30

STATE OF FLORIDA
BOARD OF MEDICINE

Final Order No. DOH-97-0188 Date 9-11-97
FILED
Department of Health
AGENCY CLERK
By Stephanie J. Dyer
Deputy Agency Clerk

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOAH CASE NO.: 96-2151
AHCA CASE NO.: 95-00064
LICENSE NO.: ME0050099

RAMESHCHANDRA B. SHAH, M.D.,

Respondent.

_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (Board) pursuant to Sections 120.569 and 120.57(1), Florida Statutes, on August 2, 1997, in Naples, Florida, for the purpose of considering the Administrative Law Judge's Recommended Order, (a copy of which is attached hereto as Exhibit A) in the above-styled cause. Petitioner was represented by Larry G. McPherson, Jr., Chief Attorney. Respondent was present and represented by Thomas R. Bopp, Esquire.

Upon review of the Recommended Order, the argument of the parties, and after a review of the complete record in this case, the Board makes the following findings and conclusions.

FINDINGS OF FACT

1. The findings of fact set forth in the Recommended Order are approved and adopted and incorporated herein by reference.

2. There is competent substantial evidence to support the findings of fact.

CONCLUSIONS OF LAW

1. The Board has jurisdiction of this matter pursuant to Section 120.57(1), Florida Statutes, and Chapter 458, Florida Statutes.

2. The conclusions of law set forth in the Recommended Order are approved and adopted and incorporated herein by reference.

3. There is competent substantial evidence to support the conclusions of law.

PENALTY

Upon a complete review of the record in this case, the Board determines that the penalty recommended by the Administrative Law Judge be accepted. WHEREFORE,

IT IS HEREBY ORDERED AND ADJUDGED that Respondent shall be placed on probation for a period of one (1) year subject to the following terms and conditions:

1. Respondent shall comply with all state and federal statutes, rules and regulations pertaining to the practice of medicine, including Chapters 455, 458, 893, Florida Statutes, and Rule 64B8, Florida Administrative Code.

2. Respondent shall appear before the Probationer's Committee at the first meeting after said probation commences, at the last meeting of the Probationer's Committee preceding termination of probation, quarterly, and at such other times requested by the committee. Respondent shall be noticed by Board staff of the date, time and place

of the Board's Probationer's Committee whereat Respondent's appearance is required. Failure of the Respondent to appear as requested or directed shall be considered a violation of the terms of probation, and shall subject the Respondent to disciplinary action.

3. In the event the Respondent leaves the State of Florida for a period of thirty days or more or otherwise does not engage in the active practice of medicine in the State of Florida, then certain provisions of Respondent's probation (and only those provisions of said probation) shall be tolled as enumerated below and shall remain in a tolled status until Respondent returns to active practice in the State of Florida. Respondent must keep current residence and business addresses on file with the Board. Respondent shall notify the Board within ten (10) days of any changes of said addresses. Furthermore, Respondent shall notify the Board within ten (10) days in the event that Respondent leaves the active practice of medicine in Florida.

4. In the event that Respondent leaves the active practice of medicine in this state for a period of thirty days or more, the following provisions of probation shall be tolled:

a. The time period of probation shall be tolled.

b. The provisions regarding supervision, whether direct or indirect by another physician.

c. The provisions regarding preparation of investigative reports detailing compliance with this Stipulation.

d. The community service requirements detailed below.

5. In the event that Respondent leaves the active practice of

medicine for a period of one year or more, the Probationer's Committee may require Respondent to appear before the Probationer's Committee and demonstrate the ability to practice medicine with skill and safety to patients prior to resuming the practice of medicine in this State.

6. Respondent shall not practice except under the indirect supervision of a physician fully licensed under Chapter 458 to be approved by the Board's Probationer's Committee. Absent provision for and compliance with the terms regarding temporary approval of a monitoring physician set forth below, Respondent shall cease practice and not practice until the Probationer's Committee approves a monitoring physician. Respondent shall have the monitoring physician present at the first probation appearance before the Probationer's Committee. Prior to approval of the monitoring physician by the committee, the Respondent shall provide to the monitoring physician a copy of the Administrative Complaint and Final Order filed in this case. A failure of the Respondent or the monitoring physician to appear at the scheduled probation meeting shall constitute a violation of the Board's Final Order. Prior to the approval of the monitoring physician by the committee, Respondent shall submit to the committee a current curriculum vitae and description of the current practice of the proposed monitoring physician. Said materials shall be received in the Board office no later than fourteen days before the Respondent's first scheduled probation appearance. The attached definition of a monitoring physician is incorporated herein. The responsibilities of a monitoring physician shall include:

a. Submit quarterly reports, in affidavit form, which shall include:

(1) Brief statement of why physician is on probation.

(2) Description of probationer's practice.

(3) Brief statement of probationer's compliance with terms of probation.

(4) Brief description of probationer's relationship with monitoring physician.

(5) Detail any problems which may have arisen with probationer.

b. Be available for consultation with Respondent whenever necessary, at a frequency of at least once per month.

c. Review 25 percent of Respondent's patient records selected on a random basis at least once every month. In order to comply with this responsibility of random review, the monitoring physician shall go to Respondent's office once every month. At that time, the monitoring physician shall be responsible for making the random selection of the records to be reviewed by the monitoring physician.

d. Report to the Board any violations by the probationer of Chapter 455 and 458, Florida Statutes, and the rules promulgated pursuant thereto.

7. The Board shall confer authority on the Chairperson of the Board's Probationer's Committee to temporarily approve Respondent's supervisory/monitoring physician. In order to obtain this temporary approval, Respondent shall submit to the Chairperson of the Probationer's Committee the name and curriculum vitae of the proposed

supervising/monitoring physician. This information shall be furnished to the Chairperson of the Probationer's Committee by way of the Board of Medicine's Executive Director, within 48 hours after Respondent receives the Final Order in this matter. This information may be faxed to the Board of Medicine at (904) 487-9622, or may be sent by overnight mail or hand delivery to the Board of Medicine, at the Department of Health, 1940 North Monroe Street, Tallahassee, Florida 32399-0750. In order to provide time for Respondent's proposed supervisory/monitoring physician to be approved or disapproved by the Chairperson of the Probationer's Committee, Respondent shall be allowed to practice medicine while approval is being sought, but only for a period of five working days after Respondent receives the Final Order. If Respondent's supervising/monitoring physician has not been approved during that time frame, then Respondent shall cease practicing until such time as the supervising/monitoring physician is temporarily approved. In the event that the proposed monitoring/supervising physician is not approved, then Respondent shall cease practicing immediately. Should Respondent's monitoring/supervising physician be approved, said approval shall only remain in effect until the next meeting of the Probationer's Committee. Absent said approval, Respondent shall not practice medicine until a monitoring/supervising physician is approved.

8. In view of the need for ongoing and continuous monitoring or supervision, Respondent shall also submit the curriculum vitae and name of an alternate supervising/monitoring physician who shall be

approved by Probationer's Committee. Such physician shall be licensed pursuant to Chapter 458, Florida Statutes, and shall have the same duties and responsibilities as specified for Respondent's monitoring/supervising physician during those periods of time which Respondent's monitoring/supervising physician is temporarily unable to provide supervision. Prior to practicing under the indirect supervision of the alternate monitoring physician or the direct supervision of the alternate supervising physician, Respondent shall so advise the Board in writing. Respondent shall further advise the Board in writing of the period of time during which Respondent shall practice under the supervision of the alternate monitoring/supervising physician. Respondent shall not practice unless Respondent is under the supervision of either the approved supervising/monitoring physician or the approved alternate.

9. Respondent shall submit quarterly reports in affidavit form, the contents of which shall be specified by the Board. The reports shall include:

a. Brief statement of why physician is on probation.

b. Practice location.

c. Describe current practice (type and composition).

d. Brief statement of compliance with probationary terms.

e. Describe relationship with monitoring/supervising physician.

f. Advise Board of any problems.

10. Respondent shall attend 20 hours of Category I Continuing Medical Education per year in the area of cardiology. Respondent

shall submit a written plan to the Chairperson of the Probationer's Committee for approval prior to the completion of said courses. The Board confers authority on the Chairperson of the Probationer's Committee to approve or disapprove said continuing education courses. In addition, Respondent shall submit documentation of completion of these continuing medical education courses in each quarterly report. These hours shall be in addition to those hours required for biennial renewal of licensure. Unless otherwise approved by the Board or the Chairperson of the Probationer's Committee, said continuing education courses shall consist of a formal live lecture format.

11. Respondent understands that during this period of probation, semi-annual investigative reports will be compiled with the Department of Health concerning compliance with the terms and conditions of probation and the rules and statutes regulating the practice of medicine.

12. Respondent shall pay all costs necessary to comply with the terms of the Final Order issued based on this proceeding. Such costs include, but are not limited to, the costs of preparation of the investigative reports detailing compliance with the terms of this proceeding, the cost of analysis of any blood or urine specimens submitted pursuant to the Final Order entered as a result of this proceeding, and administrative costs directly associated with Respondent's probation. See Section 458.331(2), Florida Statutes.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 8th day of September, 1997.

BOARD OF MEDICINE

JOHN W.GLOTFELTY, M.D.
VICE-CHAIRMAN

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES, IF REVIEW OF THE FINAL AGENCY DECISION WOULD NOT PROVIDE AN ADEQUATE REMEDY. REVIEW PROCEEDINGS ARE GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. SUCH PROCEEDINGS ARE COMMENCED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF THE DEPARTMENT OF HEALTH AND A SECOND COPY, ACCOMPANIED BY FILING FEES PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL, FIRST DISTRICT, OR WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES. THE NOTICE OF APPEAL MUST BE FILED WITHIN THIRTY (30) DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to Rameshchandra B. Shah, M.D., 213 Orange Ridge Circle, Longwood, Florida 32779-3029; to Thomas R. Bopp, Esquire, 501 East Kennedy Boulevard, Tampa, Florida 33602; to Richard Hixson, Administrative Law Judge, Division of Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee,

Florida 32399-3060; and by interoffice delivery to Larry G. McPherson, Jr., Chief Attorney, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308-5403, on or before 5:00 p.m., this _____ day of _____, 1997.

_____

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, BOARD OF MEDICINE, Petitioner, vs. RAMESCHANDRA BHAGWANDAS SHAH, M.D., Respondent.	)	CASE NO. 96-2151

RECOMMENDED ORDER

On March 6, 1997, a formal administrative hearing was held in this case by video teleconference in Tallahassee, Florida, before Richard Hixson, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Steven A. Rothenburg, Esquire
Agency for Health Care Administration
9325 Bay Plaza Boulevard, Suite 210
Tampa, Florida 33619

For Respondent: Thomas R. Bopp, Esquire
FOWLER, WHITE, GILLEN, BOGGS,
VILLAREAL & BANKER, P.A.
501 East Kennedy Boulevard
Tampa, Florida 33602

STATEMENT OF THE ISSUE

The issue for determination in this case is whether Respondent violated certain provisions of Chapter 458, Florida Statutes, as alleged in the Administrative Complaint, and if so, whether Respondent's license to practice medicine in the State of Florida should be revoked or otherwise disciplined.

PRELIMINARY STATEMENT

On February 28, 1996, Petitioner, AGENCY FOR HEALTH CARE ADMINISTRATION, BOARD OF MEDICINE, filed an Administrative Complaint charging Respondent, RAMESCHANDRA BHAGWANDAS SHAH, M.D., with one count of violating Section 458.331(1)(t), Florida Statutes, as being guilty of the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent physician as acceptable under similar conditions and circumstances. Specifically, the Administrative Complaint charged Respondent, an emergency room physician, with failure to adequately diagnose and treat an emergency room patient.

Respondent disputed the factual allegations of the Administrative Complaint, and on April 2, 1996, filed a Petition for Formal Administrative Hearing. On May 6, 1996, the matter was forwarded to the Division of Administrative Hearings to conduct these proceedings. The case was scheduled for hearing on September 6, 1996. Pursuant to the Joint Motion for Continuance filed by the parties on July 22, 1996, hearing in this matter was continued. On November 11, 1996, Petitioner filed a Motion to Hold the Case in Abeyance pending settlement negotiations, which was granted without objection. On December 18, 1996, the parties filed a Status Report requesting the matter be set for formal hearing. The case was thereafter rescheduled for formal hearing on March 6, 1996.

At formal hearing Petitioner presented the testimony of one witness, Jay Edelberg, M.D., qualified as an expert in the

practice of emergency room medicine. Petitioner also presented Composite Exhibit 1, a compilation of medical records relating to the patient in this case, which was received in evidence. Respondent testified in his own behalf, and also presented the testimony of two witnesses, Henry Elton Smoak, III, M.D., qualified as an expert in the practice of emergency room and internal medicine, and Elsie Samuel, R.N. Respondent presented one exhibit, the curriculum vitae of Dr. Smoak, which was received in evidence.

At the close of Petitioner's case in chief, Respondent made an *ore tenus* motion for directed verdict which for reasons more fully set out below is DENIED.

A transcript of the proceedings was filed March 31, 1997. On April 9, 1997, Petitioner filed a Proposed Recommended Order, and on April 11, 1997, Respondent filed a Proposed Recommended Order.

FINDINGS OF FACT

1. Petitioner, AGENCY FOR HEALTH CARE ADMINISTRATION, BOARD OF MEDICINE, is the agency of the State of Florida vested with the statutory authority to administer the provisions of Chapter 458, Florida Statutes, governing the practice of medicine.

2. Respondent, RAMESCHANDRA BHAGWANDAS SHAH, M.D., is now, and at all material times hereto was, licensed to practice medicine in the State of Florida holding license number ME 0050099. Respondent was first licensed to practice medicine in the State of Florida in 1987.

3. At all material times hereto, Respondent was employed as an emergency room physician at Polk General Hospital in Bartow,

Florida. Prior to being employed at Polk General Hospital, Respondent was employed with E.P.I., an Emergency Physician's Group. Dr. Jay Edelberg, who testified in this proceeding as an expert witness for Petitioner, is the President and CEO of E.P.I. Respondent's primary duties with E.P.I. related to emergency treatment for prisoners at various institutions under contract with E.P.I.

4. Respondent became employed at Polk General Hospital in November of 1993.

5. Polk General Hospital treats a majority of indigent patients. Polk General does not employ a cardiologist, nor does the hospital have a cardiac laboratory.

6. Nurse Elsie Samuels has been a registered nurse for eighteen years, and has worked for more than nine years in emergency rooms. Nurse Samuels is certified in advanced cardiac life support.

7. Dr. Jay Edelberg and Dr. Henry Smoak, III, were qualified in this proceeding as expert witnesses in the field of emergency room medical practice and are both highly qualified by experience and education.

Hospitalization of November 29-December 1, 1994

8. The allegations of the Administrative Complaint relate to the care and treatment of Patient L.G.T., a 59-year old male. Patient L.G.T. first presented to the emergency room of Polk General Hospital at approximately 9:00 a.m. on November 29, 1994 complaining of chest pain, a very common complaint in emergency room medical practice. Like many of the patients at

Polk General Hospital, Patient L.G.T. was indigent and without medical insurance.

9. At this time, Patient L.G.T. was initially evaluated by Dr. C. B. Clark, the emergency room physician on call at the time. Patient L.G.T. reported an episode of chest pain that had recently occurred at approximately 3:00 a.m. that morning. Upon presentation Patient L.G.T. did not exhibit or report shortness of breath, other respiratory distress, nausea, or a family history of cardiac problems. Patient L.G.T. reported that his primary symptom was a feeling of "gas" moving around. Patient L.G.T.'s cardiac risk factors included his age, gender, and a history of hypertension.

10. After the initial emergency room examination, Patient L.G.T. was referred by Dr. Clark to Dr. Thieu Nguyen, an internist at Polk General Hospital for further evaluation. As set forth above, there was no cardiologist on staff at Polk General Hospital.

11. Patient L.G.T. was admitted to Polk General Hospital on November 29, 1994, and discharged by Dr. Nguyen on December 1, 1994. During this three-day hospitalization, Patient L.G.T. underwent a thorough cardiac evaluation, including three electrocardiograms (EKGs), an echocardiogram, cardiac enzymes test, and a complete blood work-up.

12. The results of the cardiac work-up as evaluated by Dr. Ngyuen were inconclusive. The EKGs were abnormal, but non-diagnostic. In this respect, the EKGs indicated questionable anterolateral ischemia; however, Patient L.G.T. was not

experiencing chest pain during the hospitalization. The EKG results showed some depressions in the ST changes at V5-V6. This result, however, was not diagnostic of myocardial infarction because if Patient L.G.T. was experiencing a myocardial infarction a rise in ST elevation would be expected.

13. The results of the AST and LDH blood studies indicated a normal range.

14. The results of the cardiac enzyme test revealed some levels were elevated. Dr. Nguyen, however, concluded that the cardiac enzyme elevation was due to non-cardiac causes. This conclusion appears contradictory in these circumstances, and there is no indication in the record upon what basis Dr. Nguyen arrived at this conclusion.

15. Dr. Nguyen also noted that the patient's chest pain was not typical, and might be due to gastrointestinal problems.

16. Patient L.G.T. had a history of hypertension, and a cholesterol reading of 302, which was high. The normal range is 100 to 200.

17. On December 1, 1994, Patient L.G.T. was discharged from Polk General Hospital by Dr. Nguyen, with follow-up treatment ordered in three days including EKGs, blood work-up, and further cardiac enzymes. At the time of Patient L.G.T.'s discharge, Dr. Nguyen made no specific diagnosis of cardiac disease.

Emergency Room Admission of December 2, 1994

18. Patient L.G.T. returned to the emergency room of Polk General Hospital at 12:55 a.m. on December 2, 1994, approximately twelve hours after his discharge by Dr. Nguyen. Respondent was

the physician on duty at this time. Nurse Samuels was also on duty in the emergency room.

19. An initial intake evaluation was performed by the triage nurse which indicated that Patient L.G.T. reported he began experiencing chest pain at approximately 2:00 p.m. on December 1, 1994, with the pain primarily located in his chest and under his left arm. Patient L.G.T. did not at this time appear in acute distress, and denied any radiating pain. Patient L.G.T.'s vital signs were normal.

20. Patient L.G.T. was then referred to Respondent who performed a physical examination which specifically evaluated the patient for signs typical of myocardial ischemia including: constricting chest pain, perspiration, respiratory disorders, vomiting or nausea, paleness, elevated temperature, and elevated pulse rate. Respondent's physical examination of Patient L.G.T. showed no findings indicative of myocardial ischemia. Nurse Samuels was present during the physical examination by Respondent. At this time Patient L.G.T. expressed generalized complaints of discomfort, and did not indicate specific complaints which were cardiac in origin.

21. Upon completion of the physical examination, Respondent ordered a cardiac enzyme test for Patient L.G.T. The results of the cardiac enzyme test indicated that at 1:25 a.m. on December 2, 1994, that the CPK, ASTs, and LDs were in the normal range.

22. Respondent also ordered an EKG for Patient L.G.T. The computerized results of the EKG as of 1:23 a.m. on December 2, 1994 indicated that there were non-specific ST and T-wave

abnormalities. These computerized results were identical to the results of the EKG performed on L.G.T. on December 1, 1994 at 7:19 a.m. during his previous hospitalization and evaluation by Dr. Nguyen. Both expert witnesses, Dr. Edelberg and Dr. Smoak, agreed that these computerized EKG results were common for a man of L.G.T.'s age. Both experts also agreed that there was no acute change between the EKG results of December 1, 1994 and December 2, 1994.

23. Chest pain alone is not diagnostic of myocardial infarction, and may be the result of several causes including gastrointestinal problems, as indicated in this case by Dr. Nguyen during L.G.T.'s previous hospitalization.

24. At 1:05 a.m. and 1:15 a.m. on December 2, 1994, Patient L.G.T. was given nitroglycerin for relief from angina, and gastroesophageal pain. At 2:15 a.m. Patient L.G.T. reported that he was not experiencing chest pain which was reported to Respondent by the emergency room nurse.

25. At 2:45 a.m. Respondent, after evaluating the results of Patient L.G.T..'s physical examination, EKG, cardiac enzymes, and blood work-up, decided to discharge Patient L.G.T. from the emergency room. At this time Patient L.G.T.'s vital signs were normal, and he was not experiencing any chest pain.

26. After being informed that he would be discharged, Patient L.G.T. informed Nurse Samuels that he was experiencing chest and back pain, and that he also was experiencing nausea. Nurse Samuels informed Respondent of the patient's reported condition. Patient L.G.T. also told Nurse Samuels that he had

eaten spicy fish earlier that day while at home.

27. Respondent then prescribed for Patient L.G.T. a "G.I. cocktail," consisting of a combination of medications given to relieve gastrointestinal discomfort, which was administered at 2:50 a.m. on December 2, 1994.

28. At 3:10 a.m. Patient L.G.T. stated, "I can't go home, I am sick." Patient L.G.T. requested that Respondent admit him to Polk General Hospital. Respondent reviewed with Patient L.G.T. the results of his EKG, cardiac enzyme tests and physical examination, and informed him that there was no basis for admission. Patient L.G.T. kept telling Respondent to send him upstairs and admit him.

29. At this time, Respondent did not consult with Dr. Nguyen or any other internist on staff at Polk General Hospital regarding Patient L.G.T. on December 2, 1994. Respondent had reviewed Dr. Nguyen's records regarding Patient L.G.T. and was aware of the apparent contradictory conclusion that elevated cardiac enzymes were due to non-cardiac causes, but did not question this conclusion.

30. At 3:15 a.m. on December 2, 1994, Patient L.G.T. was discharged by Respondent from the emergency room at Polk General Hospital. At this time Patient L.G.T. appeared to be in stable condition, and stated to Nurse Samuels that he would call his family to take him home.

Post Discharge Incident

31. At approximately 4:20 a.m. Nurse Samuels had gone to her car and was returning to the emergency room when she was informed

that someone had collapsed in the emergency room lobby. Nurse Samuels went to investigate and found Patient L.G.T. unresponsive, with face down in vomit, with no pulse, no respiration, and urine incontinent. Both pupils were fixed and dilated.

32. A code was instituted, and Patient L.G.T. was taken back to the emergency room. All efforts to resuscitate him were unsuccessful. Patient L.G.T. was pronounced dead at approximately 5:00 a.m. on December 2, 1994. The stated diagnosis was probable aspiration/asphyxia.

33. Respondent requested that the medical examiner perform an autopsy on Patient L.G.T..

34. It is stipulated by the parties that an autopsy should have been performed on Patient L.G.T., but was not performed and that there was only a visual examination of Patient L.G.T. by the medical examiner before rendering cause of death.

CONCLUSIONS OF LAW

35. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. Section 120.57(1) and Section 455.225, Florida Statutes.

36. Disciplinary licensing proceedings are penal in nature. State ex rel. Vining v. Florida Real Estate Commission, 281 So.2d 487 (Fla. 1973). In this disciplinary licensing proceeding the Petitioner must prove the allegations of the Administrative Complaint by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1st DCA 1987).

37. "Clear and convincing evidence" requires evidence must be found to be credible, facts to which witnesses testify must be

distinctly remembered, testimony must be precise and explicit, and witnesses must be lacking in confusion as to facts in issue; 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. Slomowitz v. Walker, 429 So.2d 797 (Fla. 4th DCA 1983).

38. In this case, Respondent is charged in the Administrative Complaint with violating Section 458.331(1)(t), Florida Statutes, which provides:

> (t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $10,000 each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

39. In regard to the standard of care required of Respondent in this case, each party presented highly qualified expert testimony. Petitioner presented the expert testimony of Dr. Jay Edelberg, whose corporation formerly employed Respondent as an

emergency room physician. Dr. Edelberg testified that Respondent failed to practice medicine with the level of care required in this case in that Respondent after reviewing Patient L.G.T.'s records and evaluating the tests should have recognized a potential for cardiac problems and contacted the primary physician in this case.

40. Dr. Henry Smoak, III, a practicing emergency room physician, with extensive experience and training in emergency room medical practice testified that Respondent properly evaluated Patient L.G.T. and followed the appropriate protocol in discharging the patient. Dr. Smoak concluded that because Patient L.G.T. had just undergone a complete and thorough cardiac work-up during his three-day hospitalization, and because there were no signs of an acute change in the patient's condition, that Respondent properly discharged the patient without contacting the primary physician.

41. In this respect, the evidence is clear and convincing that test results confirmed that Patient L.G.T. had abnormal EKGs and elevated cardiac enzyme levels. Both Dr. Nguyen and Respondent were aware of these results; however, the evidence also reflects that these results were not necessarily diagnostically indicative of myocardial ischemia, nor myocardial infarction. Moreover, the evidence, while probable, is not clear and convincing that the cause of Patient L.G.T.'s death was the result of cardiac arrest.

42. While the evidence is not clear and convincing that Respondent violated Section 458.331(1)(t), Florida Statutes, by

failing to admit Patient L.G.T., the evidence is clear and convincing that Respondent under the circumstances of this case violated the approved standard of care by failing to contact Dr. Nguyen, the primary care physician who had discharged Patient L.G.T. from Polk General Hospital only twelve hours earlier, to report that the patient's pain was recurring and to consult with the primary care physician regarding the abnormalities revealed by the tests.

43. The disciplinary guidelines of the Board of Medicine, found at 59R-8.061 (formerly 61F6-20.001) Florida Administrative Code, provide a range of penalties for violations of the above-referenced provisions of Section 458.331, Florida Statutes. The range of disciplinary penalties which the Board may impose includes denial of an application, revocation, suspension, probation, reprimand, and a fine. 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 or 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 or the length of practice;
>
> f. Pecuniary benefit or self gain inuring to the applicant or licensee;
>
> g. Any other relevant factors.

44. The Respondent has no disciplinary history. The evidence does not show that Respondent's actions resulted in the death of Patient L.G.T.; however, in light of the severity of the consequences, Respondent's failure to inform and consult with the treating physician in these circumstances is not an acceptable standard of care.

PROPOSED PENALTY

It is recommended that the Respondent be found in violation of Section 458.331(1)(t), Florida Statutes, and be placed on one year of indirect probation with a 25 percent review of his patient records, and attend 20 hours of continuing medical education in cardiology.

RECOMMENDED this 28th day of May, 1997, in Tallahassee, Florida.

RICHARD HIXSON
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(904) 488-9675 SUMCOM 278-9675

Fax Filing (904) 921-6847
Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of May, 1997.

COPIES FURNISHED:

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Dr. Marm Harris, Executive Director
Board of Medicine
1940 North Monroe Street
Tallahassee, Florida 32399-0792

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.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF MEDICINE

AGENCY FOR HEALTH CARE ADMINISTRATION,

PETITIONER,

vs. CASE NO. 95-00064

RAMESHCHANDRA BHAGWANDAS SHAH, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Agency for Health Care Administration, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Rameshchandra Bhagwandas Shah, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.42, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0050099. Respondent's last known address is 213 Orange Ridge Circle, Longwood, Florida 32779-3029.

3. Respondent is not board certified.

4. On or about November 29, 1994, at approximately 9:01, Patient L.G.T., a 59 year old male, was admitted to Polk General Hospital(PGH) for a complaint of chest pain, rule out Angina, or

MI. Cardiac enzymes and Electrocardiograms (ECG's) were performed by Patient L.G.T.'s primary physician.

5. Between approximately November 29, 1994 and December 1, 1994, Patient L.G.T. remained asymptomatic with no evidence of an myocardial infarction. Patient L.G.T. was discharged at 1:30 PM on or about December 1, 1994.

6. At approximately 12:17 AM on or about December 2, 1994, Patient L.G.T., was admitted to the Emergency Room at Polk General Hospital (PGH) with a complaint of pain under his left arm across his chest, starting about 2:00 PM on or about December 1, 1994.

7. Respondent examined Patient L.G.T. and ran an ECG which was read as no acute changes. Laboratory work and physical examination were normal. Respondent found no medical reason to admit him.

8. At about 2:45 AM Respondent attempted to discharge Patient L.G.T., who continued to complain of back pain. Patient L.G.T. was given a GI cocktail (which is a combination of medications given to relieve gastrointestinal pain), but still complained of pain. Patient L.G.T. requested that Respondent admit him.

9. Respondent discharged Patient L.G.T. from the ER at approximately 3:20 AM on or about December 2, 1994, despite Patient L.G.T.'s request to be admitted. Respondent's diagnosis was angina, resolved. Respondent did not discuss Patient L.G.T.'s condition with the patient's primary physician.

10. At approximately 4:50 AM, of the same day, subsequent to his being discharged, L.G.T. was found in the Emergency Room lobby

unresponsive, face down in vomit, with no pulse or respirations.

11. Patient L.G.T. was transported back to the ER wherein all efforts to resuscitate him were unsuccessful. Patient L.G.T. was pronounced dead by Respondent at approximately 5:00 AM on or about December 2, 1994. The diagnosis was, probable aspiration/asphyxia. Patient L.G.T.'s cause of death was noted as cardiac arrhythmia and hypertensive artery disease.

12. On or about December 2, 1994, Respondent failed to adequately assess Patient L.G.T.'s complaints.

13. Respondent failed to provide an appropriate, adequate, and timely diagnosis of Patient L.G.T.'s chest pain and failed to hospitalize Patient L.G.T.. Respondent read the ECG on or about December 2, 1994 as no acute changes, when the ECG was in fact abnormal.

14. Respondent failed to obtain a consultation from a cardiologist or an internist. Given Patient L.G.T.'s medical condition the standard of care required Respondent to obtain a consultation from a cardiologist or internist.

15. An appropriate plan of treatment was not identified or pursued by the Respondent. A reasonably prudent similar physician would have hospitalized Patient L.G.T. for further treatment.

16. Respondent failed to contact Patient L.G.T.'s primary physician or review previous ECG's. A reasonably prudent similar physician would have notified Patient L.G.T.'s primary care physician to determine the appropriate plan of action.

17. Respondent failed to consider the administration of atropine or pacing to Patient L.G.T.. Atropine is a drug used to treat certain abnormalities of heart rhythm as well as other conditions.

18. Respondent is guilty of the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in that the Respondent failed to adequately assess Patient L.G.T.'s complaints, Respondent failed to provide an adequate, timely, and appropriate diagnosis of Patient L.G.T.'s chest pain, Respondent failed to call for a specialized consultation, Respondent failed to identify and pursue an appropriate plan of treatment for Patient L.G.T. Respondent failed to review Patient L.G.T.'s previous ECG's or contact Patient L.G.T.'s primary physician, and Respondent failed to give atropine, or consider pacing during the attempted resuscitation of L.G.T..

19. Based on the foregoing, Respondent violated Section 458.331(1) (t), Florida Statutes, and is guilty of the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: permanent revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an

administrative fine, issuance of a reprimand, placement of the Respondent on probation, the assessment of costs related to the investigation and prosecution of this case, other than costs associated with an attorney's time, as provided for in Section 455.227(3), Florida Statutes, and/or any other relief that the Board deems appropriate.

SIGNED this 28 day of February, 1996.

Douglas M. Cook, Director

Larry G. McPherson, Jr.
Chief Medical Attorney

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FILED
AGENCY FOR
HEALTH CARE ADMINISTRATION
DEPUTY CLERK
CLERK
DATE 3-1-96