STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 14-1115PL

KENNETH RIVERA-KOLB, M.D.,

Respondent.
_______________________________/

RECOMMENDED ORDER

On September 3, September 30, and October 22, 2014, a hearing was held by video teleconference or webcast at locations in Lauderdale Lakes, Fort Lauderdale, and Tallahassee, Florida, before F. Scott Boyd, an Administrative Law Judge assigned by the Division of Administrative Hearings.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent: (1) failed to keep proper medical records; (2) committed medical malpractice; or (3) knowingly performed professional responsibilities which he knew he was not competent to perform, as set forth in the Administrative Complaint, and if so, what is the appropriate sanction.

PRELIMINARY STATEMENT

On June 24, 2011, Petitioner, Department of Health ("Department" or "Petitioner"), issued an Administrative Complaint against Respondent, Kenneth Rivera-Kolb, M.D., ("Dr. Rivera-Kolb" or "Respondent"). The three counts of the complaint all related to Dr. Rivera-Kolb's provision of medical care at an office surgery facility to a single patient, J.D., who subsequently died at a hospital. Dr. Rivera-Kolb disputed allegations of fact in the complaint and requested a formal hearing. An unopposed Motion to Relinquish Jurisdiction was granted on September 18, 2013. After six months, motions to re-open the file and to consolidate the pleadings were filed, which were granted on March 17 and 19, 2014, respectively. The parties submitted a Joint Pre-hearing Stipulation. The facts stipulated therein are accepted and are made a part of the Findings of Fact below.

After continuance, the final hearing took place on September 3, September 30, and October 22, 2014. The Department offered the testimony of two witnesses: Respondent, Dr. Rivera-Kolb; and Orlando G. Florete, Jr., M.D., who was accepted as an expert in anesthesiology over objection of Respondent. The Department also offered twelve exhibits. Exhibits P-1 through P-10 were accepted into evidence without objection. These included the deposition of Roberto Moya, M.D., unavailable as a live witness, who had provided medical care to Patient J.D. The deposition of Dr. Carl Noback was admitted over objection as Exhibit P-11 for the limited purpose of impeaching the credibility of Respondent following his testimony at hearing. Following agreement by the Department to identify those portions of the deposition of Dr. Rivera-Kolb on which it intended to rely, Dr. Rivera-Kolb's deposition was accepted as Exhibit P-12, over objection. Respondent offered the testimony of Mr. Xavier Escobar, formerly a licensed chiropractor, and that of Dr. Rivera-Kolb on his own behalf. Respondent also offered two exhibits, R-1 and R-2, both depositions of Mr. Kenneth Whalen, medical consultant.

The parties were instructed to submit proposed recommended orders within ten days after the transcript was posted to the docket. At hearing, the Department's counsel stated she would be

strongly opposed to any extension of that time, because she was scheduled to undergo surgery on December 11, 2014.

The three-volume final hearing Transcript was filed on November 24, 2014. Petitioner timely filed a Proposed Recommended Order on December 4, 2014. It was considered in preparation of this Recommended Order. Respondent filed a Proposed Recommended Order on December 9, 2014, five days after the deadline. On the following day, December 10, 2014, Respondent filed a Motion for Enlargement of Time to File Respondent's Proposed Recommended Order. Respondent's motion for enlargement of time was not received prior to the expiration of the deadline sought to be extended, as required by Florida Administrative Code Rule 28-106.204(4) (2014). Respondent averred that Respondent's counsel's mother was seriously injured and hospitalized and that Respondent's counsel suffered a bout of vertigo. Petitioner's Motion to Strike Respondent's Proposed Recommended Order and Petitioner's Response to Respondent's Motion for Enlargement of Time to File Respondent's Proposed Recommended Order were considered; however, no prejudice to Petitioner was found, and Respondent's Proposed Recommended Order was considered.

Unless otherwise indicated, citations to the Florida Statutes or rules of the Florida Administrative Code refer to the

versions in effect on June 25, 2008, the date that violations were allegedly committed.

FINDINGS OF FACT

1. The Department is the state agency charged with regulating the practice of medicine pursuant to section 20.43, chapter 456, and chapter 458, Florida Statutes (2014).

2. At all times material to the complaint, Dr. Rivera-Kolb was a licensed medical doctor within the state of Florida, having been issued license number ME 40201.

Events of June 25, 2008

3. On June 25, 2008, Patient J.D., a 43-year-old female, was scheduled for multiple procedures at Florida Atlantic Orthopedics ("the facility"). The procedures included a two-level discogram by Dr. Thomas Rodenberg, followed by a two-level lumbar discectomy by Dr. Roberto Moya, followed by a bilateral L3 to S1 facet radiofrequency lesioning by Dr. Rodenberg.

4. On June 25, 2008, Dr. Rivera-Kolb was working at the facility. As he testified, he had been hired to "harvest information" in personal injury cases such as slip and falls or automobile accidents. He would routinely perform physical examinations, develop full medical histories, and "proceed to follow a certain pattern of doing x-rays, doing certain tests at different agreed times, to comply with regulations imposed on the PI industry." Dr. Rivera-Kolb would also render primary health

care and provide patients with anti-inflammatories and muscle relaxants as necessary.

5. As indicated by a "Pre-Op" form dated June 25, 2008, and signed with the name "L. Lerfald, R.N." in the "Signature of Nurse" block, on that morning Nurse Lerfald took various vital signs of J.D. and recorded them at 10:50 a.m. At that time, J.D. was given 8 mg of hydromorphone and 20 mg of Valium.

6. Dr. Rodenberg, an anesthesiologist at the facility, placed a central intravenous line ("IV") in J.D.'s left jugular.

7. Dr. Rivera-Kolb assumed the responsibility of monitoring J.D. and preparing an "Anesthesia Record" during the two-level discogram procedure that was to be performed first. J.D. had been a patient of Dr. Rivera-Kolb's in the weeks before the procedures, and he was aware that she had accelerated hypertension (very high blood pressure). Dr. Rivera-Kolb sat at the head of the operating table, monitored J.D.'s vital signs, and filled out the Anesthesia Record, while Dr. Rodenberg performed the discogram. Dr. Rivera-Kolb then left the operating room. The second procedure, the two-level lumbar discectomy, was performed by Dr. Moya, with Dr. Rodenberg as anesthesiologist.

8. Dr. Rivera-Kolb returned to the operating room after the discectomy and resumed the responsibility of monitoring J.D. for the third procedure, the facet radiofrequency lesioning, which was performed by Dr. Rodenberg.

9. When Patient J.D. was ready to be moved from the operating room to the Post Anesthesia Care Unit ("PACU"), she became unresponsive, with an oxygen saturation of 60 percent and a heart rate of 30.

10. Dr. Rivera-Kolb was the only physician present with the operating room staff when these changes occurred. In a written statement he later submitted to Mr. Robert Yastremzki, medical investigator at the Department of Health, Dr. Rivera-Kolb wrote:

> She was lying prone on the OR table. The moment she was overturned to a supine position on the gurney, the oxygen saturation alarm went off. There was an abrupt drop in blood pressure and pulse. The OR staff and I made sure all connections were in place. When it was corroborated that all connections were intact, I summoned Dr. Rodenberg to the OR as I reached for ventilation mask to improve oxygen delivery. The symptoms she displayed were consistent with a vasovagal syndrome secondary to local anesthetics injected in the cervical area during the procedure, which is not an uncommon complication.

11. The parties stipulated that Patient J.D. went into full cardiac arrest, and Dr. Rodenberg was emergently called back to the operating room.

12. Dr. Rodenberg arrived almost immediately.

13. J.D. received cardiopulmonary resuscitation ("CPR"), atropine by IV, and a laryngeal mask airway ("LMA"). The left jugular IV appeared to be infiltrated, so Dr. Rodenberg placed a new external jugular line on the right side. After J.D.'s vital

signs were stabilized, Dr. Rodenberg replaced the LMA with an orotracheal tube.

14. J.D. was now breathing spontaneously and saturating in the high 90's, and Dr. Rodenberg directed that she be moved to the PACU.

15. Dr. Rivera-Kolb and Nurse Lerfald moved J.D. to the PACU. Once there, her head was elevated. Shortly thereafter, Nurse Lerfald noticed that the left side of J.D.'s face was beginning to swell. Dr. Rodenberg was called back again. When Dr. Rodenberg arrived in the PACU a minute later, J.D.'s face was completely swollen. Dr. Rodenberg assumed control of J.D.'s care. He concluded that the swelling was angioedema and felt that anaphylactic shock was imminent. He detected a faint pulse and directed that the patient be returned to the operating room, where she was placed on a ventilator. A few moments later, no pulse was present, and CPR was begun a second time. J.D. was given epinephrine and atropine, and "911" was called. Dr. Moya was called in to assist.

16. When Dr. Moya arrived, he concluded that the subcutaneous emphysema was secondary to the IV lines in J.D.'s jugulars and that J.D. had bilateral apical pneumothorax. He immediately placed chest tubes, first into the right side, and then the left. When the right chest tube was placed in water to create a negative pressure, clear fluid and gas came out. When

the left chest tube was done, white milky fluid and gas were discharged. The Boca Fire and Rescue arrived and resuscitation efforts continued for approximately 25 minutes, after which blood pressure and heart rate were restored. J.D. was then transported to Boca Community Hospital.

17. Pharmacy bills reflect that both midazolam (Versed) and propofol were signed out for use in Patient J.D.'s procedures on June 25, 2008.

18. Dr. Rivera-Kolb signed the Anesthesia Record for the discogram procedure.[1/] It indicated that the anesthesia and surgery started at 11:25 a.m. and ended at 11:55 a.m. Under a section entitled "Technique," the form provided check blocks to choose the anesthesia that was used: "General"; "Epidural"; "Spinal"; "Axillary Blk"; or "Other." The block on the form next to "Other" was checked, followed by the hand-written notation "MAC local." The form reflects oxygen saturation levels of 95 and 96 for two consecutive 15-minute periods. It records other readings every five minutes. It indicates systolic blood pressure at levels of 160 and 170 and diastolic blood pressure ranging from 90 to 110. It records a respiration rate of between 10 and 20 and a heart rate between 80 and 90. It does not indicate what, if any, drugs were administered during the procedure. It does not indicate any temperature readings, breath sounds, or EKG readings.

19. Dr. Rivera-Kolb signed his name on the Anesthesia Charge Sheet on the line labeled "Anesthesiologist 1."[2/] This sheet indicates that Dr. Rodenberg was the "Surgeon/Referring MD." It shows Current Procedural Terminology (CPT) codes of "66290 x2," indicating two "lumbar discograms," and "77003," indicating "flouroscopic guided--spine." In the row marked "ASA Physical Modifiers," the notation "P3" is circled. The sheet indicates the procedure was to be conducted with "MAC" anesthesia. It indicates that the pre-op interview was begun at 11:05 a.m. and ended at 11:12 a.m., that the surgery started at 11:20 a.m. and ended at 12:00 p.m., and that anesthesia also started at 11:20 a.m. and ended at 12:00 p.m.

20. Dr. Rodenberg prepared and signed two different Anesthesia Records. Each recorded information for both the discectomy and facet radiofrequency lesioning procedures, even though Dr. Rodenberg performed the facet lesioning procedure himself and so could not appropriately also have performed the duties of anesthesiologist for that procedure.[3/] Each of these forms indicates that the surgeries started at 12:04 p.m. and ended at 13:14 p.m., that the patient was in the PACU at 13:20 p.m., and that anesthesia started at 12:01 p.m. and ended at 13:24 p.m.

21. There are differences in the two forms, however. In the section entitled "Technique," the first form has "MAC"

written in next to the "Other" block, while the second form has "MAC local" written in this space.[4/] In addition to the drugs shown as administered on the first form, the second form also shows the administration of what appears to read "Depo Medrol" and "epinephrine." Neither form documents the administration of either midazolam or propofol. Neither form records any patient temperature readings or breath sounds. While the first form records the last reading of blood pressure and heart rate at 13:15 p.m., the second form shows additional readings taken at 13:20 p.m., which reflect a considerable drop in heart rate to 40, a drop in systolic blood pressure to 75, and a drop in diastolic blood pressure to 20. The second form also contains hand-written notations in the "Remarks" area of the form which appear to read "postop instability," "See Nursing Notes," "See separate dictation(s)," "1324," and "intubated to PACU SR->sat 96%." In the "Post Op Visit" area of the second form a box marked "Complications" is also checked.

22. A hand-written note in J.D.'s file reads as follows:

> Dr[.] Noback
>
> Escobar wanted me to leave this for you. The record was corrected after the fact due to disconnected IV so there might be two slightly different versions.
> You may call if this is confusing in any way
>
> Dr. Rodenberg

Assuming that this note was made with respect to the two different Anesthesia Records, it does not provide an adequate explanation of all of the differences in the forms. Most significantly, the second form includes notations at 13:20 p.m. reflecting significant changes in J.D.'s blood pressure and heart rate, and reference to her post-operative instability and complications. These differences would not be explained by a disconnected IV, and the note does not otherwise explain them.

23. There is, however, only one Anesthesia Record prepared and signed by Dr. Rivera-Kolb in J.D.'s medical records. Dr. Rivera-Kolb testified repeatedly at hearing that this form pertained to the third procedure, that is, the facet radiofrequency lesioning.[5/] Dr. Rivera-Kolb's testimony on this point is rejected as not credible. The times indicated on the Anesthesia Record he signed are those of the first procedure, the two-level discogram, and are consistent with the time of the pre-operation procedures as documented on the form signed by Nurse Lerfald, with the Anesthesia Charge Sheet also signed by Dr. Rivera-Kolb, and with the times indicated on the Anesthesia Records prepared by Dr. Rodenberg for the second and third procedures.

24. While Dr. Rivera-Kolb insisted that he prepared and kept an Anesthesia Record for the facet radiofrequency lesioning, he offered differing accounts with respect to that form.

Dr. Rivera-Kolb's written statement to the medical investigator notes that J.D. was finally stabilized and sent to the hospital, and then continues:

> In the aftermath of the above described events, I returned to the OR and noticed the anesthesia sheet that I had used to tabulate the vital signs for Dr. Rodenberg was left on the anesthesiologist's table. I retrieved the data and went to the administrative office to hand him the document. Dr. Rodenberg was in the administrator's office with Dr. Moya and Dr. Escobar so I waited outside until their conference was over. As I handed the document to the records keeper Johan Castenada, Dr. Rodenberg exited the office. When I told him that I was placing the document on the operative record, he instructed me to destroy the record. He stated that it was unnecessary for me to get involved in this case since he had been monitoring the patient from his position in the OR and he did not need my tabulations. I was hesitant to destroy the records and asked Dr. Escobar for advice in the matter. Dr. Escobar insisted that I place the recorded data in the operative records where it stands now. He also advised me to file an incident report which I did.

25. Yet in his deposition, Dr. Rivera-Kolb testified that he did not initially record the numbers on the Anesthesia Record, but instead entered them on a Progress Note form:

> I asked him first, where's the anesthesia sheet? He responded, you know, I don't want you writing in my official documents. And then I was concerned that this could have been a Monitored Anesthesia Care case, I was going to ask him what--if there had been any changes but he said to me, this is still no anesthesia, local only case, like I told you before.
>
> * * *

> I looked for an anesthesia sheet. They told me they're supposed to be there. I opened a few drawers. I found a progress note and I wrote it on a progress note paper and later transferred it to this page [referencing the Anesthesia Record for the earlier discogram procedure].
>
> * * *
>
> I had finished all the numbers in the monitors, yes. I had finished them all but I had to go to another room to transfer it to an anesthesia sheet that I found, you know, when I asked one of the circulating nurses.

26. If the Anesthesia Record for the facet radiofrequency lesioning was not created in the operating room, but was created later in another room from notes made on a Progress Note sheet, the Anesthesia Record could not have been left on the anesthesiologist's table in the operating room following the third procedure.

27. It is undisputed that Dr. Rivera-Kolb sat at the head of the table for the first and third of J.D.'s procedures on June 25, 2008. Numerous medical records of J.D. prepared at or near the time of her procedures provide clear and convincing evidence that the procedures were to be conducted under MAC. The Anesthesia Record dated June 25, 2008, and signed at the bottom by Dr. Rivera-Kolb indicates "MAC local." A Pre-Anesthesia Evaluation form dated June 25, 2008, indicates "MAC w/ GA b/u" after the words "anesthetic plan." The two different Anesthesia Records prepared by Dr. Rodenberg indicate either "MAC" or "MAC

local." The Operative Report prepared by Dr. Moya dated June 25, 2008, and describing the second and third procedures, identifies Dr. Rodenberg as anesthesiologist and references "local MAC anesthesia." A Progress Notes form dated June 26, 2008, indicates "Anesth Rivera MD (MAC)." An Anesthesia Charge Sheet dated June 25, 2008, prepared for the discogram indicates the procedure is to be conducted under "MAC" and is signed by Dr. Rivera-Kolb as "Anesthesiologist 1." The Anesthesia Charge Sheet dated June 25, 2008, prepared for the discectomy and facet radiofrequency lesioning indicates that the anesthesia is "MAC" and shows an anesthesia start time of 12:01 p.m. and an anesthesia end time of 13:24 p.m. A Florida Atlantic Orthopedics form dated June 25, 2008, and signed by Nurse Lerfald shows "MAC," indicates the anesthesiologists as Dr. Rodenberg and Dr. Rivera-Kolb, and notes that anesthesia starts at 11:25 a.m. and ends at 13:14 p.m.

28. Dr. Rivera-Kolb's argument that all of these references to MAC surgery should be ignored because the records might have been altered by Dr. Rodenberg is rejected. If Dr. Rodenberg had an opportunity to alter the records, it is not clear why he would not have simply replaced the Anesthesia Record rather than write a note to Dr. Noback. Even if Dr. Rodenberg did have an opportunity to alter the records, however, there is no apparent motive for him to systematically alter numerous documents

prepared by different individuals to indicate that the surgeries were MAC if they were not, or any evidence that he did so. Mr. Escobar's testimony in general and, on this point in particular, was not credible.

29. The documents prepared at or near the time of J.D.'s procedures are credited over other documents prepared after the procedures were completed, which were less consistent. A Physician Office Incident Report, which appears to have been stamped as received by the Department of Health on August 11, 2008, states that "[p]atient underwent lumbar discography, percutaneous discectomy, and facet ablation under local anesthesia." Dr. Rivera-Kolb's statement for the medical investigator, dated March 2, 2010, states that "Dr. Rodenberg, the anesthesiologist, requested that I monitor the patient's vital signs and post them in the anesthesia record sheet while he performed minimally invasive procedures under local anesthesia with Monitored Anesthesia Care." Dr. Moya, in his August 21, 2014, deposition, testified, "Well, at that stage of the procedure [the discography], which is done solely under local anesthesia, the person assigned by the anesthesiologist would be someone that looks at the graphs and makes sure that all is within normal limits." Dr. Moya went on to state that Dr. Rodenberg was always the anesthesiologist for all three procedures.

Standards

30. Dr. Orlando G. Florete, Jr., holds active and valid Florida Physician's License No. ME 0058430. He is a specialist in anesthesiology with a subspecialty in pain management. He is Board certified in anesthesiology, is a Diplomate of the American Board of Anesthesiology, and was recently elected as president of the Florida Society of Interventional Pain Physicians. He practices anesthesiology on a regular and routine basis at the Jacksonville Surgery Center. He is also the medical director of a pain management office at the Baptist Hospital in Jacksonville. He has been engaged by the U.S. Department of Justice as a consultant and is an expert medical advisor for the Florida Department of Labor and Employment Security and for the Florida Department of Health. He served as clinical assistant professor in the Departments of Anesthesiology and Medicine at the University of Florida, College of Medicine, from 1994 until 2000, where he trained residents, fellows, and medical students. He has recently been engaged by the university to teach again in the field of anesthesia and pain management.

31. Dr. Florete is an expert in anesthesiology and has knowledge, skill, experience, training, and education in the prevailing professional standard of care recognized as acceptable and appropriate by reasonably prudent anesthesiologists in Florida.

32. No evidence was presented that Dr. Florete has been recently engaged in active clinical practice, consultation, the instruction of students, or a clinical research program in the general practice of medicine.

33. Dr. Florete conducted a complete review of records provided to him by the Department pertaining to J.D.'s medical treatment on June 25, 2008, including records prepared by Dr. Rivera-Kolb, Dr. Rodenberg, Dr. Moya, Mr. Escobar, and Nurse Lerfald. He also reviewed the depositions of Dr. Moya and Dr. Rivera-Kolb and heard live testimony from Dr. Rivera-Kolb.

34. As Dr. Florete testified, under the American Society of Anesthesiologist's physical status classification system, a patient classified as "P2" is a patient with systemic disease with mild limitation. A classification of "P3" means that the patient has significant or severe systemic disease with definite severe systemic or physical dysfunction. As Dr. Florete testified, the classification of a patient has an impact on the procedure and type of anesthesia used; so, an anesthesiologist must know the physical status of the patient.

35. As Dr. Florete testified, midazolam is a generic name for Versed, in the benzodiazepine class, that is a very potent intravenous sedative that can produce amnesia and loss of consciousness. Propofol, in a one percent emulsion, is a milky-colored intravenous anesthetic that can promote rapid loss of

consciousness. Dr. Florete testified, and it is found, that Versed and propofol are the most commonly used combination under monitored anesthesia care to produce that unique level of sedation that allows the surgeon to perform surgery without the patient being agitated, moving, or crying out.

36. As Dr. Florete explained, the acronym "MAC" stands for "monitored anesthesia care." Monitored anesthesia care is a type of anesthesiology in which a qualified anesthesiologist monitors the patient. MAC requires an anesthesiologist to monitor physiological variances of the patient, such as rising blood pressure, increase of heart rate, loss of airway, or agitation in the patient. In MAC, the anesthesiologist must determine what level of anesthesia is advisable and be prepared to administer the medications to induce deep sedation as required. As Dr. Florete testified, a nurse may "tabulate" a patient's oxygen levels, breathing, circulation, and temperature in a case involving only local anesthesia, but simple tabulation of these vital signs by a nurse is not permitted in a MAC case because a nurse is not qualified to make the required judgments. Only an anesthesiologist is authorized to perform monitoring in a MAC case or to fill out an Anesthesia Record. As Dr. Florete testified, a person who assumes the position at the head of the table monitoring a patient in a case of monitored anesthesia care assumes the responsibilities of an anesthesiologist.

37. As Dr. Florete testified, the prevailing professional standard of care requires an anesthesiologist to perform a physical examination of the patient and review the history of the patient prior to MAC. An anesthesiologist must keep records that document the pre-operative medical examination; indicate the type of anesthetic technique employed; indicate the start and end times of anesthesia; record the patient's vital signs over time; and indicate who provided anesthesia to the patient and when. An anesthesiologist must stay with the patient after a procedure until the patient is safely delivered into the PACU.

38. Dr. Florete testified that in a MAC case, it would be a violation of the prevailing professional standard of care for a single person to both perform surgery and attempt to act as anesthesiologist for that same procedure. In a local anesthesia case, a single person could perform both roles.

39. Dr. Florete testified that because Dr. Rivera-Kolb was not an anesthesiologist he "had no business" filling out an Anesthesia Record. Dr. Florete credibly testified that in his opinion, Dr. Rivera-Kolb's actions in monitoring Patient J.D. during surgical procedures that he knew or should have known were to be conducted under MAC and in preparing the Anesthesia Record for a procedure constituted the acceptance and performance of the responsibilities of an anesthesiologist, which Dr. Rivera-Kolb was not competent to perform.

Medical Records

40. As Dr. Florete testified, in assuming the responsibility to perform the professional duties of an anesthesiologist, it was incumbent upon Dr. Rivera-Kolb to keep complete and accurate Anesthesia Records that documented a pre-operative medical examination of J.D.; indicated the type of anesthetic technique that was employed; indicated the start and end times of the anesthesia; recorded J.D.'s vital signs over time; and indicated who provided anesthesia to her and when.

41. While Dr. Rivera-Kolb did prepare an Anesthesia Record for the discogram, it failed to record any temperature readings, breath sounds, or EKG readings. As Dr. Florete testified, this Anesthesia Record was incomplete. As for the facet radiofrequency lesioning procedure, it is clear that Dr. Rivera-Kolb, contrary to his testimony, did not keep an Anesthesia Record containing a complete and accurate report of J.D.'s vital signs or documenting who provided anesthesia and when.

42. As Dr. Rivera-Kolb admitted in his testimony, he was the only physician present after the third procedure when J.D. began to exhibit bradycardia and desaturation. Yet he did not document his evaluation of these events in J.D.'s medical records to justify his treatment of J.D. There was no evidence that Dr. Rivera-Kolb conducted a complete physical examination at the time of either the first cardiac arrest in the operating room, or

the second cardiac arrest in the PACU. Dr. Rivera-Kolb was present and assisting in the medical treatment of J.D. through two procedures and during two cardiac arrests; yet, the only medical records kept by Dr. Rivera-Kolb were those pertaining to the first procedure. While Dr. Rivera-Kolb maintained that he completed an incident report, this testimony is rejected as not credible. No such report is found in J.D.'s medical records, and Dr. Rivera-Kolb's suggestion that Dr. Rodenberg may have removed it for some unknown reason is only unsupported speculation.

43. There is clear and convincing evidence that Dr. Rivera-Kolb failed to keep legible medical records that justified the course of treatment of Patient J.D., including Anesthesia Reports and records of his evaluations.

44. Dr. Rivera-Kolb was charged with violating the standard of care both in performing as an anesthesiologist during J.D.'s procedures and in assisting in treatment of her complications afterwards. He failed to keep medical records reflecting his participation in the treatment of J.D. for either of those times.

45. The Department did not show that in earlier discipline, Dr. Rivera-Kolb was found to have failed to keep medical records.

Medical Malpractice

46. Dr. Rivera-Kolb assumed the responsibility of monitoring J.D. and preparing Anesthesia Records, thereby

practicing as an anesthesiologist when he was not competent to do so.

47. As Dr. Florete testified, the prevailing professional standard of care for a given health care provider is 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.

48. In assuming the responsibilities of an anesthesiologist, Dr. Rivera-Kolb is held to the standards recognized by reasonably prudent anesthesiologists.

49. The Department proved that Dr. Rivera-Kolb did not complete a residency, have adequate training, and did not have board certification in anesthesia, all of which Dr. Rivera-Kolb himself admitted. As Dr. Florete testified, a general practitioner engaged in providing anesthesia care would not meet the prevailing professional standard of care.

50. In evaluating Dr. Rivera-Kolb's actions after the three procedures that were performed on J.D., however it was not clearly shown that Dr. Rivera-Kolb continued to act as an anesthesiologist. To the contrary, it appears that Dr. Rivera-Kolb performed as an anesthesiologist during the procedures themselves, in part, because he knew that the surgeon was an anesthesiologist. After the procedures, Dr. River-Kolb resumed

the role of a general practitioner, deferring to Dr. Rodenberg and Dr. Moya, and even acting at their direction.

51. The prevailing professional standards of care applicable to the general practice of medicine with respect to J.D.'s post-operative complications were not established. Dr. Florete did testify that, as an "intensivist" who used to "run codes" for some hospitals in Jacksonville, he was familiar with emergency and critical care procedures. He also testified that "any medical doctor" should be able to diagnose pneumothorax "within one minute," because air trapped under the skin produces bulges or swelling which when pressed produces an unmistakable "crackling" sound as the gas is pushed through the tissue. He provided compelling testimony as to the proper diagnosis and treatment of pneumothorax. However, it was not shown that Dr. Florete was qualified to give expert testimony regarding the prevailing standards of care for a general practitioner.[6/]

52. Moreover, even if these had been established as the prevailing professional standards of care applicable to a general practitioner, it is not clear that they were violated by Dr. Rivera-Kolb in his treatment of Patient J.D. on June 25, 2008.

53. Dr. Rivera-Kolb was charged with failing to fully evaluate the cause of the bradycardia and the desaturation once the first cardiac arrest occurred. The evidence showed that

Dr. Rivera-Kolb immediately put a mask over J.D. and began to ventilate her. Dr. Rodenberg arrived within one minute and assumed control over the situation. Dr. Florete credibly testified that because of training and experience, an anesthesiologist should take the lead in such "code" situations, followed by the surgeon, and finally a general practitioner. It was therefore appropriate for Dr. Rivera-Kolb to defer to Dr. Rodenberg when he arrived. The evidence did not show that before Dr. Rodenberg arrived, there was sufficient time for Dr. Rivera-Kolb to have performed a complete physical examination of J.D. or to auscultate J.D.'s lungs, even if he had had a stethoscope, which he testified that he did not. There is no evidence that in this brief period of time, Dr. Rivera-Kolb caused any significant delay in recognizing the evolving medical emergency or in beginning treatment of J.D.

54. Dr. Rivera-Kolb was also charged with medical malpractice in connection with the treatment of Patient J.D. after she had been stabilized following the first cardiac arrest and moved to the PACU. The Department alleges that Dr. Rivera-Kolb misdiagnosed J.D.'s condition, failed to identify the pneumothorax, and caused delay of treatment. One allegation of misdiagnosis stems from the written statement provided to the Department's medical investigator, as quoted earlier:

> The symptoms she displayed were consistent with a vasovagal syndrome secondary to local

> anesthetics injected in the cervical area during the procedure, which is not an uncommon complication.

Dr. Florete did testify that vasovagal syndrome could be drug induced. However, contrary to Dr. Rivera-Kolb's statement, it is clear that no local anesthetic would have been administered intravenously through J.D.'s jugular for her procedures. The statement therefore fails to provide an explanation of J.D.'s condition to that extent. In his deposition, Dr. Rivera-Kolb admitted this, testifying that he became confused when writing the statement "two years later." He said that he was thinking that perhaps the jugular IV had pulled away from the vein and was "dripping all those chemicals" into her. Dr. Rodenberg did in fact conclude that the left jugular IV was infiltrated, which is why he inserted the second external jugular line into J.D.'s right side. In any event, Dr. Rivera-Kolb's statement was written some 20 months after the event. It is not clear that Dr. Rivera-Kolb's statement was his diagnosis on June 25, 2008. It may have been that the analysis in his statement was simply Dr. Rivera-Kolb's recollection of Dr. Rodenberg's diagnosis or simply his own opinion in looking back at the events of that day.

55. Another allegation of misdiagnosis is predicated on Nurse Lerfald's identification of J.D.'s facial swelling. Nurse Lerfald went to get Dr. Rodenberg as soon as she noticed it. Patient J.D.'s face was "completely swollen" when they returned,

and Dr. Rodenberg immediately assumed control of her treatment. However, there is scant evidence as to how much time passed between the time the swelling was first noticed and the time Dr. Rodenberg arrived. Nurse Lerfald's statement doesn't discuss it. Dr. Rodenberg's statement notes only that when he was called back to the PACU "[a]bout ten minutes had elapsed since the initial period of instability," with no mention of how long it took him to respond after he received the summons. Dr. Rivera-Kolb testified in his deposition that after the swelling was noticed, he put the head of J.D.'s bed down and pushed the endotracheal tube down, saying "[i]t took about less than a minute" before Dr. Rodenberg arrived. While Dr. Florete also testified that it should take "less than a minute" to diagnose pneumothorax from observation of the swelling, it was not clearly shown that Dr. Rivera-Kolb had even that much time before Dr. Rodenberg assumed control for the second time.

56. It is clear that once the pneumothorax was identified, it should have been immediately treated by inserting a large-bore needle into each side of the chest to allow the air to escape while waiting to place the chest tubes.

57. The failure of Dr. Rivera-Kolb to insert such needles immediately after the diagnosis was also alleged to constitute malpractice. But, it is undisputed that the pneumothorax was identified by Dr. Moya; after which diagnosis, Dr. Moya

immediately began to insert the chest tubes. The diagnosis and treatment occurred very close in time. It was not clear from the evidence that there was any "wait" time after the diagnosis but prior to Dr. Moya's insertion of the tubes in which Dr. Rivera-Kolb could have acted, even assuming it was appropriate for him, as a general practitioner, to take over treatment of the patient from the orthopedic surgeon who had just made the diagnosis.

58. Even if there had been competent testimony as to the prevailing professional standard of care for a general practitioner, the evidence did not clearly show that Dr. Rivera-Kolb failed to meet that standard or failed to use reasonable care.

59. The Department established by clear and convincing evidence that Dr. Rivera-Kolb committed medical malpractice when, as a general practitioner, he engaged in providing anesthesia care.

Scope of Practice

60. The Department presented evidence indicating that propofol was in fact administered to J.D. on June 25, 2008. First, there were pharmacy bills in J.D.'s medical record indicating propofol had been issued for her procedures on that date. Second, there were written statements from Nurse Lerfald and Dr. Rivera-Kolb himself that when the left chest tube was placed, air bubbles and a white-colored fluid were discharged.

Dr. Florete indicated that the discharge of the whitish fluid from the chest tube was evidence that propofol was given to J.D., because no other drugs administered in this case other than propofol would have produced a white milky fluid.[7/]

61. It was not necessary for the Department to show that Dr. Rivera-Kolb himself administered propofol to J.D., that he knew that Dr. Rodenberg had done so during J.D.'s second procedure, or even that he "feared that that was the case" in order to show that Dr. Rivera-Kolb accepted or performed professional responsibilities which he knew he was not competent to perform. The evidence is clear and convincing that Dr. Rivera-Kolb knew, or should have known, that the procedures were to be conducted under MAC.[8/] He signed more than one paper indicating this, once in a block designated as "Anesthesiologist 1." He also knew, from his earlier treatment of Patient J.D., that she had accelerated hypertension and that MAC procedures might be advisable. Despite his testimony to the contrary, it is clear that Dr. Rivera-Kolb accepted the responsibility to act as an anesthesiologist during two procedures and to prepare the Anesthesia Record for at least the first of these, and then proceeded to do so. The fact that Dr. Rivera-Kolb knew that Dr. Rodenberg was an anesthesiologist and was in the room performing the surgeries does not excuse Dr. Rivera-Kolb's actions or lessen his responsibility. If

Dr. Rivera-Kolb at the time of the facet radiofrequency lesioning did not know specifically what sedatives were and were not administered earlier by Dr. Rodenberg or some other person, that fact would not be exculpatory, but incriminating.

62. Dr. Rivera-Kolb is not board certified in anesthesiology. He has not completed a residency in anesthesiology and has not had adequate training in anesthesiology for him to perform the duties of an anesthesiologist.

63. Dr. Rivera-Kolb knew that he was not competent to perform the professional responsibility of providing monitored anesthesia care to Patient J.D. during her procedures.

64. There is clear and convincing evidence that Dr. Rivera-Kolb accepted and performed the professional responsibilities of an anesthesiologist, which he knew that he was not competent to perform.

65. Dr. Rivera-Kolb's actions in knowingly accepting and performing professional responsibilities which he knew that he was not competent to perform exposed J.D. to potentially severe injury or death.

Prior Discipline

66. In December 2003, an Administrative Complaint was filed against Dr. Rivera-Kolb in the Department's Case No. 2001-22573. The complaint alleged that he failed to keep required medical

records, prescribed a legend drug other than in the course of his professional practice, and committed medical malpractice in violation of sections 458.331(1)(m), (1)(q), and (1)(t), Florida Statutes (2001), respectively.

67. In December 2003, another Administrative Complaint was filed against Dr. Rivera-Kolb in Case No. 2002-13550. The complaint alleged that he failed to keep required medical records and committed medical malpractice in violation of sections 458.331(1)(m) and (1)(t), Florida Statutes (2002), respectively.

68. In February 2006, Dr. Rivera-Kolb entered into a Consent Agreement with the Department of Health in settlement of these two complaints. In a Final Order incorporating the Consent Agreement issued on April 19, 2006, the Department imposed a reprimand, fine, and two-year period of probation against Dr. Rivera-Kolb's license. The Consent Agreement contained no provision finding that Dr. Rivera-Kolb had committed any of the offenses alleged in the complaint.

69. Dr. Rivera-Kolb was not under any legal restraints on June 25, 2008.

70. It was not shown that Dr. Rivera-Kolb received any special pecuniary benefit or self-gain from his actions on June 25, 2008.

71. It was not shown that the incidents involved any trade or sale of controlled substances.

CONCLUSIONS OF LAW

72. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes (2014).

73. A proceeding to suspend, revoke, or impose other discipline upon a license is penal in nature. State ex rel. Vining v. Fla. Real Estate Comm'n, 281 So. 2d 487, 491 (Fla. 1973). Petitioner must therefore prove the charges against Respondent by clear and convincing evidence. Fox v. Dep't of Health, 994 So. 2d 416, 418 (Fla. 1st DCA 2008)(citing Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996)).

74. The clear and convincing standard of proof has been described by the Florida Supreme Court:

> 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 explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Davey, 645 So. 2d 398, 404 (Fla. 1994)(quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

75. Disciplinary statutes and rules "must always be construed strictly in favor of the one against whom the penalty would be imposed and are never to be extended by construction." Griffis v. Fish & Wildlife Conserv. Comm'n, 57 So. 3d 929, 931 (Fla. 1st DCA 2011); Munch v. Dep't of Prof'l Reg., Div. of Real Estate, 592 So. 2d 1136 (Fla. 1st DCA 1992).

76. Petitioner charged Respondent under section 458.331, Florida Statutes, which provided, in relevant part:

> (1) The following acts constitute grounds for . . . disciplinary action . . . .
>
> *   *   *
>
> (m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.
>
> *   *   *
>
> (t)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.
>
> *   *   *

> (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.

<u>Section 458.331(1)(m)</u>

77. Florida Administrative Code Rule 64B8-9.003(3) provided:

> The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

78. Petitioner showed by clear and convincing evidence that Respondent failed to keep complete and accurate Anesthesia Records regarding the treatment of J.D. which reflected who provided anesthesia and when, in violation of

section 458.331(1)(m), as charged in the Administrative Complaint.

Section 458.331(1)(t)

79. Section 456.50(1)(g) defined "medical malpractice" in relevant part 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.

80. Section 766.102(1), Florida Statutes, provided in part:

> 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.

81. Section 766.102(8) provides that if a health care provider is providing evaluation, treatment, or diagnosis for a condition that is not within his specialty, a specialist trained in the evaluation, treatment, or diagnosis for that condition shall be considered a similar health care provider.

82. Petitioner established by clear and convincing evidence that Respondent committed medical malpractice by practicing as an anesthesiologist when he had no adequate training in anesthesia, contrary to prevailing professional standards of care for an anesthesiologist, in violation of section 458.331(1)(t)1., as charged in the Administrative Complaint.[9/]

83. Petitioner did not show that Respondent committed gross medical malpractice or repeated medical malpractice.

84. Petitioner failed to establish the prevailing professional standard of care for a general practitioner in the circumstances surrounding Patient J.D.'s post-operative complications, as recognized as acceptable and appropriate by reasonably prudent general practitioners, or prove that Respondent's actions failed to meet that standard of care.

Section 458.331(1)(v)

85. Petitioner showed by clear and convincing evidence that Respondent knew that he was not competent to perform as an anesthesiologist; yet, he accepted and performed the responsibilities of an anesthesiologist by monitoring a patient during monitored anesthesia care and preparing the Anesthesia Record. Petitioner established by clear and convincing evidence that Respondent violated section 458.331(1)(v), as charged in the Administrative Complaint.

Penalty

86. Petitioner imposes penalties upon licensees consistent with disciplinary guidelines prescribed by rule. See Parrot Heads, Inc. v. Dep't of Bus. & Prof'l Reg., 741 So. 2d 1231, 1233-34 (Fla. 5th DCA 1999).

87. Penalties in a licensure discipline case may not exceed those in effect at the time the violations were committed.

Willner v. Dep't of Prof. Reg., Bd. of Med., 563 So. 2d 805, 806 (Fla. 1st DCA 1990), rev. denied, 576 So. 2d 295 (Fla. 1991). At the time of the incidents, Florida Administrative Code Rule 64B8-8.001(2)(m) provided that for a first-time offender failing to keep required medical records, as described in section 458.331(1)(m), the prescribed penalty range was "[f]rom a reprimand to denial or two (2) years suspension followed by probation and an administrative fine from $1,000.00 to $10,000.00."

88. Rule 64B8-8.001(2)(t) provided that for a first-time offender committing medical malpractice, as described in section 458.331(1)(t), the prescribed penalty range was "[f]rom one (1) year probation to revocation or denial, and an administrative fine from $1,000.00 to $10,000.00."

89. Rule 64B8-8.001(2)(v) provided that for a first-time offender practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which he knew or had reason to know that he was not competent to perform, as described in section 458.331(1)(v), the prescribed penalty range was "[f]rom two (2) years suspension to revocation or denial and an administrative fine from $1,000.00 to $10,000.00."

90. It is not appropriate to apply penalties for the second or third offense. Although the 2003 administrative complaints

also alleged that Respondent committed medical malpractice and failed to keep required medical records, those charges were never proven; the Final Order and Consent Agreement specifically avoided such a determination.

91. In addition, the only charge of medical malpractice in the Administrative Complaint that was proven was based upon Respondent's actions in practicing as an anesthesiologist when he had no adequate training to do so. The Florida Statutes expressly provide that such conduct is a distinct offense under section 458.331(1)(v), under which Respondent was also charged, as discussed earlier. Where the elements of two charged offenses are exactly the same, there is but one disciplinable offense for purposes of imposition of penalty.

92. Rule 64B8-8.001(3) provided that, in applying the penalty guidelines, the following aggravating and mitigating circumstances should also 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, 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.

93. Respondent's actions in knowingly accepting and performing professional responsibilities of an anesthesiologist, which he knew that he was not competent to perform, exposed J.D. to potentially severe injury or death, and may be considered an aggravating factor under paragraph (a) of the rule.

94. Respondent's proven violation of three counts involved more than one offense, an aggravating factor.

95. In considering the 2003 administrative complaints under rule paragraphs (d) and (e) above, it is important to note that

there was no finding of a statutory violation. In Kaplan v. Department of Health, Board of Osteopathic Medicine, 8 So. 3d 391 (Fla. 5th DCA 2009), the court permitted the consideration of prior discipline imposed although there had been no finding of a violation. However, the Kaplan case appears to be predicated upon the particular wording of the mitigation and aggravation rule of the Board of Osteopathic Medicine, which directed consideration of the number of times the licensee had been previously disciplined. In the Board of Medicine rule applicable here, paragraph (d) directs consideration of the number of times the same offense or offenses have previously been committed. As noted earlier, the 2003 Consent Order and Final Order do not contain the requisite findings, and paragraph (d) provides no basis for aggravation. On the other hand, it is appropriate under Kaplan to consider the fact of prior discipline under the more general wording of paragraph (e), even in the absence of a specific finding of statutory violation.

96. A final aggravating factor, under paragraph (h), is that Respondent here was charged with violating the standard of care both in performing as an anesthesiologist during J.D.'s procedures and in assisting in treating her complications afterwards, and he failed to keep adequate medical records for either of those times.[10/]

97. On the other hand, Respondent was not under any legal restraints on June 25, 2008. It was not shown that Respondent received any special pecuniary benefit or self-gain from his actions. The incidents did not involve any trade or sale of controlled substances.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a final order be entered by the Department of Health, Board of Medicine, finding that Dr. Rivera-Kolb violated sections 458.331(1)(m), (t), and (v), Florida Statutes, as charged in the Administrative Complaint, and imposing an administrative fine of $20,000.00 and a four-year suspension of his license to practice medicine.

DONE AND ENTERED this 19th day of December, 2014, in Tallahassee, Leon County, Florida.

F. SCOTT BOYD
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of December, 2014.

ENDNOTES

[1/] While Dr. Rivera-Kolb's testimony about documents that appeared to contain his signature was a bit inconsistent, he clearly testified in his deposition that he wrote the numbers on the Anesthesia Record and went on to say, "That's why I signed it."

[2/] Dr. Rivera-Kolb also admitted in his deposition that he signed the Anesthesia Charge Sheet, but claimed, "I didn't know what it was." At hearing, he would not even expressly admit that he had signed it, stating only that "It looks like my signature." The contention that Dr. Rivera-Kolb did not knowingly sign his name in the block next to "Anesthesiologist 1" on the form is rejected as not credible.

[3/] Dr. Florete testified that performing such "double duty" would not meet the prevailing standard of care for the practice of anesthesiology, though the actions of Dr. Rodenberg are not the subject of this proceeding.

[4/] References here to "first form" and "second form" are not intended to indicate which was prepared first, for there is no evidence on that point, but only to distinguish them.

[5/] This hearing testimony conflicts with Dr. Rivera-Kolb's own deposition testimony, in which he indicated that it was the Anesthesia Record for the second procedure he participated in--the facet radiofrequency lesioning--that was missing from J.D.'s records: "I know I wrote in two records, during the first procedure and during the second procedure. I can't find the records for the second procedure anywhere."

[6/] Dr. Florete was not offered or accepted as an expert in the general practice of medicine. See §§ 458.331(1)(t)1. & 766.102(5)(b), Fla. Stat. Respondent's objection to testimony of Dr. Florete regarding the prevailing professional standard of care applicable to a general practitioner was sustained at hearing.

[7/] In making this finding, no weight was given to Dr. Rivera-Kolb's testimony that two years after the incident, he was told that J.D. had been given propofol by Ms. Kathleen McCutcheon, the scrub nurse for the procedures. He testified in his deposition:

> I called her to see if she could, you know, if she could help me in the case later on and she told me, did you know that Dr. Rodenberg

> gave this patient propofol? And I said absolutely not, but do you know what, I feared that that was the case.

Nurse McCutcheon was not called as a witness. The basis for her belief that propofol had in fact been administered was not in evidence, and her statement itself was hearsay.

8/ Dr. Rivera-Kolb's testimony that Dr. Rodenberg provided him with reasonable assurance that the procedures were not MAC is rejected as not credible under all of the circumstances.

9/ Dr. Florete also testified that Respondent violated the standard of care when he provided MAC to J.D. without knowing what medications she had received, in failing to record her breathing and temperatures, in failing to take steps to address her hypertension, and in failing to stay with her after the procedures until she was placed in the PACU. However, Respondent was not charged with committing malpractice with respect to these acts or omissions occurring during J.D.'s procedures.

10/ Compare Public Health Trust of Dade County v. Valcin, 507 So. 2d 596 (Fla. 1987), in which the Florida Supreme Court held that the unavailability of medical records due to an adverse party's negligence may create a shifting of the burden of proof in a civil medical malpractice case.

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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.