STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 16-4346PL

BABAK SAADATMAND, M.D.,

Respondent.
_______________________________/

RECOMMENDED ORDER

On October 4, 2016, Administrative Law Judge Lisa Shearer Nelson of the Division of Administrative Hearings (DOAH) conducted a hearing in this case pursuant to section 120.57(1), Florida Statutes (2016), in Tallahassee, Florida.

APPEARANCES

For Petitioner: Michael E. Morris, Esquire
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For Respondent: Brian A. Newman, Esquire
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STATEMENT OF THE ISSUE

The issue to be determined in this proceeding is whether Respondent, Babak Saadatmand, M.D. (Respondent or

Dr. Saadatmand), has violated section 458.331(1)(m) and (t), Florida Statutes (2013), as alleged in the Administrative Complaint.

PRELIMINARY STATEMENT

On June 19, 2015, Petitioner, Department of Health (Petitioner or the Department), filed an Administrative Complaint against Respondent, alleging that he violated section 458.331(1)(m) and (t) in his care and treatment of patient R.D. in the emergency room at Parrish Medical Center. On August 5, 2015, Respondent disputed the allegations in the Administrative Complaint and requested a hearing pursuant to section 120.57(1). On July 28, 2016, the matter was referred to DOAH for assignment of an administrative law judge.

On August 4, 2016, DOAH issued a Notice of Hearing and scheduled the case for October 3 and 4, 2016. Discovery was undertaken by the parties, and on September 16, 2016, Petitioner moved to continue the hearing based upon the unavailability of its expert witness. Respondent opposed the continuance, suggesting that a video deposition of the expert witness could be used in lieu of live testimony, and the motion for continuance was denied.

The parties filed a Joint Pre-hearing Stipulation on September 26, 2016, containing factual stipulations that have been incorporated into the findings of fact below. On

September 29, 2016, Petitioner moved to view the videotapes of two of its witnesses' depositions during the formal hearing. A motion hearing was conducted on September 30, 2016, after which it was agreed that, rather than use hearing time for viewing the depositions, commencement of the hearing would be delayed until October 4, 2016. During the time originally scheduled for hearing on October 3, the administrative law judge would watch the video deposition of Petitioner's expert witness. Consistent with this agreement, the hearing then began on October 4, 2016, and at that time Joint Exhibit 1 was admitted into evidence. Petitioner's Exhibits 1 through 5 were admitted into evidence, which included the depositions of J.G.; C.D.; Annie L. Akkara, M.D.; Babak Saadatmand, M.D.; and David J. Orban, M.D.; after which the Department rested. Respondent testified on his own behalf and presented the expert testimony of David J. Orban, M.D., and Respondent's Exhibits 1 and 2 were admitted into evidence.

The one-volume Transcript of the proceedings was filed with DOAH on October 19, 2016. Both parties filed Proposed Recommended Orders on October 31, 2016, which have been carefully considered in the preparation of this Recommended Order. All references to Florida Statutes are to the codification in effect at the time of the incident giving rise to this proceeding, unless otherwise indicated.

FINDINGS OF FACT

Based upon the testimony and documentary evidence presented at hearing, the demeanor and credibility of the witnesses, and the entire record of this proceeding, the following findings of fact are made:

The Parties

1. Petitioner, the Department of Health, is the agency charged with the regulation of the practice of medicine pursuant to chapters 20, 456, and 458, Florida Statutes.

2. Respondent, Babak Saadatmand, M.D., is a medical doctor licensed by the Board of Medicine. Dr. Saadatmand holds Florida license number ME 114656.

3. Respondent graduated from the University of Maryland, College of Medicine, in 1988, and completed his residency at Case Western Reserve. He then completed a residency in emergency medicine at Cook County Hospital in Chicago, Illinois.

4. Respondent was board-certified in internal medicine, but no longer holds that certification because at the time it was due for renewal, he was no longer eligible because his practice was devoted to emergency medicine as opposed to internal medicine. He remains board-certified in emergency medicine.

5. Respondent has held positions that required him to supervise residents and give lectures at Yale University, New York College of Medicine, and Indiana University. Dr. Saadatmand

chose to practice emergency medicine as a traveling physician for the last three years, because of the financial benefits available by doing so while he gained additional experience in emergency medicine. However, he has since or now accepted a position as the assistant program director of the emergency medicine residency program at Jackson Memorial Hospital in Miami, Florida, where his job responsibilities will include the supervision of residents.

6. Dr. Saadatmand holds a medical license in several other states in addition to Florida, and has not been disciplined in any state where he is licensed.

Dr. Saadatmand's Treatment of R.D.

7. In June and July of 2014, Respondent was working as a traveling physician at Parrish Medical Center in Titusville, Florida. While most of his assignments in various emergency facilities have been six months long, the assignment at Parrish Medical Center was for approximately one month.

8. Respondent treated patient R.D. on June 27, 2014, at Parrish Medical Center emergency room. R.D. was accompanied by his wife, C.D.

9. R.D. was a 52-year-old male when he presented to Parrish Medical Center. He had a history of T-cell lymphoma and had been treated for his cancer through the Space Coast Cancer Center. Just days before his presentation to the emergency room on

June 27, 2014, he had been cleared to return to his place of employment. However, on June 27, 2014, R.D.’s supervisor called R.D.’s wife, C.D., and asked her to come get R.D. as he was too ill to be at work.

10. R.D. arrived at Parrish Medical Center in the early afternoon, and was triaged by a nurse at approximately 2:13 p.m. The notes from the triage nurse’s assessment recorded, among other things, R.D.’s vital signs upon arrival; his chief complaint, including its duration and intensity; a brief medical history; a list of his current medications; and a drug/alcohol use history.

11. Registered Nurse Sharon Craddock was the emergency room nurse who completed the initial assessment, or triage assessment, of R.D.’s condition. According to her triage notes in the Parrish Medical Center records, R.D.’s chief complaint upon arrival was constipation, which was described as constipation for three days, with bilateral abdominal pain. The pain was described as aching, pressure, shooting, and throbbing, and R.D.’s pain level was reported in Ms. Craddock’s notes as being an eight on a ten-point scale. Her description of his abdomen was “soft, non-tender, round, and obese.” Nurses are directed to record the pain level reported by the patient, and not to alter the pain level based on the nurse’s observation.[1/]

12. R.D.'s vital signs were taken upon his arrival at Parrish Medical Center and were recorded in the electronic medical records as follows: temperature, 98.4F; pulse, 127H; respiration, 20; blood pressure, 120/70; and pulse oximeter, 95. The only abnormal reading reflected in R.D.'s vital signs was his pulse, which was above 100, considered to be the upper limit of normal.

13. R.D. reported that he had a medical history which included T-cell lymphoma and that he did not smoke or drink. His current medications were listed as aspirin, Zyrtec, Amaryl, Metformin, Prilosec, Percocet, Pravastatin, and a multivitamin. The Percocet dosage was listed as one tablet, three times daily, as needed for pain.

14. Ms. Craddock also recorded a nursing note for R.D. at 3:37 p.m., and she was in the room when Respondent first went in to see R.D. Ms. Craddock's nursing note indicates, "Pt with a hx of stomach CA with a recent 'clean bill of health' presents with ABD pain and constipation. Occasionally takes Percocet for pain. Wife at BS. Pt. sleepy, states he normally takes a nap this time of day. Pending MD eval with orders."

15. The Parrish Medical Center chart documents that R.D. was calm, cooperative, and asleep at 15:37 hours (3:37 p.m.). This presentation is generally inconsistent with a patient who is in severe abdominal pain.

16. Dr. Saadatmand saw R.D. at approximately 3:56 p.m. Consistent with the custom at Parrish Medical Center, he worked with a scribe who took Respondent's dictation for notes during his visit with the patient, and then loaded those notes into the electronic medical record. Respondent would then have the opportunity to review the notes as transcribed and direct the scribe to make any necessary changes.

17. Dr. Saadatmand's notes indicate that R.D. presented with abdominal pain, and was experiencing moderate pain that was constant with cramping. The description of R.D.'s pain as moderate was based upon Dr. Saadatmand's observation of R.D. The chief complaint listed was constipation.

18. Dr. Saadatmand took a history from R.D., who reported that he had been diagnosed with gastric lymphoma in 2013, and was treated with radiation and chemotherapy. R.D. and his wife, C.D., reported to Respondent that they feared his cancer might be returning, as his current symptoms were similar to those he experienced when his cancer was first diagnosed. He had returned to Space Coast Cancer Center for some additional screening two to three weeks before the emergency room visit, which included a CT of the abdomen and an upper and lower endoscopy. R.D. and his wife both believed that the results of the screening were normal.

19. Respondent recorded this conversation in the electronic medical record as "[R.D.] had a recent follow up with

Dr. Rylander and had normal EGD and colonoscopy. [R.D.] had recent CT scan with cancer center."

20. Space Coast Cancer Center does not use Parrish Medical Center to perform its CT scans or other testing, so the results of the recent CT scan were not available for Respondent to view. Respondent believed that R.D. and C.D. had followed the directions of R.D.'s oncologists, and R.D. had been a compliant patient.

21. Respondent asked R.D. about his use of Percocet. He did not ask how much he was taking, but how often and whether the use had changed. He considered the answer to this question to be important, because a change in the use could indicate a change in R.D.'s pain intensity.

22. R.D. did not report any change in the amount that he was taking, which was generally an "every other day thing for him." Respondent testified that, given that the type of Percocet that R.D. was prescribed was an extra-strength as opposed to a standard version of Percocet, it was highly likely that R.D. would suffer from opioid-induced constipation. R.D. reported to Respondent that he had not attempted any laxatives.

23. R.D. also denied having any nausea or surgical history. The lack of a surgical history is significant because patients with a recent surgical history and abdominal pain may be

experiencing complications related to the surgery, which would account for the patient's pain.

24. There is no reference to R.D.'s diabetes in either the nursing triage notes or Dr. Saadatmand's notes. The only reference in the past medical history is the report of cancer. The list of medications R.D. was taking at home includes Metformin HCI. No evidence was presented to establish whether Metformin is a drug prescribed only for diabetes or whether it is an accepted treatment for other conditions. Moreover, there is no evidence presented to establish how Respondent was to know that R.D. was diabetic if R.D. did not report the condition.

25. In addition to taking R.D.'s medical history, Respondent performed a review of systems and a physical examination, including palpation of his abdomen. In his chart, the electronic medical record states under "review of systems," "All systems: Reviewed and negative except as stated." Under the category "Gastrointestinal," the record indicates "Reports: Abdominal pain, Constipation. Denies: Nausea, vomiting, Diarrhea."

26. In the physical examination section of the electronic medical record, it is noted that R.D. was alert and in mild distress. The cardiovascular examination indicates that R.D. had a regular rate, normal rhythm, and normal heart sounds, with no systolic or diastolic murmur. With respect to his abdominal

exam, Respondent indicated, "Present: Soft, normal bowel sounds. Absent: Guarding, Rebound, Rigid." The notation that the abdomen was soft with normal bowel sounds is another way of noting that the abdomen is non-tender.

27. Because R.D. was tachycardic upon presentation to the emergency room, Dr. Saadatmand noted R.D.'s anxiety about the possibility of his cancer returning, and checked his pulse a second time. When Respondent checked R.D.'s pulse, it had slowed to 90, which is within a normal range.

28. In light of R.D.'s normal vital signs, normal abdominal examination, and the length of his pain and constipation, Respondent determined that the most likely cause for Respondent's pain was constipation, and communicated that determination to R.D. and C.D. He asked whether R.D. had used a laxative and was told he had not. Dr. Saadatmand told R.D. and his wife that the pain medication that he took could be a source for his constipation, and that it would be prudent to try a laxative and see if that produced results before considering any further diagnostic tests.

29. Respondent did not order any lab tests for patient R.D. on June 27, 2014, because his vital signs and abdominal examination were normal. He did not order an EKG for R.D. because there were no symptoms to indicate a cardiac issue.

30. Respondent also did not order a CT scan of the abdomen or pelvis for patient R.D. on June 27, 2014. He felt that, in terms of R.D.'s concern about cancer recurrence, there were tests available to R.D.'s oncologist that would be more useful in detecting any recurrence of R.D.'s cancer that are not available through an emergency room visit. For example, a PET scan would be the most helpful, but is not something that Respondent could order through the emergency room because it is not considered an emergent study.

31. The Department has not alleged, and the evidence did not demonstrate, that R.D. suffered from any emergency condition that additional testing would have revealed and that went undetected by Dr. Saadatmand.

32. Respondent did order a prescription-strength laxative, i.e., Golytely, for R.D., which is a laxative commonly used to treat constipation and to prepare patients for a colonoscopy.

33. Dr. Saadatmand communicated his recommendation to R.D. and C.D., who seemed relieved that the problem might be limited to constipation. He also advised them to return to the emergency room should R.D.'s symptoms get worse or if he developed a fever, because those developments would indicate a change in his condition.

34. R.D. received discharge instructions that are consistent with Dr. Saadatmand's discussion with R.D. and his

wife. The discharge instructions referred R.D. to his primary care physician, noted the prescription for Golytely, and provided information related to the community health navigator. The Patient Visit Information sheet received by R.D. specifically noted that the patient was acknowledging receipt of the instructions provided, and stated, "I understand that I have had EMERGENCY TREATMENT ONLY and that I may be released before all my medical problems are known and treated. Emergency medical care is not intended to be a substitute for complete medical care. My Emergency Department diagnosis is preliminary and may change after complete medical care is received. I will arrange for follow-up care."

35. R.D. also received printed materials about constipation and how to address the problem. These instructions stated that the patient should contact his or her primary care provider if the constipation gets worse, the patient starts to vomit, or has questions or concerns about his or her condition or care. It also instructed the patient to return to the emergency room if he or she had blood in his or her bowel movements or had a fever and abdominal pain with the constipation. R.D. signed the acknowledgment that he had read and understood the instructions given to him by his caregivers. The acknowledgment specifically referenced the instructions regarding constipation. The written

instructions are consistent with the verbal advice provided by Respondent.

R.D.'s Subsequent Treatment

36. Unfortunately, R.D.'s symptoms did not improve. He developed a fever and his pain level increased significantly. As stated by his wife, his pain the following day was "way worse" than when he saw Dr. Saadatmand. After a call to her niece, a nurse that worked in the emergency room at Parrish Medical Center, C.D. took R.D. back to the hospital on June 28, 2014, at approximately 6:30 p.m. At that point, he had a heart rate of 125, a temperature of 101.6 degrees, and tenderness in the lower left quadrant of his abdomen.

37. Testing indicated that R.D. had intra-abdominal masses and small collections of extra-luminal gas that suggested the possibility of a contained micro-perforation. There is no allegation in the Administrative Complaint that the micro-perforation existed at the time R.D. saw Respondent.

38. R.D. died on August 23, 2014, as a result of end-stage T-cell lymphoma.

The Expert Witnesses

39. The Department presented the expert testimony of Annie Akkara, M.D. Dr. Akkara is board-certified in emergency medicine and has been licensed to practice medicine in Florida for approximately nine years. All of her practice has been in the

greater Orlando area in the Florida hospital system. She worked full-time for one year when she first moved to Florida, and since that time approximately 80 percent of her practice has involved reviewing medical charts for Veracode Associates, to determine whether diagnostic codes are fully supported in the medical records. She takes emergency room shifts on an as-needed basis, and has supervisory responsibility over patient extenders, such as nurses and physicians' assistants, but not over other physicians. Dr. Akkara has never served on any committee for a medical staff at a hospital or helped develop protocols for an emergency room, and has not conducted any type of medical research. Although her position requires her to review electronic medical records, she was not familiar with the program used by Parrish Medical Center.

40. Dr. Akkara reviewed the medical records for the emergency room visits for both June 27 and 28, 2014, as well as the records from the inpatient admission after the June 28 visit. She also reviewed the expert witness reports of Drs. Orban and Smoak.

41. Dr. Saadatmand presented the expert testimony of David Orban, M.D. Dr. Orban practices emergency medicine in the Tampa area. He attended medical school at St. Louis University and completed residencies in orthopedics and emergency medicine. Dr. Orban has been licensed to practice medicine in Florida since

1982 and has been board-certified in emergency medicine since 1981.

42. Before he practiced in Florida, Dr. Orban served as an instructor in surgery at the Washington University School of Medicine, and from 1970 through 1983, was an assistant professor of medicine at the University of California, Los Angeles (UCLA). In that position, he supervised residents in the emergency medicine program and helped to develop the program's curriculum. Dr. Orban left UCLA in 1983 and moved to Florida, in order to help establish the emergency medicine residency program at the University of Florida.

43. Currently, Dr. Orban is the director of emergency medicine for the University of South Florida (USF), College of Medicine, and the Medical Director Emeritus for the Tampa General Hospital Emergency Room. The USF emergency medicine residency program is a competitive program which receives approximately 1,200 applications each year for ten residency positions. Dr. Orban continues to spend approximately 20-24 hours each week practicing in the emergency room, in addition to his teaching responsibilities. He both sees patients on his own and supervises residents who are seeing patients. He has extensive experience in evaluating non-traumatic abdominal pain in the emergency room.[2/]

Allegations Related to the Standard of Care

44. Dr. Akkara testified that in her opinion, Dr. Saadatmand's care and treatment departed from the standard of care in a variety of ways. She agreed that Respondent assessed R.D.'s abdomen, but believed that he erred in not specifically documenting that the abdomen was not tender. In this case, the patient record specifically states, "Abdominal exam: Present: Soft, Normal bowel sounds. Absent: Guarding, Rebound, Rigid." In Dr. Akkara's view, the notes should have been more specific, and she found fault with the fact that the notes did not use the words "tender" or "non-tender."

45. Dr. Orban, on the other hand, noted that Respondent specifically documented the absence of guarding, rigidity and rebound tenderness, and described the abdomen as "soft, with normal bowel sounds." Dr. Orban testified that assessing an abdomen for guarding, rigidity, and rebound are all forms of checking for abdominal tenderness. He did not hesitate to interpret Respondent's medical records for R.D. as reflecting a normal exam, meaning no tenderness was discovered. Dr. Orban's opinion is supported by the differences in the medical records from R.D.'s June 27 and 28 emergency room visits, and what options are provided in the electronic medical record when a positive finding for tenderness is chosen. Dr. Orban's testimony is credited.

46. The Administrative Complaint alleges and Dr. Akkara opined that Respondent departed from the appropriate standard of care by failing to obtain a complete set of normal vital signs before R.D. was discharged from the hospital. The only vital sign that was ever abnormal during R.D.'s June 27 visit was his heart rate, which upon arrival was 127. Respondent rechecked R.D.'s heart rate when he examined him, and upon re-examination it was 90, well within normal limits.

47. Dr. Orban did not believe that the standard of care required the physician, as opposed to possibly supportive staff, to obtain a complete set of vital signs prior to ordering a patient's discharge. The evidence established that while there is sometimes a nursing standard in emergency rooms requiring a nurse to obtain a second set of vital signs before a patient is discharged, there is no corresponding standard that requires the physician to repeat all of the vitals as well. Dr. Akkara admitted that while she attempts to get a complete set of vital signs before she discharges a patient, she does not always succeed in doing so. The evidence did not demonstrate a departure from the standard of care for not obtaining a second set of vital signs prior to discharge, especially where, as here, all of R.D.'s vital signs were normal when he arrived at the emergency room, except for his heart rate, and Dr. Saadatmand did, in fact, re-assess R.D.'s heart rate prior to discharge.

48. The Administrative Complaint alleges that Respondent fell below the standard of care by not ordering routine lab work for R.D. The Administrative Complaint does not allege what purpose the routine lab work would serve in the emergency treatment of R.D.

49. Dr. Akkara testified that routine lab work should have been completed before discharge, and that it was a departure from the standard of care not to do so. She stated that the labs were necessary to assess white blood cell count, glucose levels, and kidney function, and in those cases where tenderness was noted in the upper right quadrant of the abdomen, also could indicate issues with the patient's liver enzymes. Dr. Akkara acknowledged, however, that it is possible for a CBC (complete blood count) to be frequently misleading in patients with abdominal pain, and is often normal with patients with appendicitis. Blood work often cannot distinguish between serious and benign abdominal conditions, and Dr. Akkara admitted that with respect to R.D., given the records from the subsequent admission, any results from a CBC ordered on June 27 would not have altered the treatment of the patient or changed his ultimate outcome.

50. Dr. Orban testified that in the majority of cases where a CBC is ordered in the emergency room, it is not helpful. Ordering a CBC is helpful where a patient has a fever because it

would help identify infection, or where a patient appears anemic. Other than those instances, it is not all that useful and is over-utilized.

51. A chemistry panel measures a patient's serum levels for things like sodium, creatinine, and glucose. Dr. Orban testified that, even with a diabetic patient, unless the patient is experiencing vomiting, mental status changes, blurred vision, frequent urination, or other symptoms associated with diabetes, a blood chemistry panel would not be helpful for assessing a patient with non-traumatic abdominal pain.

52. Records for R.D.'s June 28 visit (the day after Respondent saw R.D.) note that he was diabetic, while the June 27 records do not. However, it was not established that either R.D. or his wife ever told anyone, whether nursing staff or Dr. Saadatmand, that he was diabetic. There is no testimony that his prescription for Metformin was to treat diabetes, as opposed to some other condition, and there was no evidence to indicate that diabetes is the only condition for which Metformin can be prescribed. Dr. Akkara repeatedly referred to R.D.'s diabetes as a basis for her opinions, but never identified the records that formed a basis for her knowledge of R.D.'s diabetic condition. The evidence presented does not establish that ordering a blood chemistry or CBC was required by the appropriate

standard of care related to the care and treatment of R.D. in the emergency room on June 27, 2016.

53. Dr. Akkara also testified that Respondent departed from the standard of care by failing to obtain a CT scan of the abdomen and pelvis. Her opinion is based, at least in part, on her belief that Respondent failed to document that R.D.'s abdomen was non-tender. She agreed with Dr. Orban that if a patient has no abdominal tenderness, then a CT scan is probably not warranted.

54. In addition, Dr. Orban testified credibly that over the last ten years, there has been a trend toward over-utilization of CT scans, with the concomitant increased risk of radiation-induced cancer. In this case, R.D. had reported having a CT scan just weeks before this emergency room visit. His abdomen was not tender. In a case such as this one, where the patient presents with non-traumatic abdominal pain and a normal abdominal examination and no fever, a CT scan is not warranted.
Dr. Orban's testimony is credited. There is not clear and convincing evidence to establish that the standard of care required Respondent to order a CT scan under the circumstances presented in this case.

55. Dr. Akkara testified that Respondent also violated the standard of care by not ordering an EKG for R.D. However, she acknowledged that R.D. did not present with any cardiac-related

symptoms and denied chest pain. The purpose of an EKG is to explore any cardiac-related symptoms, and R.D. did not present with any. Dr. Akkara did not provide any protocols that dictate when an EKG should be ordered. Dr. Akkara also acknowledged that ordering an EKG would have no impact on the care provided to R.D., and that a patient does not need an EKG just because he or she walks in the emergency room with tachycardia.[3/]

56. The Department did not establish that the failure to order an EKG violated the applicable standard of care in this case.

57. The Department also has charged Respondent with failing to arrange for follow-up care and failing to discuss follow-up care, as well as reasons for R.D. to return to the emergency room, if necessary. However, as noted in paragraphs 32-34, Dr. Saadatmand discussed follow-up care with R.D. and told him what circumstances would require a return visit to the emergency room. Dr. Akkara acknowledged that the discharge instructions given to R.D. were adequate.

58. As stated by Dr. Orban, the role of an emergency room physician with regard to the assessment of patients is to identify emergency situations and treat them. Emergency situations are those that are acute, rapidly decompensating, and that require either medical or surgical intervention, with most likely a hospital admission for more definitive care. It is not

the emergency physician’s responsibility to manage a patient’s chronic conditions. It is routine to advise patients with non-acute conditions to follow up with their established physicians and to provide written instructions to that effect. Dr. Saadatmand’s actions in providing instructions, both in terms of follow-up and possible return to the emergency room, were consistent with the standard of care.

59. Finally, the Administrative Complaint finds fault with Dr. Saadatmand for not conducting another abdominal examination and not re-assessing R.D.’s vital signs prior to discharge. As noted previously, the only vital sign that was abnormal when R.D. arrived was his heart rate. Respondent did re-assess R.D.’s heart rate prior to discharge, and it was normal. With respect to a second examination of Respondent’s abdomen, the Department did not establish that one was necessary. Here, Respondent’s initial examination was normal, and there was a reasonable explanation for his discomfort that Respondent believed needed to be addressed before going any further. Dr. Akkara offered no protocol or other authority other than her own clinical experience to support the opinion that serial examinations of the abdomen were required. On the other hand, Dr. Orban testified that where, as here, where the first examination was normal and there was no fever or vomiting, no second examination would be required.[4/] Dr. Orban’s testimony is credited.

60. In summary, the Department did not establish that Respondent violated the applicable standard of care in his care and treatment of R.D. Further, his medical records, while not perfect, justify the course of treatment provided in this case.

CONCLUSIONS OF LAW

61. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding pursuant to sections 120.569, 120.57(1), and 456.073(4), Florida Statutes (2016).

62. This is a proceeding in which the Department seeks to discipline Respondent's license as a medical doctor. The Department has the burden to prove the allegations in the Administrative Complaint by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 595 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 at 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)). This burden

of proof may be met where the evidence is in conflict, but it "seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., 590 So. 2d 986, 988 (Fla. 1st DCA 1991).

63. Because this proceeding is considered penal in nature, Respondent can only be found guilty of those allegations specifically referenced in the Administrative Complaint. Trevisani v. Dep't of Health, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005); see also Christian v. Dep't of Health, 161 So. 3d 416, 417 (Fla. 2d DCA 2014); Ghani v. Dep't of Health, 714 So. 2d 1113, 1114-15 (Fla. 1st DCA 1998). Thus, only those allegations actually charged in the Administrative Complaint are considered in this Recommended Order. Moreover, charges in a disciplinary proceeding must be strictly construed, with any ambiguity construed in favor of the licensee. Elmariah v. Dep't of Prof'l Reg., 574 So. 2d 164, 165 (Fla. 1st DCA 1990); Taylor v. Dep't of Prof'l Reg., 534 So. 2d 782, 784 (Fla. 1st DCA 1988). Charging statutes must be construed in terms of their literal meaning, and words used by the Legislature may not be expanded to broaden their application. Beckett v. Dep't of Fin. Servs., 982 So. 2d 94, 99-100 (Fla. 1st DCA 2008); Dyer v. Dep't of Ins. & Treas., 585 So. 2d 1009, 1013 (Fla. 1st DCA 1991).

64. Count I of the Administrative Complaint charges Respondent with violating section 458.331(1)(t)1., which provided:

> Notwithstanding s. 456.072(2) but as specified in s. 456.50(2):
> 1. Committing medical malpractice as defined in s. 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed to require more than one instance, event, or act.

65. Section 456.50(1)(g) defined medical malpractice as follows:

> (g) "Medical malpractice" means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. Only for the purpose of finding repeated medical malpractice pursuant to this section, any similar wrongful act, neglect, or default committed in another state or country which, if committed in this state, would have been considered medical malpractice as defined in this paragraph, shall be considered medical malpractice if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.

66. Section 766.102, Florida Statutes, provided in pertinent part:

> (1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 766.202(4), the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the

> health care provider represented a breach of the prevailing professional standard of care for that health care provider. 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.

67. The Administrative Complaint alleges that Respondent failed to meet the prevailing standard of care in his care and treatment of patient R.D. in one or more of the following ways: by failing to assess R.D.'s abdomen for tenderness, by failing to obtain a complete set of normal vital signs prior to discharge of R.D., by failing to conduct routine lab work, by failing to obtain a CT scan of the abdomen and pelvis, by failing to obtain an EKG, by failing to arrange for follow-up care if the patient was stable enough for discharge, by failing to discuss follow-up care and reasons to return to the emergency department, by failing to conduct another abdominal exam prior to discharge, and by failing to reassess R.D.'s vital signs prior to discharge.

68. The Department did not establish a violation of Count I of the Administrative Complaint by clear and convincing evidence.

69. Count II of the Administrative Complaint charges Respondent with violating section 458.331(1)(m), which provided that a physician may be disciplined for:

> Failing to keep legible, as defined by department rule in consultation with the

> board, medical records that identify the licensed physician or the physician or 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.

70. The Department contends that Respondent violated section 458.331(1)(m) by failing to document R.D.'s history of diabetes, by failing to document the assessment of R.D.'s abdomen for tenderness, by failing to document a discussion with R.D. regarding follow-up care and reasons to return to the emergency department, by failing to document obtaining a complete set of normal vital signs prior to discharging the patient, and/or by failing to document that the patient felt well enough to leave with just medicine for constipation.

71. As noted by Respondent in his Proposed Recommended Order, there is no reference in section 458.331(1)(m) to a standard of care. In Barr v. Department of Health, Board of Dentistry, 954 So. 2d 668, 669 (Fla. 1st DCA 2007), a dentist was charged with violating the appropriate standard of care with respect to his treatment of a patient's root canal and with respect to his patient records related to the care. The ALJ found no fault with the actual treatment rendered, but found that

his deficient records amounted to a violation of the standard of care. The dentist appealed and the First District reversed, stating:

> The Board argues that particularly egregious recordkeeping violations could rise to the level of a "standard of care" violation. Because this renders [section 466.028(1)(m)] useless, it is clearly erroneous. We believe there is a significant difference between improperly diagnosing a patient, which constitutes a [466.028(1)(x)] violation, and properly diagnosing a patient, yet failing to properly document the actions taken on the patient's chart, which constitutes a subsection (m) violation.

72. Florida Administrative Code Rule 64B8-9.001 is the Board of Medicine's rule that provides standards for the adequacy of medical records. Paragraph (2) requires medical records that are "in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken." It does not require that every word of a physician's conversation with a patient be recorded, and it does not require an explanation as to alternative treatments that may have been considered but were not undertaken. Colbert v. Dep't of Health, 890 So. 2d 1165, 1167 (Fla. 1st DCA 2004); Breesmen v. Dep't of Health, 567 So. 2d 469, 471 (Fla. 1st DCA 1990).

73. Here, the medical records related to Respondent's care and treatment of R.D. were adequate. The Department did not demonstrate a violation by clear and convincing evidence.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a final order dismissing the Administrative Complaint.

DONE AND ENTERED this 5th day of December, 2016, in Tallahassee, Leon County, Florida.

LISA SHEARER NELSON
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 5th day of December, 2016.

ENDNOTES

1/ There are various places in the nursing notes where R.D.'s pain is listed as 8 out of 10, 9 out of 10, and 10 out of 10. There is also a discrepancy in the records concerning the duration of his pain. While most entries reflect pain of three days' duration, Respondent's note as recorded by the scribe says the pain was of one days' duration. A review of the record as a whole supports the conclusion that R.D. had suffered pain for a while (hence the workup by the oncologist), but that the constipation had lasted for approximately three days, and that R.D.'s pain was moderate, as recorded in the doctor's note.

2/ The undersigned had the opportunity to observe both expert witnesses: Dr. Akkara by reviewing her video deposition and Dr. Orban by observing his live testimony. Both physicians seem comfortable with their positions. However, Dr. Orban's

experience, both as a practitioner and as a professional involved in both developing and implementing programs teaching the appropriate approach to emergency room care, far outweighed Dr. Akkara's, and his testimony as a whole was simply more credible. Dr. Akkara's approach would perhaps be considered a more conservative approach to the practice of emergency medicine, but her testimony did not persuasively establish that her approach represented the appropriate standard of care. Much of her testimony seemed geared toward what she deemed to be prudent, as opposed to what is the generally accepted standards of practice or established protocols require. McDonald v. Dep't of Prof'l Reg.., Bd. of Pilot Commrs., 582. So. 2d 660 (Fla. 1st DCA 1992); Purvis v. Dep't of Prof'l Reg., Bd. of Veterinary Med., 461 So. 2d 134, 136 (Fla. 1st DCA 1984).

3/ When R.D. returned to Parrish Medical Center on June 28, the attending physician did not order an EKG. When one was ordered in mid-July, it was normal.

4/ Dr. Orban testified that performing serial examinations of the abdomen would be appropriate if the physician sees a patient that is sick that presents with a history of uncontrollable vomiting and a fever. In that situation the physician might choose to hold the patient in the emergency room for observation and then re-examine them, but it is a fairly rare practice. It also used to be the standard where a physician suspected something like appendicitis. That is not the case here.

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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.