted to be some free fluid. This was felt to be due to the patient's prior surgery, however, a more acute process could not be ruled out. There were also some distended loops of small bowel with apparent decompression of the distal small bowel which suggested at least a partial small bowel obstruction, although again, the diagnosis included ileus. A CT of the pelvis was unremarkable except as noted on the CT scan. There was some free fluid and free air within the pelvis. Since transfer to West Florida Hospital and the patient's attending physician could not be arranged, decision was made to admit to Dr. Barber on GYN service.
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> IMPRESSION: Severe abdominal pain 6 days post exploratory surgery with bilateral salpingo-oophorectomy, partial omentectomy, appendectomy and adhesiolysis. No signs at this time of active infection or perforation. The most likely diagnosis is a severe postoperative ileus, however, the patient warrants close observation.

18. An ileus occurs when the bowel is "asleep" and not moving. Dr. Barber transferred R.R. to the Intensive Care Unit overnight for close observation.

19. R.R.'s temperature at the time of admission was 96.8. The History of Present Illness taken from R.R. does not mention the rise in temperature following discharge from West Florida Hospital, or the phone call to Dr. Lee's office.

20. On December 20, 2005, Dr. Althar saw R.R. in consultation. At that time, her white count was 8.4 with 48 bands, indicating overwhelming sepsis. Dr. Althar took her immediately to surgery. Surgery revealed a bowel perforation of the sigmoid colon, and Dr. Althar performed a sigmoid colectomy, end colostomy, and Hartmann procedure. R.R. suffered some complications after surgery, which were not unexpected, and remained in the hospital until her discharge January 16, 2006.

21. The Department presented the expert testimony of Robert W. Holloway, M.D. Dr. Holloway graduated from Vanderbilt University Medical School; completed his residency in Obstetrics and Gynecology at the University of Alabama at Birmingham; and completed a fellowship in gynecology oncology at Georgetown University Hospital. Dr. Holloway has been licensed as a medical doctor in Florida since 1990, and is board certified in obstetrics and gynecology, and gynecologic oncology. He is currently the co-Medical Director of the Gynecologic Oncology program at the Florida Hospital Cancer Institute in Orlando, Florida, and a clinical instructor for the Obstetrics and Gynecology Residency Program at Orlando Regional Medical Center.

22. Dr. Holloway is in an office on the Florida Hospital campus, where there are four attending physicians and three follows in training. Fifty to 60 percent of his patients are oncology patients, with the remainder having benign issues.

23. Dr. Holloway opined that in this case, the bowel perforated most likely late Sunday evening or early Monday morning, probably 6-12 hours before R.R. woke up in extreme pain. He found no violation of the standard-of-care regarding the denuding of the serosa in the original surgery, viewing it as an anticipated outcome with a difficult case of endometriosis. However, he opined that Dr. Lee fell below the appropriate standard-of-care when he failed to evaluate the patient on Friday afternoon when she had a temperature of 102 degrees.

24. Dr. Holloway indicated that the most common indications of bowel perforation in post-operative patients are abdominal pain and fever. He knew of no cases where a perforation occurred with the patient presenting with fever alone. He also agreed that it is common for physicians to rely on their staff to triage patients, and to relay information back to patients. It is common, according to Dr. Holloway, for doctors to train staff to tell the patient to call back or go to the emergency room if a problem does not resolve itself, and staff normally does the majority of charting.

25. With respect to the directions to the patient to call back or go to the emergency room, Dr. Holloway could not say that those directions are always noted in the chart for patients in his office, although they frequently are. Most importantly, Dr. Holloway could not conclude that Ms. Harper did not give the instructions to R.R. because it was not specifically noted in the

chart, and he would be apt to give the staff the benefit of the doubt. He could not conclude from the absence of the note that proper instructions were not given.

26. Dr. Holloway also indicated that he did not believe the bowel had perforated as of Friday afternoon when the call was made to Dr. Lee's office.

27. Respondent presented the testimony of John Douglas Davis, M.D., who serves as the Director of Gynecology and Associate Residency Director of the Department of Obstetrics and Gynecology at the University of Florida College of Medicine. Dr. Davis graduated from medical school at Wake Forest University and received his post-doctoral training at the University of Florida. Dr. Davis is licensed as a medical doctor in the State of Florida, and has been board certified in obstetrics and gynecology since 1992. Ninety-five percent of his patients are gynecological patients.

28. Dr. Davis did not believe that Respondent violated the appropriate standard-of-care in his treatment of R.R. He opined that it is reasonable to rely on staff to perform triage functions with respect to calls from patients, and would interpret the note from Ms. Harper as not being indicative of bowel perforation. He testified that it was more likely to assume that the fever was caused by a pulmonary source, and the prescription for Levaquin was consistent with that assumption.

In addition, the CT scan upon admission to SRMC was consistent with findings of pneumonia, and in Dr. Davis' view, the eventual determination that the bowel perforated does not mean that pneumonia was not also present.

29. Like Dr. Holloway, Dr. Davis testified that bowel perforation does not present without severe abdominal pain, which was not reported to Dr. Lee. Dr. Davis opined that R.R.'s fever of 102 degrees must be interpreted in light of the patient's situation at discharge from the hospital, which Dr. Lee already knew. Most importantly, Dr. Davis testified that not seeing R.R. on Friday afternoon did not have an impact on her subsequent clinical course. His testimony is credited.

30. In summary, it is found that Ms. Harper did instruct the patient to go to the emergency room at West Florida Hospital should her symptoms not improve after a couple of hours with the new medication. Dr. Lee's reliance on her to give that instruction is within the standard-of-care for a reasonably prudent similar physician under similar conditions and circumstances.

CONCLUSIONS OF LAW

31. The Division of Administrative Hearings has jurisdiction over the subject matter and the parties to this action in accordance with sections 120.569 and 120.57(1), Florida Statutes.

32. This is a proceeding to take disciplinary action against Respondent's license to practice as a physician. Because of the penal nature of these proceedings, the Department has the burden of proving the allegations in the Administrative Complaint by clear and convincing evidence. Dep't of Banking and Fin. v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987). As stated by the Supreme Court of Florida,

> Clear 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 lacking in confusion as to the facts in issue. The evidence must be of such a 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.

In re Henson, 913 So. 2d 579, 590 (Fla. 2005), quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

33. Moreover, in disciplinary proceedings, the statutes and rules for which a violation is alleged must be strictly construed in favor of Respondent. Elmariah v. Dep't of Prof'l Reg., 574 So. 2d 164 (Fla. 1st DCA 1990); Taylor v. Dep't of Prof'l Reg., 534 So. 2d 782, 784 (Fla. 1st DCA 1988).

34. The Administrative Complaint states in pertinent part:

> 16. Section 458.331(1)(t), Florida Statutes (2005), subjects a doctor to discipline for committing malpractice as defined in section 456.50. Section 456.50, Florida Statutes (2005), defines medical malpractice as the failure to practice medicine in accordance with the level of care, skill, and treatment

> recognized in general law related to health care licensure.
>
> 17. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes (2005), defines the standard of care to mean ". . . The 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. . . ."
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> 18. Respondent failed to meet the standard of care recognized by a reasonably prudent similar physician under similar circumstances by failing to have Patient R.R. evaluated, either by himself/herself or an emergency room physician, within 12 to 24 hours after the patient called on December 16, 2005, complaining of a temperature of 102, in order to rule out a pelvic abscess.
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> 19. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes.

35. The Department has failed to meet its burden of proof.

36. This case rests on the evaluation of the telephone call(s) on Friday, December 16, 2005, between R.R. and Ms. Harper of Dr. Lee's office. There is no question that the two versions of the telephone exchange are irreconcilable, and that the witnesses were asked to remember details of a conversation taking place over five years ago. After careful review of the complete record, there is not clear and convincing evidence that Ms. Harper did not tell R.R. to pick up a prescription for

Levaquin and that, if the fever did not respond within about two hours, to go to the emergency room.

37. R.R.'s experience was no doubt traumatic and life-changing. However, her description of the telephone call simply does not correspond with what written record there exists of the exchange. Nor does her account fit with the patient history she gave upon admission at SRMC, where she apparently reported that she was doing well until her admission the morning of December 19, 2005. By contrast, Ms. Harper's account was straightforward and logical, and consistent with her contemporaneously recorded notes to Dr. Lee, to the patient record and to the medication log. Her explanation of the protocol she follows and the directions she routinely provides to post-surgical patients was consistent with the testimony of Dr. Lee regarding the protocol he wants followed.

38. The Department suggests that her testimony should be rejected because she admitted that she did not remember the conversation "verbatim." However, most people would not remember a conversation verbatim ten minutes after it occurs, much less five years later. The more important question would be whether she had an independent recollection of the events related to the phone call: a question that was not asked of her.

39. The Department placed great significance on the fact that, while the medical record indicated that a prescription for Levaquin had been called in to the pharmacy, the record did not

specifically state that Ms. Harper called the patient back and advised her to go to the emergency room if she saw no results within a couple of hours. However, the Department has not charged Respondent with failing to maintain medical records to justify the course of treatment, in violation of section 458.331(1)(m). A licensee cannot be disciplined for a violation not charged. Trevisani v. Dep't of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005); Ghani v. Dep't of Health, 714 So. 2d 1113 (Fla. 1st DCA 1998); and Willner v. Dep't of Prof. Reg., 563 So. 2d 805 (Fla. 1st DCA 1990).

40. Here, both experts testified that it is not unusual for staff to triage patients and make return phone calls such as the one at issue in this case. Dr. Holloway testified that, given the testimony of Dr. Lee and Ms. Harper, he would give them the benefit of the doubt, and both experts stated that the fact that the details of the return call were not documented did not mean that the return phone call and the directions to go to the emergency room did not take place.

41. It is possible that, given the amount of pain medication and the fever she was experiencing, R.R. simply did not hear the instructions to go to the emergency room if her symptoms did not improve. That being said, had her symptoms continued and had she followed the advice to go to the emergency room, she would have been evaluated within the 12-24 hours Dr. Holloway indicated would be appropriate.

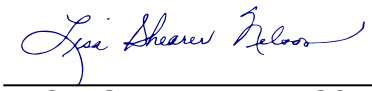
42. In any event, the undersigned accepts as credible the opinion of Dr. Davis who testified that Dr. Lee's actions did not fall below the accepted standard-of-care. Based on the record presented, the facts taken as a whole do not present clear and convincing evidence that Dr. Lee violated section 458.331(1)(t) as alleged in the Administrative Complaint.

RECOMMENDATION

Upon consideration of the facts found and conclusions of law reached, it is

RECOMMENDED that the Florida Board of Medicine enter a Final Order dismissing the Administrative Complaint in its entirety.

DONE AND ENTERED this 23rd day of September, 2011, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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This 23rd day of September, 2011.

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.