STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,
BOARD OF MEDICINE,

Petitioner,

Case No. 19-1931PL

vs.

JOHN CAREY TOMBERLIN, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

On October 15, 2019, Administrative Law Judge Yolonda Y. Green of the Division of Administrative Hearings ("DOAH") conducted a duly-noticed hearing pursuant to section 120.57(1), Florida Statutes (2019), in Panama City Beach, Florida.

APPEARANCES

For Petitioner: Jasmine Green, Esquire
Cynthia Nash-Early, Esquire
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For Respondent: Brian Newman, Esquire[1/]
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STATEMENT OF THE ISSUES

The issues to be determined are whether Respondent, John Carey Tomberlin, M.D. ("Respondent" or "Dr. Tomberlin"), violated section 458.331(1)(t)1., Florida Statutes (2014), by failing to identify a subdural hematoma on the left side of Patient J.A.'s brain, as alleged in the Administrative Complaint; and if so, what penalty should be imposed.

PRELIMINARY STATEMENT

On June 22, 2018, the Department of Health, Board of Medicine ("Petitioner" or "the Department"), filed a two-count Administrative Complaint alleging Respondent violated section 458.331(1)(m) and (t)1., in his interpretation of a CT scan of Patient J.A.'s head. On July 11, 2018, Respondent notified the Department that he disputed the allegations in the Administrative Complaint and requested a hearing involving disputed issues of material fact. On April 15, 2019, the Department referred this matter to DOAH for assignment of an administrative law judge, which was assigned to the undersigned.

On June 10, 2019, Petitioner filed a Notice of Dismissal of Count II, which dismissed the allegation of a violation of section 458.331(1)(m). The remaining count in the Administrative Complaint alleges that Respondent violated section 458.331(1)(t)1., by failing to identify a subdural hematoma on the left side of Patient J.A.'s brain.

The undersigned issued a Notice of Hearing scheduling this case for June 20, 2019. On June 10, 2019, Respondent filed an Unopposed Motion to Continue, seeking a continuance based on a scheduling conflict, which the undersigned granted. The undersigned rescheduled this case for October 15 and 16, 2019, and it commenced as scheduled.

The parties filed an Amended Joint Pre-Hearing Stipulation on October 8, 2019, containing factual stipulations that have been incorporated into the Findings of Fact below.

At the hearing, Petitioner presented the expert testimony of Joseph Andriole, M.D. Petitioner's Exhibit 1 was admitted over objection and Petitioner's Exhibits 2 and 3 were admitted without objection. Respondent testified on his own behalf and presented the expert testimony of Katherine Lursen, M.D., Respondent's expert witness. Respondent's Exhibits 3, 4, and 6 were admitted without objection, and Respondent's Exhibit 5 was proffered.

The one-volume Transcript of the proceeding was filed with DOAH on December 4, 2019. On December 12, 2019, the undersigned considered and granted Respondent's Unopposed Motion for Extension of Time to File Proposed Recommended Orders. Thus, the deadline for Proposed Recommended Orders ("PROs") was December 20, 2019. The parties timely filed PROs, which have been considered in preparation of this Recommended Order.[2/]

This proceeding is governed by the law in effect at the time of the commission of the acts alleged to warrant discipline. See McCloskey v. Dep't of Fin. Servs., 115 So. 3d 441 (Fla. 5th DCA 2013). Thus, references to statutes are to Florida Statutes (2014), unless otherwise noted.

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:

Parties

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

2. At all times material to this proceeding and Petitioner's Administrative Complaint, Respondent was licensed to practice medicine in the state of Florida, having been issued license number ME 60438.

3. Respondent's practice address of record is 2600 Hospital Drive, Bonifay, Florida 32425.

4. Respondent, a board-certified radiologist, has been practicing since 1987. Respondent attended University of Alabama for medical school and is also licensed in that state. He has worked in rural areas in covering a variety of practice

settings, including prisons, clinics, and hospitals. In his practice as a radiologist, he testified that he reviews 100 to 200 CT scans per week.

Facts Related to Patient J.A.'s CT Scan

5. On August 29, 2014, Patient J.A., a seventy-four year old male, presented to Doctor's Memorial Hospital in Bonifay, Florida.

6. Patient J.A. presented with a history of suffering a physical attack including being struck over the head with a chair and being repeatedly punched in the head. The attack resulted in complaints of dizziness and a contusion on the left side of the head. To fully assess the injury sustained during the attack, Patient J.A. underwent a CT scan of the head without contrast.

7. Respondent was tasked with interpreting the CT scan.

8. On August 29, 2014, Dr. Tomberlin dictated a report of his findings as follows: "Bone and soft tissue windows are included. Soft tissue density can be seen within some of the paranasal sinuses. The calvarium is intact. The ventricles are symmetrical. Pineal calcifications are noted. There is no acute hemorrhage, midline shift, mass effect or extra-axial fluid collection." His opinion was as follows: "(1) Negative CT brain scan; and (2) Minimal sinusitis with both acute and chronic elements noted."

9. On August 29, 2014, Respondent did not detect a subdural hematoma in the CT scan images of Patient J.A.'s head.

10. A subdural hematoma is a collection of blood in the head on the outside of the brain beneath the dura, a fibrous lining of the brain.

11. Patient J.A. died on September 16, 2014.

12. Dr. Tomberlin acknowledged that he did not perceive the hematoma at the time of his initial review, despite exercising due care in his review of the CT scan. He explained that he missed the hematoma due to several factors: there was no indication of a midline shift; hyperdensity was white and dense in comparison to the rest of the brain tissue; the brain was very large; and the size (described as small) of the subdural hematoma. He noted that while elderly patients are at a higher risk for subdural hematoma, Patient J.A. had a healthy and larger brain despite his age.

13. Dr. Tomberlin testified that after he learned that Patient J.A. had died, he performed a post-mortem review of the CT scan and discovered the subdural hematoma.

Expert Witnesses

Dr. Andriole

14. The Department presented the testimony of Joseph Gerald Andriole, M.D. Dr. Andriole was accepted as an expert in diagnostic radiology. Dr. Andriole is a board-certified

diagnostic radiologist with a subspecialty in interventional radiology. He has been licensed to practice medicine in Florida since 1986. He attended Howard University School of Medicine and completed his residency in diagnostic radiology at Case Western Reserve University Hospital. Dr. Andriole is not trained in and is not board certified in neuroradiology.

15. Since reducing his full-time practice to three to four days per month in 2012, Dr. Andriole reviews approximately 15 CT scans of the head per month in an outpatient setting.

Dr. Lursen

16. Respondent presented the testimony of Katherine Perrien Lursen, M.D., who was accepted as an expert in diagnostic radiology. Dr. Lursen, a diagnostic radiologist, is licensed to practice medicine in Alabama. Dr. Lursen is not licensed to practice medicine in Florida, but she maintains an expert witness certificate, having been issued certificate number MEEW6548, which authorizes her to testify in Florida cases. For the reasons set forth herein, she is also familiar with the standards of reviewing CT scans.

17. Dr. Lursen earned her medical degree from the University of Alabama at Birmingham and completed her residency in radiology. She also completed a fellowship in neuroradiology. Dr. Lursen is board certified in diagnostic

radiology with a certification in the subspecialty of neuroradiology.

18. Dr. Lursen has practiced diagnostic radiology for nine years. In her full-time practice, she services three hospitals as a neuroradiologist and reviews approximately 120 to 150 CT scans of the head each month.

19. She serves as the chair of the radiology department at Mobile Infirmary, a 700-bed hospital in Mobile, Alabama, the largest hospital in Mobile. As the department chair, she helps develop protocols for radiology at Mobile Infirmary, including the appropriate method to interpret radiology images. Dr. Lursen also serves on a hospital peer-review committee and reviews cases where the standard of care is at issue.

20. In addition to her practice related duties, Dr. Lursen teaches at the Alabama College of Osteopathic Medicine and instructs students during rotations.

Allegations Related to the Standard of Care

21. Dr. Andriole reviewed the hospital records for Patient J.A. for August 29, 2014, including the admission record that reflected Patient J.A. was “hit in the head” in the left temple area and a contusion was noted on the left temple. Dr. Andriole also reviewed the CT scan of Patient J.A.’s head and Respondent’s CT report. Based on his review of the CT scan, CT report, and hospital records, Dr. Andriole opined that

Dr. Tomberlin departed from the standard of care by failing to identify the subdural hematoma on the left side of Patient J.A.'s brain.

22. When the standard of care is at issue, the individual opinion of an expert witness does not establish the standard of care. The standard of care is based on the level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.[3/]

23. Petitioner's expert, Dr. Andriole, was tasked with establishing the actions a reasonably prudent radiologist would exercise when interpreting a CT scan of the head. Dr. Andriole testified that "the standard of care states that a physician would provide the type of interpretation that would be expected from a competent, prudent physician at the time under similar circumstances." He also testified that the standard of care required Dr. Tomberlin to identify "expected abnormalities" that result from the type of head injury or trauma suffered by Patient J.A.

24. Based on the testimony at hearing, Dr. Andriole's expert testimony fell short of establishing the standard of care a reasonably prudent physician would exercise under the circumstances to detect an abnormality.

25. When addressing the standard of care, Dr. Andriole's testimony was as follows:

> Q. What is the standard of care for a radiologist reviewing the CT scan of the head or brain?
>
> A. [T]he standard of care states that a physician would provide the type of interpretation that would be expected from a competent, prudent physician at the time under the circumstances.

26. Dr. Andriole testified that a physician would provide the type of interpretation that would be expected, but failed to state standards upon which the undersigned could evaluate Dr. Tomberlin's interpretation of the CT scan.

27. Further, Dr. Andriole reached his opinion without regard to the findings in the CT report, which reflected Dr. Tomberlin's assessment of the CT scan. In considering whether Dr. Tomberlin met the standard of care, Dr. Andriole testified that a reasonably prudent physician would consider the underlying cause of injury or trauma to aid in interpretation of the CT scan, which Dr. Tomberlin considered. Dr. Andriole acknowledged that the abnormality was smaller than average for a subdural hematoma. He also acknowledged that Dr. Tomberlin carefully reviewed the CT scan because he identified small abnormalities in the sinuses that were smaller than the subdural hematoma.

28. Dr. Andriole agreed that the type of error in this case, a perceptional error, may still meet the standard of care. Dr. Andriole acknowledged that a three to five percent error rate can occur when reviewing radiology images.

29. Dr. Lursen, on the other hand, opined that Dr. Tomberlin met the standard of care in his review of the CT scan for Patient J.A. Dr. Lursen pointed to Respondent's interpretation of the CT scan and highlighted that his reference to absence of midline shift, absence of mass effect, and calvarium (being) intact show Dr. Tomberlin was looking for a subdural hematoma.

30. Dr. Lursen credibly testified that when interpreting a CT scan of the head of a trauma patient, the standard of care requires a physician to look at several factors to detect an abnormality. Dr. Lursen testified that assessing whether there is a midline shift and mass effect is important because those are two signs of intracranial hemorrhage, including subdural hematoma. The standard of care also requires that the radiologist look for areas of hyperdensity because hyperdensity is an indicator of intracranial hemorrhage. Density refers to the amount of gray versus the amount of black and white on an image. If an image is hyperdense, then it is whiter than the surrounding or adjacent structure or tissue. The radiologist

should determine whether there is a skull fracture. Finally, the radiologist should look for acute hemorrhage.

31. Dr. Lursen noted that Respondent's CT report reflected an appropriate assessment of care a reasonably prudent physician would exercise to detect a subdural hematoma.

32. Despite the appropriate assessment, however, it is undisputed that Respondent failed to identify the subdural hematoma.

33. Dr. Lursen opined that failure to identify the hematoma was not a departure from the standard of care due to its atypical appearance. Dr. Lursen considered the presentation of the subdural hematoma to be atypical because of its "tiny" size, and the absence of typical traits, "including, mass effect, midline shift, or injury to the skull in the CT images." She testified that the density of the hematoma was closer to the shade of the brain mass and there was no skull fracture.

34. Further, a classical subdural hematoma is C-shaped and causes a midline shift of the brain, which was not apparent on Patient J.A.'s CT scan.

35. Dr. Lursen provided testimony that Respondent's failure to identify the hematoma fell with an accepted three to five percent error rate. That error rate includes the presumption that the radiologist has conducted himself in a manner in interpreting the film or image that is prudent under

the circumstances. According to Dr. Lursen, a radiologist can have a three to five percent error rate and still have met the standard of care. In this case, Dr. Lursen credibly testified that Respondent's failure to identify the subdural hematoma fell within that three to five percent error rate, but he still met the standard of care.

36. Dr. Lursen testified that Dr. Tomberlin's error fell within the category of an observational or perceptual error. An observational or perceptual error occurs when a radiologist follows the appropriate method for reviewing images but does not perceive the abnormality upon initial review.

37. Dr. Lursen's opinion that Dr. Tomberlin's failure to identify the subdural hematoma was a perceptual error, which did not fall outside the standard of care is credited.

Ultimate Findings of Fact

38. In determining whether Dr. Tomberlin met the standard of care, the question is not whether either of the experts could identify the abnormality, but whether Dr. Tomberlin used the degree of skill and care that a reasonably prudent physician in the medical community would exercise to detect the abnormality.

39. To be convincing, the opinion needs to establish clearly the existence of a standard of care in the profession and explain how such standard applies to the facts of the case. An expert's opinion on the standard of care must result from an

analysis of the facts to determine what a reasonably prudent physician in the radiology community would do given the circumstances.

40. The undersigned finds in Dr. Lursen's expert testimony that Dr. Tomberlin met the standard of care in his interpretation of Patient J.A.'s CT scan more persuasive than Dr. Andriole's testimony.[4/]

41. Thus, the Department did not establish by clear and convincing evidence that Respondent violated the applicable standard of care in his interpretation of the CT scan of Patient J.A.'s head.

CONCLUSIONS OF LAW

42. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to sections 120.569, 120.57(1), and 456.073(5), Florida Statutes (2019).

43. The Department has authority to investigate and file administrative complaints charging violations of the laws governing the practice of nursing. § 456.073, Fla. Stat.

44. 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). Fox v. Dep't of Health, 994 So. 2d 416 (Fla. 1st DCA 2008); Pou v. Dep’t of Ins. & Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998).

45. The clear and convincing evidence level of proof:

> [E}ntails both a qualitative and quantitative standard. The evidence must be credible; the memories of the witnesses must be clear and without confusion; and the sum total of the evidence must be of sufficient weight to convince the trier of fact without hesitancy.
>
> 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 Henson, 913 So. 2d 579, 590 (Fla. 2005)(quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)). While this burden of proof may be met where the evidence is in conflict, it “seems to preclude evidence that is ambiguous.” Westinghouse Elec. Corp. v. Shuler Bros., 590 So. 2d 986, 988 (Fla. 1st DCA 1991).

46. 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).

47. 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.

48. 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.

49. Section 766.102 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.

50. The Administrative Complaint alleges Respondent failed to meet the prevailing standard of care by failing to identify the subdural hematoma on Patient J.A.'s CT scan. Both experts

agreed that the failure to perceive and identify an abnormality that can be seen on an image does not always amount to a departure from the standard of care, such is the case here, despite the outcome for the patient.

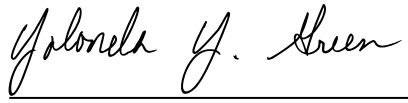
51. As set forth in the Findings of Fact herein, the evidence in this case was not clear and convincing that Respondent violated an applicable standard of care by failing to identify the subdural hematoma.

52. Based on the foregoing, the Department did not meet its burden to prove, by clear and convincing evidence, that Respondent committed a violation as alleged in the Administrative Complaint.

RECOMMENDATION

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

DONE AND ENTERED this 21st day of January, 2020, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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this 21st day of January, 2020.

ENDNOTES

[1/] Mr. Newman served as counsel of record for Dr. Tomberlin during the final hearing. On December 12, 2019, Ms. Hood was substituted as counsel for Dr. Tomberlin.

[2/] The undersigned granted the parties request for extension of time to file PROs. Pursuant to Florida Administrative Code Rule 28-106.216(2), the parties waived the timeline for this Administrative Law Judge to issue this Recommended Order within 30 days after receiving the Transcript.

[3/] See Section 766.102 Fla. Stat.

[4/] The undersigned had the opportunity to observe the live testimony of both expert witnesses. Both physicians were confident in their respective positions. However, Dr. Lursen's experience, both as a practitioner and as a professional involved in both developing and implementing programs teaching the appropriate approach for interpreting CT scans of the head, outweighed Dr. Andriole. Dr. Lursen was found to be more credible as she outlined an analysis of all factors to determine whether Respondent met the standard of care. Dr. Andriole appeared to understand what the standard of care typically requires, but his testimony did not persuasively establish that

his approach represented the appropriate standard of care. Much of his testimony seemed directed toward what he deemed to be prudent, as opposed to what the generally accepted standard of practice would 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).

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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.