STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 16-3127PL

OSAKATUKEI O. OMULEPU, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, a formal administrative hearing was conducted before Administrative Law Judge Mary Li Creasy in Fort Lauderdale, Florida, on October 26 and 27, 2016.

APPEARANCES

For Petitioner: Kristen M. Summers, Esquire
John Wilson, Esquire
Department of Health
Prosecution Services Unit
Bin C-65
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For Respondent: Monica Felder-Rodriguez, Esquire
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STATEMENT OF THE ISSUES

Whether Respondent, a licensed physician, committed record-keeping violations and repeated medical malpractice by committing three or more incidents of medical malpractice, as alleged in the Second Amended Administrative Complaint; and, if so, what is the appropriate penalty?

PRELIMINARY STATEMENT

On June 8, 2016, Petitioner, Department of Health, filed an Amended Administrative Complaint seeking disciplinary sanction of the medical license of Respondent, Osakatukei Omulepu, M.D. Respondent filed a request for formal hearing, and the matter was referred to the Division of Administrative Hearings (DOAH) on June 8, 2016. On the same day, DOAH assigned Administrative Law Judge (ALJ) F. Scott Boyd to conduct the proceeding. This matter was transferred to the undersigned on June 15, 2016. The hearing was initially set for July 27, 28, and 29, 2016, and then rescheduled for October 26, 27, and 28, 2016. On October 5, 2016, Petitioner filed a Motion to Relinquish Jurisdiction for leave to amend the Amended Administrative Complaint. The Motion was denied; however, the ALJ and Respondent waived the provisions of section 120.569(2)(a), Florida Statutes (2016), allowing Petitioner to convene a probable cause panel to add additional counts for record-keeping violations. The Second Amended Administrative Complaint was filed on October 26, 2016.

The hearing was held as scheduled on October 26 and 27, 2016. At the hearing, Petitioner presented the testimony of seven witnesses: Patient L.L.; Patient P.N.; Patient D.M.; Patient N.F.; R.D., Patient N.F.'s mother; Lianys Blain; and Dr. Scott Greenberg, M.D., as an expert witness. Petitioner's Exhibits 2, 3 (pages 3, 41, 83, and 133 only), 5, 6 (pages 13, 84, and 85 only), 9, 10 (pages 307, 308, and 968 only), 11, 12 (page 25 only), 13, and 14 were admitted into evidence.

Respondent presented the testimony of Michel Samson, M.D., as an expert witness. Respondent's Exhibits 1, 4, 6 through 11, 14, 20, and 21 were admitted into evidence. Included in Respondent's exhibits were the deposition transcripts for Constantino Mendieta, M.D., Linda Mondragon, and Cassandra Salazar, which were provided in lieu of live testimony.

A two-volume Transcript of the proceeding was filed on November 18, 2016, and November 28, 2016. Both parties filed timely proposed orders which were given due consideration in the preparation of this Recommended Order. Unless otherwise indicated, citations to the Florida Statutes or rules of the Florida Administrative Code refer to the versions in effect at the time of the alleged violations.

FINDINGS OF FACT

1. Petitioner is responsible for the investigation and prosecution of complaints against medical doctors licensed in the

state of Florida, who are accused of violating chapters 456 and 458 of the Florida Statutes.

2. Respondent is licensed as a medical doctor in Florida, having been issued license number ME 99126 on June 15, 2007.

3. Respondent is not board-certified in any specialty recognized by the Florida Board of Medicine.

4. Respondent has never had disciplinary action against his license to practice medicine.

5. In May 2015, Respondent performed cosmetic surgery procedures, including liposuction and fat injection procedures (commonly referred to as a "Brazilian Butt Lift" or "BBL"), at Vanity Cosmetic Surgery (Vanity), Encore Plastic Surgery (Encore), and Spectrum Aesthetics (Spectrum).

6. Liposuction is an elective cosmetic procedure that involves the removal of fat from a patient. Fat is removed with a cannula, or a long, thin, metal rod, attached to a suctioning device. The cannula is repeatedly passed through the patient's subcutaneous layer until the desired amount of fat is removed.

Facts Related to Patient L.L.

7. On May 2, 2015, Patient L.L., a 29-year-old female patient, contacted Vanity to undergo liposuction.

8. On May 2, 2015, prior to her procedure, Patient L.L. underwent bloodwork that revealed she had a normal hematocrit

level, normal hemoglobin level, and a normal red blood cell count.

9. Respondent determined that Patient L.L. was of sufficiently good health to undergo liposuction.

10. Respondent performed liposuction on Patient L.L. at Vanity on May 14, 2015.

11. Several hours after being discharged to a hotel, Patient L.L. experienced pain, weakness, elevated heart rate (tachycardia), and excessive bleeding. Patient L.L. presented to Homestead Hospital, where she was admitted for three days of post-operative care and monitoring. L.L.'s recovery took several months and resulted in her losing her job.

12. Upon admission, Patient L.L.'s hematology report revealed a low hematocrit, low hemoglobin, and a low red blood cell count, which signified severely diminished blood levels and necessitated her to be transfused with two units of blood and plasma.

Facts Related to Patient D.M.

13. On April 25, 2015, Patient D.M., a 31-year-old female patient, contacted Spectrum to undergo liposuction with gluteal fat transfer.

14. On April 29, 2015, prior to her procedure, Patient D.M. underwent bloodwork that revealed she had a normal hematocrit

level, normal hemoglobin level, and a normal red blood cell count.

15. Also prior to her procedure, Patient D.M. indicated in her medical questionnaire that she was pregnant approximately five times.

16. Because Patient D.M. disclosed her prior pregnancies to Respondent, Respondent knew, or should have known, that Patient D.M. had a potentially weak or thin abdominal wall.

17. Respondent determined that Patient D.M. was of sufficiently good health to be an appropriate candidate to undergo liposuction with gluteal fat transfer.

18. Respondent performed liposuction with gluteal fat transfer on Patient D.M. at Spectrum on May 15, 2015.

19. Following the surgery, Patient D.M. experienced extreme pain, resulting in her admission to Westchester Hospital.

20. Upon admission, Patient D.M.'s hematology report revealed a low hematocrit and low hemoglobin, which signified severely diminished blood levels and necessitated her to be transfused with three units of blood.

21. During an exploratory surgery, Patient D.M. was found to have several holes in her liver and damage to her chest and abdominal wall.

Facts Related to Patient N.F.

22. On February 4, 2015, Patient N.F., a 35-year-old female patient, contacted Spectrum to undergo liposuction with gluteal fat transfer.

23. On April 23, 2015, prior to the procedure, Patient N.F. underwent bloodwork that revealed she had a normal hematocrit level, normal hemoglobin level, and a normal red blood cell count.

24. Also prior to her procedure, Patient N.F. indicated in her medical questionnaire that she was pregnant at least twice.

25. Because Patient N.F. disclosed her prior pregnancies to Respondent, Respondent knew, or should have known, that Patient N.F. had a potentially weak or thin abdominal wall.

26. Respondent determined that Patient N.F. was of good health and an appropriate candidate to undergo liposuction.

27. Respondent performed liposuction with gluteal fat transfer on Patient N.F. at Spectrum on May 15, 2015.

28. Following the surgery, Patient N.F. experienced abdominal pain, weakness, and an inability to walk, resulting in her admission to Baptist Hospital.

29. During an exploratory surgery, Patient N.F. was found to have a hole in her small bowel (colon), which was leaking fluid into her abdominal cavity.[1/]

Facts Related to Patient P.N.

30. On May 16, 2015, Patient P.N., a 35-year-old female patient, was scheduled to undergo liposuction with gluteal fat transfer at Encore.

31. On May 4, 2015, prior to her procedure, Patient P.N. underwent bloodwork that revealed she had a normal hematocrit level, normal hemoglobin level, and a normal red blood cell count.

32. Respondent determined that Patient P.N. was of sufficiently good health and an appropriate candidate to undergo liposuction.

33. Respondent performed liposuction with gluteal fat transfer on Patient P.N. as scheduled.

34. Following the surgery, Patient P.N. experienced extreme pain and heavy bleeding, resulting in her admission to Memorial Regional Hospital.

35. Upon admission, Patient P.N.'s hematology report revealed a low hematocrit level, and low hemoglobin, which signified severely diminished blood levels and necessitated a blood transfusion.

Facts Related to Concentration of Tumescent Solution

36. Before harvesting Patients L.L.'s, D.M.'s, N.F.'s, and P.N.'s fat, Respondent infiltrated tumescent solution into the areas that were prepared to undergo liposuction.

37. Tumescent solution is a mixture of natural saline, epinephrine, and lidocaine and is used to decrease the risk of excessive bleeding caused by large-volume liposuction procedures.

38. Epinephrine, the active ingredient in tumescent solution, constricts blood vessels and reduces blood loss.

39. The minimum concentration of epinephrine in tumescent solution needed to achieve its intended purpose of reducing blood loss is 1:1,000,000.

40. This concentration was first popularized by Dr. Jeffrey Klein in 1965. After experimenting with several concentrations of epinephrine, Dr. Klein concluded that a 1:1,000,000 concentration of epinephrine appropriately balanced patient safety with effectiveness. The most dilute concentration of epinephrine Dr. Klein experimented with was 1:2,000,000.

41. Dr. Klein's concentration of epinephrine in tumescent solution of 1:1,000,000 is the standard concentration in the state of Florida for BBL procedures.

42. The medical records reflect that during each of the four procedures, Respondent used tumescent solution with an epinephrine concentration of 1:4,000,000. This concentration is too diluted to have the intended effect of restricting blood loss.

43. However, the tumescent solution was prepared by the circulators who assisted during the surgeries. The circulators

credibly testified that when preparing the tumescent solution, they used enough epinephrine to create at least a 1:1,000,000 concentration of epinephrine. The circulators prepared the tumescent solution by adding lidocaine with 1:100,000 epinephrine and one cubic centimeter (cc) of epinephrine to a one-liter (1000 cc) bag of normal saline.

44. The circulators explained that the additional epinephrine that was used was not documented in the patients' operating room records because there was no designated space on the form for this information.

45. In light of the circulators' credible testimony, no evidence was presented to support the conclusion that Respondent fell below the standard of care by using an inappropriate concentration of epinephrine in the tumescent solution. Further, there was no causal connection demonstrated between the patients' blood loss, a fairly common complication associated with BBL procedures, and the concentration of epinephrine used.

Facts Related to Damage to Internal Organs

46. During Patient N.F.'s liposuction procedure, Respondent used a cannula to remove 4,000 ccs of supernatant fat from Patient N.F.'s abdomen, waist, back, bra rolls, and flanks.

47. While manipulating the cannula, Respondent pushed the cannula through Patient N.F.'s abdominal wall and punctured her small bowel.

48. Because Respondent perforated Patient N.F.'s small bowel, Patient N.F.'s abdominal cavity was contaminated, and 10 to 15 centimeters of Patient N.F.'s bowel later had to be resected and removed.

49. After Patient N.F.'s hospitalization, her mother confronted Respondent who admitted that he "messed up," and suggested that his instrument "cuts through muscle and fat like butter," and may have contributed to the perforation.

50. During Patient D.M.'s liposuction procedure, Respondent used a cannula to remove 4,000 ccs of supernatant fat from Patient D.M.'s abdomen, waist, back, bra rolls, and flanks.

51. While manipulating the cannula, Respondent pushed the cannula through Patient D.M.'s abdominal wall, damaging her chest wall, and Respondent punctured her liver at least five times.

52. Respondent was responsible for ensuring that the cannula used during liposuction procedures was manipulated with precision and extreme care to avoid contact with the patients' internal organs.

53. In order for the cannula to come into contact with an internal organ (with the exception of the heart and lungs), Respondent pushed the cannula at an inappropriate angle through a thick layer of muscle called the abdominal wall. The tough abdominal wall has a noticeably different consistency than the soft layers of subcutaneous fat. A surgeon is required to

operate with a level of skill and care to be able to discern between subcutaneous fat and muscle tissue while passing the cannula through the patient.

54. The standard of care in Florida requires surgeons to use extreme care to ensure that the abdominal wall is not breeched. This is especially true when the patient's medical history suggests the possibility of a thin abdominal wall.

55. According to both Petitioner's and Respondent's experts the perforation of an internal organ during a liposuction procedure, even once, is an extremely rare incident.

56. In fact, Respondent's world-renowned BBL expert, Dr. Mendieta explained, "I'm constantly thinking bowel, bowel, bowel perforation or I'm constantly thinking trying to avoid, so it is constantly on my mind in terms of what I am trying to avoid, so I'm always angling my cannula and making sure that I'm on the right plane."[2/]

57. Dr. Mendieta admitted that although perforating an internal organ is a "known complication" related to liposuction, it can result from medical negligence.

58. Respondent argues he is absolved of any responsibility for the puncture of internal organs because Patients D.M. and N.F. signed consent forms that included the risk of "damage to deeper structures, including nerves, blood vessels, muscles, and lungs."

59. Significantly, the informed consent forms for liposuction signed by the patients did not include damage to the liver, small bowel, or other intra-abdominal organs.

60. Petitioner's expert, Dr. Greenberg, explained that the language in the consent form does not contemplate damage to internal organs shielded by the abdominal wall, and a lay person would be unlikely to make such an inference.

61. Dr. Greenberg credibly testified that it is a violation of the standard of care to damage a patient's internal organs during a liposuction procedure, regardless of whether it is a known complication.

62. Dr. Mendieta countered that the only way for a surgeon to violate the standard of care would be to either intentionally stab the patient, or to perform the surgery in such a reckless and careless manner, improperly angling the cannula, that damage to the surrounding structures is either inevitable or purposeful.

63. As noted by all three experts, absent being present during the procedure, having it well-documented in the Respondent's notes, or talking with Respondent, it is not possible to tell with certainty what transpired. Respondent refused to testify on his own behalf. Respondent asserted his Fifth Amendment Privilege against self-incrimination, instead of clarifying any of the disputed issues.

64. Based on the forgoing, Petitioner demonstrated by clear and convincing evidence that the puncture of the patients' internal organs was the result of Respondent's violation of the standard of care and improper angling of the cannula during the procedures.

Facts Related to the Alleged Medical Records Violation

65. The circulators at Vanity, Encore, and Spectrum Aesthetics testified that they prepared the tumescent solution that Respondent used during his liposuction procedures at Respondent's direction.

66. The circulators testified that when preparing the tumescent solution, they used enough epinephrine to create at least a 1:1,000,000 concentration of epinephrine. However, the additional epinephrine that was purportedly used was never documented in the patients' operating room records.

67. Respondent argues that it was the responsibility of the circulators who prepared the solutions or the facilities at which he operated that maintain the records, which bear responsibility for the accuracy of the records.

68. Respondent is the surgeon who performed the surgery on each patient. The operative records for each surgery bear the same signature in every signature block for "Surgeon Signature," "Physician Signature," "Osakatukei O. Omulepu, M.D.," and "Osak

Omulepu, MD." In most instances, the signature is clearly legible as O.O. Omulepu.

69. The record supports by clear and convincing evidence that Respondent signed or approved these records and bears responsibility for their accuracy. However, Respondent reviewed and signed the medical records, all of which omitted the additional ampule of epinephrine that was purportedly added, without correcting the apparent discrepancy.

CONCLUSIONS OF LAW

70. 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 (2016).

71. 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)).

72. 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)).

73. 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).

74. The grounds proving Petitioner's assertion that Respondent's license should be disciplined must be those specifically alleged in the Second Amended Administrative Complaint. See e.g., Trevisani v. Dep't of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005); Kinney v. Dep't of State, 501 So. 2d 129 (Fla. 5th DCA 1987); and Hunter v. Dep't of Prof'l Reg., 458 So. 2d 842 (Fla. 2d DCA 1984).

Counts I through IV - Standard of Care Violations

75. Section 458.331(1)(t), Florida Statutes, provides that it is a violation for a medical doctor to commit medical malpractice, as defined in section 456.50, Florida Statutes. The

statute goes on to state that "the Board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph."

76. Section 456.50(1)(g) defines "medical malpractice" as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

77. The "level of care, skill, and treatment recognized in general law related to health care licensure" means the standard of care specified in section 766.102, Florida Statutes.

78. Subsections (1), (2), and (3)(b) of section 766.102 state (in relevant 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.
>
> (2)(a) If the injury is claimed to have resulted from the negligent affirmative medical intervention of the health care provider, the claimant must, in order to prove a breach of the prevailing professional standard of care, show that the injury was

> not within the necessary or reasonably foreseeable results of the surgical, medicinal, or diagnostic procedure constituting the medical intervention, if the intervention from which the injury is alleged to have resulted was carried out in accordance with the prevailing professional standard of care by a reasonably prudent similar health care provider.
>
> (b) The provisions of this subsection shall apply only when the medical intervention was undertaken with the informed consent of the patient in compliance with the provisions of s. 766.103.
>
> (3)(b) The existence of a medical injury does not create any inference or presumption of negligence against a health care provider, and the claimant must maintain the burden of proving that an injury was proximately caused by a breach of the prevailing professional standard of care by the health care provider.

79. The Second Amended Administrative Complaint alleges the following violations of the standard of care:

> 1. Failing to use the proper concentration of epinephrine in the tumescent solution used during surgery. (D.M., N.F., L.L. and P.N.)
>
> 2. Failing to inject the proper amount of fatty tissue. (D.M.)
>
> 3. Injecting fat into the sciatic nerve. (N.F.)
>
> 4. Puncturing or perforating internal organs. (D.M. and N.F.)

80. For all four patients, the Second Amended Administrative Complaint alleges Respondent used tumescent solution with a concentration of one part per 4 million units. At the hearing,

evidence and testimony was provided from all of the circulators involved in these cases. The evidence and testimony was clear that the tumescent solution used by Respondent was always prepared the same way--one cc of epinephrine was added to each liter of saline, creating a tumescent solution with a concentration of at least one part per million of epinephrine. This is the concentration Petitioner alleges should have been used, and Respondent did not fall below the standard of care with respect to the amount of tumescent solution used in these procedures.

81. The Second Amended Administrative Complaint alleges that Respondent injected 1250 ccs of fat into Patient D.M.'s buttocks bilaterally, and that the standard amount of fatty tissue injected is approximately 500 ccs. No evidence was presented to support this allegation. To the contrary, the evidence in this case establishes that it is within the standard of care for surgeons who routinely do this procedure to inject 1500 ccs or more of fat into each side of the buttocks. The Respondent did not fall below the standard of care by injecting 1250 ccs of fat into Patient D.M.

82. The Second Amended Administrative Complaint states that the Respondent injected fatty tissue into Patient N.F.'s sciatic nerve, and that this was below the standard of care. The evidence did not establish that fatty tissue was injected into the

patient's sciatic nerve, and thus there is no evidence to support this allegation.

83. Finally, the Second Amended Administrative Complaint alleges that Respondent fell below the standard of care by puncturing or perforating internal organs (Patients D.M. and N.F.). Respondent asserts that these minimal allegations are insufficient to put him on notice of the nature of the alleged violation. Respondent correctly points out that nothing in the administrative complaint specifically alleges that Respondent improperly angled the cannula.

84. However, the allegations certainly put the Respondent on notice that his admitted multiple punctures to internal organs in these two patients was a basis upon which the Petitioner sought to discipline his license. Respondent could have used interrogatories or the deposition of the Petitioner's expert to discern detailed ultimate facts regarding how Petitioner believed the negligence to have occurred.

85. The clear and convincing testimony of the experts was that organ punctures during liposuction are exceedingly rare complications which do not occur in the absence of recklessness in the placement of the cannula, and insufficient attention to the feel of the procedure itself as the cannula passes through fat, tissues, muscles and the abdominal wall.

86. An organ puncture during liposuction is not a per se act of medical negligence. Nevertheless, in this case, Respondent admitted to Patient N.F's mother that he "messed up" and sliced through Patient N.F.'s small bowel with his cannula like it was "butter." This exceedingly rare complication occurred in not one, but two, of Respondent's procedures, on the same day.

87. Respondent's assertion of his Fifth Amendment Privilege against self-incrimination permits the fact-finder to draw adverse inferences from his silence. Baxter v. Palmigiano, 425 U.S. 308 (1976).

88. The only inference that can be drawn is that Respondent violated the standard of care and committed malpractice by the reckless and improper angling of the cannula for these two procedures, resulting in the perforation of internal organs.

89. Petitioner proved by clear and convincing evidence that Respondent violated section 458.331(1)(t) by puncturing Patient D.M.'s liver multiple times and Patient N.F.'s small bowel.

Count V - Repeated Medical Malpractice

90. As discussed herein, Petitioner failed to demonstrate by clear and convincing evidence that Respondent committed repeated medical malpractice by committing three or more incidents of medical malpractice on Patients D.M., N.F., L.L., and/or P.N. Accordingly, Respondent did not violate

section 458.331(1)(t), Florida Statutes (2014), by committing repeated medical malpractice.

Counts VI-IX – Medical Records Violations

91. Section 458.331(1)(m) provides that it is a violation for a physician to fail 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.

92. Petitioner proved by clear and convincing evidence that Respondent failed to create or keep medical records that accurately reflected the amount of epinephrine administered to Patients L.L., D.M., N.F., and P.N.

93. As a result, Petitioner proved by clear and convincing evidence that Respondent violated section 458.331(1)(m).

Penalty Assessment

94. Respondent has no prior discipline against his medical license.

95. 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).

96. 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'l Reg., Bd. of Med., 563 So. 2d 805, 806 (Fla. 1st DCA 1990), rev. denied, 576 So. 2d 295 (Fla. 1991). Id.

97. At the time of the incidents, Florida Administrative Code 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 from one year probation to revocation or denial and an administrative fine from $1,000.00 to $10,000.00. The recommended penalty for a second violation of section 458.331(1)(t) ranged from two years of probation to revocation and an administrative fine from $5,000.00 to $10,000.00.

98. 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 from a reprimand to denial or two (2) years of suspension followed by probation, and an administrative fine from $1,000.00 to $10,000.00. The recommended penalty for a second violation of

section 458.331(1)(m) ranged from probation to suspension followed by probation or denial and an administrative fine from $5,000.00 to $10,000.00.

99. 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.

100. A significant aggravating factor is that Respondent's actions exposed Patients D.M. and N.F. to severe injury or death.[3/] Aggravating factor (c) applies because Petitioner established six separate offenses committed by Respondent. Additionally, under paragraph (h), Respondent was charged with violating the standard of care and it was found that he failed to keep adequate medical records. This is mitigated by Petitioner's prior nine years of discipline-free history.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a final order finding that Respondent violated sections 458.331(1)(t) and 458.331(1)(m), Florida Statutes, as charged in Petitioner's Second Amended Administrative Complaint; imposing a fine of $14,000.00[4/]; issuing a reprimand against Petitioner for the record-keeping violations; placing Respondent on probation for a period of two years; and imposing costs of the investigation and prosecution of this case.

DONE AND ENTERED this 6th day of January, 2017, in Tallahassee, Leon County, Florida.

MARY LI CREASY
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 6th day of January, 2017.

ENDNOTES

[1/] Petitioner's tendered expert, Dr. Scott Greenberg, was qualified to provide an opinion with regard to liposuction. However, the undersigned found that Dr. Greenberg was not an expert on the gluteal fat transfer procedure portion of the BBL. It is this portion of the procedure during which Petitioner alleges Respondent injured Patient N.F.'s sciatic nerve. Accordingly, Dr. Greenberg was prohibited from offering testimony on the gluteal fat transfer and there was no evidence presented upon which to make findings of fact regarding Patient N.F.'s nerve damage. Petitioner made a proffer of this testimony for the record.

[2/] Respondent's Ex. 1, Deposition transcript of Dr. Mendieta 47/15-20.

[3/] Respondent's suggestion, that Patient D.M.'s liver puncture and injury to her abdomen and chest wall were minor because there was no treatment provided, is rejected. D.M. endured significant pain. Just because repair was not possible does not render the injury less than serious.

[4/] The penalty includes $5,000.00 each ($10,000.00 total) for the malpractice committed against Patients D.M. and N.F., plus

$1,000.00 each for the four record-keeping violations. Although the recommended penalty for the second through fourth record-keeping violations range from $5,000.00 to $10,000.00, the undersigned does not believe assessing the higher penalty serves a deterrent effect because these four violations all occurred within a 48-hour period. Additionally, it should be noted that the Second Amended Complaint, which included the record-keeping counts for the first time, was not filed until the morning of the final hearing.

COPIES FURNISHED:

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Tallahassee, Florida 32399-3253
(eServed)

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.