Final Order No. DOH-00-2004- FOF -MOA
FILED DATE - 11/1/2000
Department of Health
By: Vicki R. Kenon
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 1996-12965
DOAH CASE NO.: 99-4716
LICENSE NO.: ME0060883

CESAR AUGUSTO LARA, 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 October 6, 2000, in Orlando, 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 Britt L. Thomas, Senior Attorney. Respondent was not present but was represented by Jon M. Pellett, 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.

DISPOSITION

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

IT IS HEREBY ORDERED AND ADJUDGED that the Administrative Complaint filed in this cause is hereby DISMISSED.

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

DONE AND ORDERED this 17th day of October, 2000.

BOARD OF MEDICINE

For Tanya Williams
GEORGES A. EL-BAHRI, M.D.
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. 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 AGENCY FOR HEALTH CARE ADMINISTRATION 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 Cesar Augusto Lara, M.D., 1217 Ewing Avenue, Clearwater, Florida 34616; to Jon M. Pellett, Esquire, Barr, Murman, Tonelli, Slother & Sleet, 201 E. Kennedy Boulevard, Suite 1750, Tampa, Florida 33602; to J. Lawrence Johnston, Administrative Law Judge, Division of Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-3060; and by interoffice delivery to Kathryn L. Kasprzak, Chief Medical Attorney, and Simone Marstiller, Senior Attorney - Appeals, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308-5403, on or before 5:00 p.m., this 1st day of November, 2000.

Connie Singletary

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. CESAR AUGUSTO LARA, M.D., Respondent.	)	Case No. 99-4716

RECOMMENDED ORDER

On May 2, 2000, a formal administrative hearing was held in this case in Clearwater, Florida, before J. Lawrence Johnston, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Britt Thomas, Esquire
Laudelina McDonald, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317-4229

For Respondent: Grover C. Freeman, Esquire
Jon M. Pellett, Esquire
Freeman, Hunter & Maloy
201 East Kennedy Boulevard, Suite 1950
Tampa, Florida 33602

STATEMENT OF THE ISSUE

The issue in this case is whether Respondent, Cesar Augusto Lara, M.D., should be disciplined on charges alleged in the Administrative Complaint filed by Petitioner, the Department of Health (DOH), in DOH Case No. 96-12965. Essentially, the charges are that Respondent practiced medicine below acceptable standards after receiving a questionable chest X-ray on a patient on November 17, 1994.

PRELIMINARY STATEMENT

On August 13, 1999, DOH filed an Administrative Complaint against Respondent in DOH Case No. 96-12965. Respondent disputed the charges and requested a formal administrative proceeding. The case was referred to the Division of Administrative Hearings (DOAH) and set for final hearing in Clearwater, Florida, on May 2, 2000.

The parties filed a Joint Prehearing Stipulation on April 26, 2000. Respondent filed a Motion for Official Recognition of various statutes and rules and a Second Motion for Taking Official Recognition of certain facts. At final hearing, the former was granted. Ruling was reserved on the latter; now the latter motion is granted as to facts 3, 4, and the part of 5 stating that articles were written, but it is denied as to the other facts.

At final hearing, Petitioner called two witnesses (including one expert) and had Petitioner's Exhibits 1 through 8 admitted in evidence. Respondent testified in his own behalf, called five other witnesses (including two experts) and had Respondent's Exhibits 1 through 9 admitted in evidence. Without objection, Respondent also was granted leave to depose an additional witness after the hearing and have the deposition transcript admitted as Respondent's Exhibit 10.

After presentation of the evidence, Petitioner ordered a transcript, and the parties were given ten days from the filing of the transcript and late exhibit in which to file proposed recommended orders. The Transcript was filed on May 22, 2000,

and Respondent's Exhibit 10 was filed on June 2, 2000. Without objection, Petitioner's Motion to Extend Time to File [Proposed] Recommended Order was granted, and the time for filing proposed recommended orders was extended to June 16, 2000. The timely proposed recommended orders filed by both parties have been considered.

FINDINGS OF FACT

1. Respondent is a Florida licensed physician, having been issued license number ME 0060883. He has been licensed to practice medicine in the State of Florida since 1991. Respondent is board certified in family practice. He maintains a private office practice in Clearwater. He is well-respected and has never been disciplined by the Florida Board of Medicine.

2. This case concerns Respondent's care and treatment of patient D.G. After leaving the care of Respondent, D.G. was diagnosed with lung cancer. The patient died of the disease in August 1995, before having given any sworn testimony or statement regarding Respondent's care and treatment.

3. Respondent began providing medical care to D.G. for upper respiratory problems in January 1994. She had a history of smoking and told Respondent that she had just quit. Some time later, D.G. presented to Respondent with complaints of swelling in the left hand and an inability to move her thumb. Respondent attempted conservative treatment of D.G.'s left hand and thumb; but when her condition did not improve, Respondent referred her to an orthopedic surgeon, Dr. Michael Rothberg, on March 31, 1994. Following referral to Dr. Rothberg, Respondent continued to serve

as D.G.'s primary care physician, taking care of other problems unrelated to her left hand and thumb.

4. On November 3, 1994, Dr. Rothberg had D.G. return to Respondent to obtain surgical clearance for surgery on her hand to be performed under regional block anesthesia on November 29, 1994. Dr. Rothberg specifically requested that Respondent include the following laboratory (lab) studies as part of the surgical clearance: CBC and SMAC routine blood studies; urinalysis; and an EKG.

5. Respondent saw the patient for surgical clearance on November 14, 1994. Respondent conducted a physical examination and ordered the laboratory studies requested by Dr. Rothberg. In addition, Respondent decided to get a chest X-ray as part of his surgical clearance.

6. Based on his physical examination of the patient, Respondent found D.G. to be generally healthy without any respiratory symptoms or contraindications for surgery. Pending receipt of the lab results, Respondent felt that D.G. could undergo the planned surgery by Dr. Rothberg; he did not anticipate lab results that would contraindicate the planned surgery. Respondent dictated a report to that effect in the patient's presence in the examination room. The typed dictation was initialed by Respondent two days later, on November 16, 1994.

7. Respondent testified that, at the conclusion of the office visit on November 14, 1994, he requested that D.G. return to his office in 4-to-6 weeks for follow-up. Petitioner questioned Respondent's sworn testimony on the ground that there

was no documentation in the medical record supporting it. But it was Respondent's routine practice to have patients return to his office following surgery so that he could follow the recovery of his patients from the surgery. In addition, Respondent marked an "encounter form" to indicate his desire for D.G. to return to the office for follow-up in 4-to-6 weeks.

8. An "encounter form" is a common communication tool between a physician and his office staff. It provides a means by which the patient is billed for the services provided. It also provides the staff with direction on scheduling patients for return or follow-up visits. The patient presents the encounter form to Respondent's office staff on the way out of the office. Necessary patient payments are made, and the next appointment is scheduled. The office then utilizes the form to secure third-party payments.

9. Petitioner suggested that the encounter form in evidence as Respondent's Exhibit 2 was fabricated on the ground that Respondent did not produce it until a short time before final hearing. Respondent denied the suggestion, explaining that he did not look for it at first because he did not realize how important it was. Respondent's testimony is accepted, and the suggestion of fabrication is rejected.

10. Should the patient refuse the appointment requested by Respondent on an encounter form, or wish to call back and schedule it later, Respondent's office staff routinely would make a notation on the form indicating that the appointment was not scheduled or that the patient would call to schedule. In this

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case, no such notations were made on the form. Based on routine office practice, the absence of any such notation would signify, in all probability, that D.G. was given a follow-up appointment in the requested time frame before she left Respondent's office, that the appointment was entered in Respondent's computer, and that D.G. was given a card indicating the date of her appointment.

11. By the time of the hearing, there was no way to verify D.G.'s follow-up appointment using Respondent's office computer. Some time in 1998, Respondent switched his office computer system. The new system does not have appointment information going back to 1994, and the old system with old appointment information was not retained.

12. Two days later, on November 16, 1994, Respondent received an imaging report of D.G.'s chest X-ray. The radiologist reported questionable slight prominence of left hilar region, inferiorly, on the posterior-anterior view. On lateral view, no definitive density could be discerned. The radiologist suggested that comparison with old films would be helpful; if old films were not available, he recommended CT examination.

13. Respondent initialed the radiologist's report the next day, November 17, 1994. Respondent testified that it was his routine practice to initial such a report when he reviewed it. He testified that he decided not to withdraw surgical clearance based on the report.

14. Petitioner questioned Respondent's testimony on the ground that there is no medical record documenting Respondent's decision, other than Respondent's dated initials on the imaging

report. But Respondent's testimony in this regard is accepted, and Petitioner's suggestion that Respondent was not even aware of the content of the report is rejected.

15. Respondent's medical record on D.G.'s medical record contains no other information until a pharmacist telephoned Respondent's office on January 18, 1995, to ask Respondent to authorize refilling a prescription for erythromycin. Respondent had his office relay to the pharmacist that Respondent would not authorize refilling the prescription unless Respondent saw the patient in his office. Respondent did not mention the missed appointment or questionable X-ray to the pharmacist, and D.G. never called for an appointment.

16. On or about March 14, 1995, D.G. presented to another physician, Dr. Christopher Purcell, complaining of a five-day cough, pain in the left scapular region, and congestion and wheezing. There was no indication in Dr. Purcell's record that D.G. mentioned the questionable imaging report dated November 16, 1994. (Dr. Purcell did not testify.)

17. On April 11, 1995, Dr. Purcell received D.G.'s medical records from Respondent's office, including the imaging report dated November 16, 1994. Dr. Purcell immediately ordered a repeat X-ray and referred D.G. for a consultation with a specialist on the same day. Not long after, D.G. was diagnosed with lung cancer. She died on August 10, 1995, from squamous cell lung cancer with metastasis to the thoracic spine.

18. Notwithstanding the absence of any medical records between Respondent's dated initials on the imaging report on

November 17, 1994, and January 18, 1995, Respondent testified to a clear recollection of discussing the report with D.G. He testified that he told her they would have to follow-up and resolve the questionable findings but that it could wait until follow-up after her planned surgery.

19. Respondent testified that, for reasons unknown to him, D.G. canceled her follow-up appointment, never rescheduled, and never returned. There was no documentary evidence of D.G.'s canceled appointment, but the evidence was that no such evidence would exist except for cancellations or "no-shows" on the day of an appointment, in which case there would be a notation on a daily appointment sheet. For cancellations prior to the day of an appointment, the appointment would be erased from the calendar so the appointment time could be used for another patient.

20. At the time, Respondent had no system in place for contacting patients who canceled an appointment without rescheduling. Now, after commencement of a lawsuit against him on the facts of this case, Respondent has instituted a "911" system of flagging patients whose medical condition requires the rescheduling of canceled or missed appointments.

21. Petitioner contends that the evidence was clear and convincing that Respondent did not advise D.G. of the results of her chest X-ray or any plan for follow-up, notwithstanding Respondent's testimony that he did. Petitioner not only points to the suspicious absence of medical records (in contrast to Respondent's otherwise complete and accurate medical records) but also points out the patient's history of general good compliance

with Respondent's orders and her failure to tell either her husband or Dr. Purcell about the questionable imaging report dated November 16, 1994.

22. As for the absence of medical records, it was Respondent's routine practice upon receipt of a questionable X-ray or other lab report to ask for the patient's file and telephone the patient. Then, depending on the nature of the report and the patient involved, Respondent either would discuss the report and a plan for follow-up on the telephone or arrange for an appointment to discuss those matters in person in Respondent's office. If Respondent discussed the matter on the telephone, he normally would document the telephone call and the plan in the patient's medical record. However, it is possible that Respondent made the call to D.G. from outside the office without having her medical record available; it also is possible that he had to leave a message for D.G. and that her medical record was not readily available to him when she returned the call. Either scenario could have led to Respondent's failure to make a record of his telephone call to D.G.

23. Respondent concedes that D.G. was a compliant patient who generally followed his orders and recommendations. She was interested and concerned about health issues affecting her and would not be inclined to ignore medical advice on them. But changes in Respondent's relationship with D.G.'s health care plan--PruCare--could explain why D.G. did not keep her follow-up appointment with Respondent. It was public knowledge that PruCare was terminating its contracts with several area

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physicians including Respondent, effective January 1, 1995. Respondent gave written notification of these events to his PruCare patients. PruCare also notified its insureds. Both the terminated physicians and PruCare placed advertisements in local newspapers asserting the merits of their positions in the dispute that arose from the termination. Newspaper articles also were published on the issue. It is highly probable that D.G. became aware of the contract termination in one way or another.

24. As a result of the contract termination, PruCare would not cover visits to Respondent after January 1, 1995. Most PruCare patients changed primary care physicians to keep the financial benefit of their PruCare policies. It is possible that D.G.'s follow-up appointment was scheduled for just after the first of the year and that she called to cancel, anticipating following up with a new PruCare-approved primary care physician. Even if the follow-up appointment was scheduled for December 1994, it is quite conceivable that D.G. canceled it in the same anticipation.

25. Normally, D.G. would discuss her health concerns with her husband. But her husband also testified that she did not discuss everything with him. Specifically, he had no knowledge that she was having a chest X-ray taken prior to her hand surgery. Nor did he know the specifics of any of the lab studies done for Respondent's clearance for surgery.

26. It is more difficult to explain the patient's apparent failure to mention the questionable imaging report to Dr. Purcell on March 14, 1995 (based on the absence of any medical record

documenting such a disclosure to him.) Assuming completeness of Dr. Purcell's medical records, it could well be that Respondent did not impress on D.G. the possible significance of the findings during his telephone conversation with her after review of the imaging report. He might not have seen the need to do so prior to the follow-up appointment he was anticipating. He also might not have wanted to so as not to unnecessarily complicate the impending hand surgery by making the patient overly anxious about the imaging report and what it could signify.

27. Taking all of the evidence into consideration, it is found that Petitioner did not prove by clear and convincing evidence Respondent's alleged failure to advise D.G. of the results of her chest X-ray or any plan for follow-up.

28. Besides Respondent, three physicians testified as experts in this case. All agree that the "level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances" (the "standard of care") required Respondent to notify the patient to discuss the report and a plan of follow-up, which could include: physical examination; review of older X-rays (to determine if there was a change between X-rays); a repeat X-ray; a CT study (for a clearer image than an X-ray); and referral to a specialist. The disagreements among the experts centered on the urgency of follow-up and the assumed facts.

29. Respondent's two experts accepted the veracity of Respondent's testimony that Respondent discussed with the patient the imaging report and his plan for follow-up at the appointment

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scheduled for follow-up for the hand surgery. Petitioner's expert assumed the contrary.

30. Petitioner's expert testified that it was incumbent on Respondent to follow-up within 24-48 hours. But it was not clear from his testimony if "follow-up" in this context meant anything other than notification to the patient and discussion of a plan for timely follow-up. If so, Petitioner's expert was at odds with the other experts, all of whom clearly testified to their opinions that the other means of follow-up could be accomplished within anywhere from two weeks to two months. (As for physical examination, Respondent already had examined the patient on November 14, 1994, and there were no symptoms. As for review of older X-rays, the only previous X-ray was from 1989, and Respondent testified to his opinion that simply reviewing an X-ray that old would not meet the "standard of care.")

31. Respondent and his experts placed responsibility on the patient to follow her doctor's recommendations. They did not think the "standard of care" required Respondent to contact D.G. to remind her, much less require her, to reschedule her appointment. In all probability, D.G. would have rescheduled but for PruCare's cancellation of its contract with Respondent. Through a combination of circumstances for which they did not think Respondent should be held responsible, the patient did not reschedule her appointment and was "lost to follow-up" by Respondent.

32. Based on the pertinent factual findings and the expert testimony, Petitioner did not prove by clear and convincing

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evidence that Respondent practiced medicine below the "standard of care."

33. Petitioner also suggested that Respondent was at fault for not directing D.G. to a particular primary care physician for medical care after January 1, 1995. But Respondent and his staff testified that PruCare did not make Respondent aware of his patients' options for primary care after the contract termination. There was no evidence to dispute their testimony to that effect. Nor was there any evidence that the "standard of care" required Respondent to direct D.G. to a particular primary care physician for medical care after January 1, 1995.

34. Finally, Petitioner suggested that Respondent had an obligation to follow-up on the missed appointment when the pharmacist telephoned on January 18, 1995. Petitioner's argument would have been stronger had the patient telephoned instead of the pharmacist. As it was, the evidence was not clear and convincing that a telephone call from a pharmacist should have triggered the realization that D.G. had missed her follow-up appointment. In addition, there was no evidence that the "standard of care" required Respondent to follow-up on the missed appointment at that point. Besides, it would have been reasonable for Respondent to assume at that point that D.G. probably would not return to him but would see a new primary care physician contracted to PruCare under the patient's health care plan.

35. Clearly, early detection and treatment of cancer is important. But, while not particularly relevant to the question

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of whether Respondent practiced within the "standard of care," it is noted that all of the physicians testifying as experts agreed that the outcome probably would not have been different had D.G.'s cancer been diagnosed in November 1994. Unfortunately, lung cancer is difficult to detect; when detected, it usually is beyond cure, and death usually follows relatively soon thereafter.

CONCLUSIONS OF LAW

36. Section 458.331(1)(t), Florida Statutes, authorizes the Board of Medicine to discipline a physician on proof of:

> 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.

37. Section 458.331(3), Florida Statutes, provides:

> In any administrative action against a physician which does not involve revocation or suspension of license, the division shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.

Petitioner concedes that its burden in this case was to prove the allegations by clear and convincing evidence. See also Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987). (Even though Petitioner's Proposed Recommended Order only sought imposition of a fine, costs, and continuing education requirements, the Administrative Complaint sought revocation or suspension.)

38. In this case, Petitioner did not prove by clear and convincing evidence that Respondent failed 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."

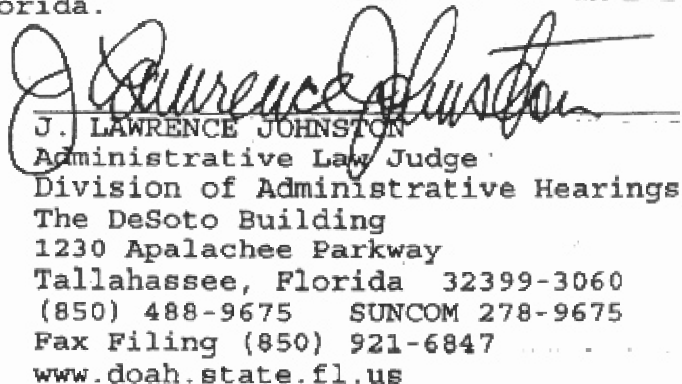
39. Petitioner attempted to assert that Respondent's failure to document his telephone discussion of the questionable imaging report and his plan for follow-up with the patient and failure to document her cancellation of her post-surgery follow-up appointment constituted practice medicine below the "standard of care." But the Administrative Complaint did not allege failure to document the medical record as a part of the alleged failure to practice medicine at or above the "standard of care." Petitioner cannot in effect amend the Administrative Complaint to do so at this time. See Abdul Ghani, M.D. v. Dept. of Health, 714 So. 2d 1113 (Fla. 1st DCA 1998).

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Board of Medicine enter a final order finding Respondent not guilty.

DONE AND ENTERED this 17th day of July, 2000, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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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.

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,	)	
	)	
PETITIONER,	)	
	)	
v.	)	CASE NO. 1996-12965
	)	
CESAR AUGUSTO LARA, M.D.,	)	
	)	
RESPONDENT.	)	
	)	

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Health, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Cesar Augusto Lara, M.D., hereinafter referred to as "Respondent," and alleges:

1. Effective July 1, 1997, Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 455, Florida Statutes, and Chapter 458, Florida Statutes. Pursuant to the provisions of Section 20.43(3), Florida Statutes, the Petitioner has contracted with the Agency for Health Care Administration to provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards, as appropriate.

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 0060883. Respondent's last known address is 1217 Ewing Avenue, Clearwater, FL 34616.

3. Respondent area of specialty is Family Practice. He is Board certified.

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4. On or about January 4, 1994, patient D.G., a fifty year old female presented to Respondent with complaints of severe cough, aches, pains, lost voice, sore throat for the previous three days. After this first appointment Respondent examined, diagnosed, and treated patient D.G. on a number of occasions for various medical conditions in the capacity of patient's primary care physician.

5. On or about November 14, 1994, Respondent examined patient D.G. for surgical clearance for a joint arthroplasty of the left thumb under general anesthesia scheduled to be performed by a orthopedic surgeon.

6. Respondent ordered patient D.G. to undergo prior to surgery the following lab work: EKG, urinalysis, the SMA battery test (a biochemical profile of the patient), CBC (complete blood count), PT/PTT (prothrombin time/partial thromboplastin time), and chest x-ray.

7. On or about November 16, 1994, patient D.G. underwent a chest x-ray. In his x-ray report, the radiologist noted as his findings the following: "Views of the chest demonstrate slight prominence of left hilar region inferiorly. On lateral view, no definitive density is discerned. If previous examinations are not available for comparison, then CT (computed tomography) examinations would be suggested for further evaluation. Cardiac silhouette and bony thorax are unremarkable."

8. The radiologist reiterated his advice for chest x-ray comparison or CT scan for patient D.G. in the conclusion of his x-ray report, under "impressions": "Questioned left subhilar density on PA view. Comparison with old films would be helpful and if not available, then CT examination would be suggested."

9. Respondent did not locate and obtain for comparison patient D.G.'s chest x-rays taken prior to on or about November 16, 1994, as advised by the radiologist.

10. Respondent did not refer patient D.G. for a chest CT-scan, as advised by the radiologist.

11. Respondent did not follow-up on the advice of the radiologist who performed patient D.G.'s chest x-rays on or about November 16, 1994.

12. Respondent did not contact patient D.G. to advise her of the chest x-ray findings and the recommendations of the radiologist who performed them.

13. Subsequently, in or around March-April, 1995, patient D.G. was diagnosed with lung carcinoma.

14. Respondent failed 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 with regard to patient D.G. in that Respondent failed to locate and obtain for comparison patient D.G.'s chest x-rays taken prior to on or about November 16, 1994, as advised by the radiologist; failed to refer patient D.G. for a chest CT-scan, as advised by the radiologist; failed to follow-up the advice of the radiologist who performed patient D.G.'s chest x-rays on or about November 16, 1994; failed to contact patient D.G. to advise her of the chest x-ray findings and the recommendations of the radiologist who performed them.

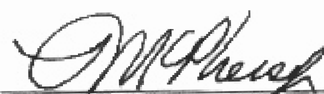
15. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, in that he is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable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

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 as provided for in Section 455.624(4), Florida Statutes, and/or any other relief that the Board deems appropriate.

SIGNED this 13 day of August, 1998.

Robert G. Brooks, M.D., Secretary



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PCP Members: Skinner, Glotfelty, Cherney

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Stephanie J. Dixon
DATE 8-13-99