Final Order No. DOH-08-0712- S -MQA
FILED DATE - APR 18 2008
Department of Health
By [signature]
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NOS.: 2002-18534
2004-22912
2004-27542
2005-02980
2005-03228
LICENSE NO.: ME0062066

BRANISLAV STOJANOVIC, M.D.,

Respondent.
______________________________/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on April 4, 2008, in West Palm Beach, Florida, for the purpose of considering a Settlement Agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Upon consideration of the Settlement Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED AND ADJUDGED that the Settlement Agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference with the following clarification:

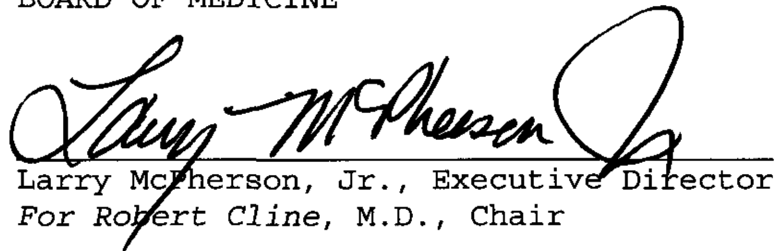
The costs set forth in Paragraph 3 of the Stipulated Disposition shall be set at $20,000.00.

Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Settlement Agreement as clarified above.

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

DONE AND ORDERED this 16 day of APRIL, 2008.

BOARD OF MEDICINE



Larry McPherson, Jr., Executive Director
For Robert Cline, M.D., Chair

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 Branislav Stojanovic, M.D., 420 North East 3rd Street, Ft. Lauderdale, Florida 33301; to Anthony C. Vitale, Esquire, The Health Law Offices, 2333 Brickell Avenue, Suite A-1, Miami, Florida 33129-2497; to Allen R. Grossman, Esquire, Metzger, Grossman, Furlow & Bayo, LLC, 1408 N. Piedmont Way, Tallahassee, Florida 32308; and by interoffice delivery to Ephraim Livingston, Department of Health, 4052 Bald Cypress Way, Bin #C-

65, Tallahassee, Florida 32399-3253 this 18 day of April, 2008.

Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2005-03228**

BRANISLAV M. STOJANOVIC, M.D.,

RESPONDENT.
_______________________________/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Branislav M. Stojanovic, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the state of Florida, having been issued license number ME 62066.

3. Respondent's address of record is 420 North East 3rd Avenue, Fort Lauderdale, Florida 33301.

4. Respondent is not board certified in any specialty area, but practices in the area of psychiatry.

5. Part I of Chapter 394, Florida Statutes, contains "The Florida Mental Health Act," commonly known as "The Baker Act." Specifically Section 394.467, Florida Statutes (2004), relates to involuntary inpatient placement and specifies the criteria and procedures to be followed for involuntary inpatient placement.

6. According to Section 394.467, Florida Statutes (2004), a psychiatrist is required to personally examine the patient and provide or support a recommendation that the patient meets the specified criteria for involuntary inpatient placement. For continued involuntary placement, a second opinion must be obtained within 72 hours of the initial involuntary placement that the criteria are met and a petition for involuntary inpatient placement must be immediately filed in the circuit court. While the administrator of the facility in which the patient is placed is responsible for the actual filing of the petition, the two psychiatrists whose opinions support the involuntary inpatient placement are responsible for ensuring

that the petition is filed and that no patient is held without the statutory procedures being followed.

FACTS RELATED TO PATIENT E.S.#1

7. On or about October 26, 2004, patient E.S.#1 (ES1), a then twenty-one (21) year-old person, was admitted to the Psychiatric Unit of Florida Medical Center with a diagnosis of Bipolar Disorder.

8. ES1 was noted to be suicidal and on a Baker Act admission. The Baker Act was signed by David Masters on October 26, 2004, at 1330 hours.

9. The "Initial Psychiatric Evaluation" done by Respondent on October 27, 2004, is not timed, is illegible and is inadequate.

10. All other care for the patient was rendered by I.P., another physician (Dr. I.P.), who wrote orders and progress notes.

11. ES1 signed a "Specific Authorization for Psychotropic Medications," but there is no signature of a Guardian, Guardian Advocate, or other responsible party despite the fact that the patient was on an involuntary status.

12. ES1 also signed a "Request for Voluntary Admission," but it is not dated.

13. Although ES1 was hospitalized for nine (9) days, the record

contains no subsequent "Petition for Involuntary Placement," nor the required second opinion, and the patient's legal status is never clear.

COUNT ONE

14. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) as if fully set forth herein.

15. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician 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.

16. Respondent's medical records are not accurate, complete or legible, and do not justify the course of treatment of the care of ES1.

17. Respondent failed to keep medical records justifying his course of treatment of ES1 in violation of Section 458.331(1)(m), Florida Statutes (2004), one or more of the following ways:

a) Respondent's medical records were so illegible as to be useless in determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely; and

b) the medical records are incomplete because they do not contain documents required by Part I of Chapter 394, Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

COUNT TWO

18. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) as if fully set forth herein.

19. Section 458.331(1)(g), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to perform any statutory or legal obligation placed upon a licensed physician.

20. As described in paragraphs five (5) and six (6) above, Part I of Chapter 394, Florida Statutes (2004), contains "The Florida Mental Health Act," commonly known as "The Baker Act."

21. ES1 was hospitalized without the proper Baker Act procedures being followed for longer than seventy-two (72) hours without a subsequent Petition for Involuntary Placement or a required second opinion.

22. Respondent violated Section 458.331(1)(g), Florida Statutes (2004), by failing to perform the statutory and legal obligations placed upon him by Part I of Chapter 394 Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

FACTS RELATED TO PATIENT M.M.

23. *On or about January 17, 2005, patient M.M., a then forty-one* (41) year-old person, was admitted with a diagnosis of Schizoaffective Disorder and noted to be on a Baker Act at admission.

24. The Initial Psychiatric Evaluation done by Respondent is not timed, is illegible and is inadequate.

25. The statement on the Initial Psychiatric Evaluation "The patient is competent to sign for voluntary admission and authorization for treatment" is not checked.

26. Except for two days, the rest of the M.M.'s care was rendered by Dr. I.P.

27. Although M.M. was hospitalized for ten (10) days, the record contains no subsequent Petition for Involuntary Placement or required second opinion.

28. The record contains a Letter of Plenary Guardianship dated March 7, 2000, appointing S.M. guardian of M.M., but the record contains no indication that S.M. was ever contacted.

COUNT THREE

29. Petitioner realleges and incorporates paragraphs one (1) through six (6) and paragraphs twenty-three (23) through twenty-eight (28) as if fully set forth herein.

30. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician 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.

31. Respondent's medical records are not accurate, complete or legible, and do not justify the course of treatment of the care of M.M.

32. Respondent failed to keep medical records justifying his course of treatment of M.M. in violation of Section 458.331(1)(m), Florida Statutes (2004), in one or more of the following ways:

a. Respondent's medical records are so illegible as to be useless in determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely; and

b. the medical records are incomplete because they do not contain documents required by Part I of Chapter 394, Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

COUNT FOUR

33. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) and paragraphs twenty-three (23) through 28 (twenty-eight) as if fully set forth herein.

34. Section 458.331(1)(g), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to perform any statutory or legal obligation placed upon a licensed physician.

35. As described in paragraphs five (5) and six (6) above, Part I of Chapter 394, Florida Statutes (2004), contains "The Florida Mental Health Act," commonly known as "The Baker Act."

36. M.M. was hospitalized without the proper Baker Act procedures being followed for longer than seventy-two (72) hours without a subsequent Petition for Involuntary Placement or a required second opinion.

37. Respondent violated Section 458.331(1)(g), Florida Statutes (2004), by failing to perform the statutory and legal obligations placed upon him by Part I of Chapter 394 Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

FACTS RELATED TO PATIENT A.S.

38. On or about January 19, 2005, patient A.S., a then thirty-three (33) year-old person, was admitted voluntarily with a diagnosis of Bipolar Disorder.

39. The Initial Psychiatric Evaluation done by Respondent on January 19, 2005, is not timed, is illegible and is inadequate.

40. The statement on the Initial Psychiatric Evaluation "The patient is competent to sign for voluntary admission and authorization for treatment" was not checked, although the patient was listed as voluntarily admitted.

41. Respondent only saw A.S. one additional time on January 25, 2005, and that note is also illegible.

COUNT FIVE

42. Petitioner realleges and incorporates paragraphs one (1) through six (6) and paragraphs thirty-eight (38) through forty-one (41) as if fully set forth herein.

43. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician 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.

44. Respondent's medical records are not accurate, complete or legible, and do not justify the course of treatment of the care of A.S.

45. Respondent failed to keep medical records justifying his course of treatment of A.S. in violation of Section 458.331(1)(m), Florida Statutes

(2004), in that his medical records are so illegible as to be useless in determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely.

FACTS RELATED TO PATIENT E.S.#2

46. On or about January 24, 2005, patient E.S.#2 (ES2), a then sixty-four (64) year-old person was admitted on a Baker Act admission with a diagnosis of Psychosis NOS.

47. The Initial Psychiatric Evaluation done by Respondent on January 25, 2005, was not timed, was illegible and was inadequate.

48. Respondent saw the ES2 on January 29, and 30, and February 1, 2005. Respondent's notes are illegible.

49. Dr. I.P. saw ES2 on all other occasions.

50. There was no required second opinion obtained; however, the patient's legal status was clarified by a copy of an order appointing the patient's wife his legal guardian.

51. Respondent's original notes and evaluation and subsequent notes are illegible and inadequate.

COUNT SIX

52. Petitioner realleges and incorporates paragraphs one (1) through six (6) and paragraphs forty-six (46) through fifty-one (51) as if fully set forth herein.

53. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as *defined by department rule in consultation with the board, medical records* that identify the licensed physician or the physician 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.

54. Respondent's medical records are not accurate, complete or legible, and do not justify the course of treatment of the care of ES2.

55. Respondent failed to keep medical records justifying his course of treatment of ES2 in violation of Section 458.331(1)(m), Florida Statutes (2004), in that his medical records are so illegible as to be useless in

determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely.

FACTS RELATED TO PATIENT R.T.

56. On or about October 9, 2004, patient R.T., a then thirty-eight (38) year-old person, was voluntarily admitted with a diagnosis of cardiac arrhythmia and Conduct Disorder.

57. On October 11, 2004, a psychiatric consult was requested, and Respondent was called.

58. The Consent for Treatment is not signed, and a note says "Patient unable to sign."

59. On or about October 15, 2004, apparently R.T. became uncontrollable, and was transferred to the psychiatric unit on a Baker Act admission.

60. Dr. I.P. did a psychiatric consult on October 16, 2004, which is almost illegible.

61. R.T. was admitted on October 18, 2004, and discharged on October 25, 2004, on a Baker Act with a diagnosis of Schizoaffective Disorder.

62. The Initial Psychiatric Evaluation done by Respondent on October 19, 2004, is not timed, is illegible and is inadequate.

63. Respondent's notes of October 20, 23, and 26 (even though R.T. was discharged on October 25), 2004, are illegible.

64. The statement "The patient is competent to sign for voluntary admission and authorization for treatment" is not checked.

65. The Baker Act form is illegibly signed, it is not dated or timed, nor is the name of the signor typed or printed as required.

66. The "Application for Voluntary Admission" was never signed, and R.T. signed an "Application for Release" on October 24, 2004.

67. Although R.T. was hospitalized for sixteen (16) days, the record contains no Petition for Involuntary Placement or the required second opinion. The patient's legal status was never clear.

68. R.T. was essentially treated without any authorization from October 9, 2004, until the Baker Act was signed by Respondent on an unknown date.

69. On or about January 17, 2005, R.T. was readmitted, with a diagnosis of Schizoaffective Disorder and noted to be a voluntary patient.

70. R.T. was discharged on January 27, 2005.

71. The Initial Psychiatric Evaluation done by Respondent on January 18, 2005, is not timed, is illegible and is inadequate.

72. Respondent's notes of January 19 and 25, 2005, are illegible.

73. Although the patient is noted to be voluntary, the statement in the Initial Psychiatric Evaluation "The patient is competent to sign for voluntary admission and authorization for treatment" is not checked.

74. R.T. signed the Application for Voluntary Admission and Consent for Treatment forms.

COUNT SEVEN

75. Petitioner realleges and incorporates paragraphs one (1) through six (6) and paragraphs fifty-six (56) through seventy-four (74) as if fully set forth herein.

76. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician 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.

77. Respondent's illegible medical records are not accurate and do not completely document or justify the course of treatment or the care of R.T. because it is impossible to determine if the diagnosis of the patient's condition was appropriate, adequate, accurate, or timely.

78. Respondent failed to keep medical records justifying his course of treatment of R.T. in violation of Section 458.331(1)(m), Florida Statutes (2004), in one or more of the following ways:

a. Respondent's medical records are so illegible as to be useless in determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely: and

b. the medical records are incomplete because they do not contain documents required by Part I of Chapter 394, Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

COUNT EIGHT

79. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) and paragraphs fifty-six (56) through seventy-four (74) as if fully set forth herein.

80. Section 458.331(1)(g), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to perform any statutory or legal obligation placed upon a licensed physician.

81. As described in paragraphs five (5) and six (6) above, Part I of Chapter 394, Florida Statutes (2004), contains "The Florida Mental Health Act," commonly known as "The Baker Act."

82. R.T. was hospitalized without the proper Baker Act procedures being followed for longer than seventy-two (72) hours without a subsequent Petition for Involuntary Placement or a required second opinion, without a timely or legible Baker Act form, and R.T. was essentially treated without any authorization from October 9, 2004, until the Baker Act was signed by Respondent on an unknown date.

83. Respondent violated Section 458.331(1)(g), Florida Statutes (2004), by failing to perform the statutory and legal obligations placed upon him by Part I of Chapter 394 Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

FACTS RELATED TO PATIENT P.H.#1

84. On or about October 6, 2004, patient P.H.#1 (PH1), a then thirty-seven (37) year-old person, was voluntarily admitted with a diagnosis of Bipolar Disorder.

85. PH1 was discharged on October 18, 2004.

86. The Initial Psychiatric Evaluation done by Respondent on October 16, 2004, is not timed, is illegible and is inadequate.

87. The statement in the Initial Psychiatric Evaluation "The patient is competent to sign for voluntary admission and authorization for treatment" is not checked.

88. Respondent's notes of October 9, 10, 12, and 13, 2004, are illegible.

COUNT NINE

89. Petitioner realleges and incorporates paragraphs one (1) through six (6) and paragraphs eighty-four (84) through eighty-eight (88) as if fully set forth herein.

90. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician 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.

91. Respondent's medical records are not accurate, complete or legible, and do not justify the course of treatment of the care of PH1.

92. Respondent failed to keep medical records justifying his course of treatment of PH1 in violation of Section 458.331(1)(m), Florida Statutes (2004), in that his medical records are so illegible as to be useless in determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely.

FACTS RELATED TO PATIENT R.L.

93. On or between September 27, 2004, and October 29, 2004, patient R.L. was admitted and discharged with a diagnosis of Psychosis and Dementia and noted to be on a Baker Act. R.L. was listed as coming from an Adult Living Facility (ALF).

94. The Initial Psychiatric Evaluation done by Respondent on September 29, 2004, is not timed, and is illegible and is inadequate.

95. Respondent's notes of October 6, 9, 10, 17, 18, 19, 20, 23, 24, 26, and 27, 2004, are illegible.

96. The medical file indicates that R.L. has a legal guardian, but the record contains no indication that the legal guardian was ever contacted.

97. Patient R.L. was admitted a second time from on or about November 9, 2004, to November 29, 2004, with the same diagnosis. On this admission, the Baker Act was signed by Dr. I.P. on November 9, 2004.

98. The Initial Psychiatric Evaluation done by Respondent on November 9, 2004, is not timed, is illegible and is inadequate.

99. Respondent's notes of November 10, 16, 17, 20, 21, 23, and 24, 2004, are also illegible.

100. Although patient R.L. was hospitalized twice, first for thirty days and then for twenty days, the record contains no Petition for Involuntary Placement filed during either hospitalization and the record contains no required second opinion.

101. The patient's legal status was never clear during either admission.

102. There was no explanation for the failure to notify the patient's guardian.

103. The patient appears to suffer from Dementia and appears to have been sent to the hospital when his behavior at the ALF became out of control.

COUNT ELEVEN

104. Petitioner realleges and incorporates paragraphs one (1) through six (6) and paragraphs ninety-three (93) through one hundred three (103) as if fully set forth herein.

105. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician 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.

106. Respondent's illegible medical records are not accurate and do not ~~completely document or justify the course of treatment of the care~~ of

R.T. because it is impossible to determine if the diagnosis of the patient's condition was appropriate, adequate, accurate, or timely.

107. Respondent's medical records do not justify the course of treatment of the care of R.L.

108. Respondent failed to keep medical records justifying his course of treatment of R.L. in violation of Section 458.331(1)(m), Florida Statutes (2004), in one or more of the following ways:

a. Respondent's medical records are so illegible as to be useless in determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely; and

b. the medical records are incomplete because they do not contain documents required by Part I of Chapter 394, Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

COUNT TWELVE

109. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) and paragraphs ninety-three (93) through one hundred three (103) as if fully set forth herein.

110. Section 458.331(1)(g), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to perform any statutory or legal obligation placed upon a licensed physician.

111. As described in paragraphs five (5) and six (6), Part I of Chapter 394, Florida Statutes (2004), contains "The Florida Mental Health Act," commonly known as "The Baker Act."

112. R.L. was hospitalized twice without the proper Baker Act procedures being followed because he was held for longer than seventy-two (72) hours without a subsequent Petition for Involuntary Placement or a required second opinion in both hospitalizations.

113. Respondent violated Section 458.331(1)(g), Florida Statutes (2004), by failing to perform the statutory and legal obligations placed upon him by Part I of Chapter 394 Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

FACTS RELATED TO PATIENT P.H.#2

114. On or about November 22, 2004, patient P.H.#2 (PH2), a then forty-four year old person, was admitted with a diagnosis of Paranoid Schizophrenia and noted to be on a Baker Act admission; however, the Baker Act was not signed.

115. PH2 was discharged on December 13, 2004.

116. PH2 did sign an application for Voluntary Admission, but it was not witnessed or dated.

117. The Initial Psychiatric Evaluation done by Respondent on November 23, 2004, is not timed, is almost illegible and is inadequate. Additionally, although Respondent documented in the evaluation that the patient is grossly delusional, paranoid and hearing voices, he still indicated that the "Patient is competent to sign for voluntary admission and authorization for treatment."

118. A Department of Health expert opined that these two statements are mutually exclusive.

119. Respondent's notes of November 26 and 30 and December 1, 5, 6, 11, and 12, 2004, are also illegible.

120. The patient's legal status was never clear.

COUNT THIRTEEN

121. Petitioner realleges and incorporates paragraphs one (1) through six (6) and paragraphs one hundred fourteen (114) through one hundred twenty (120) as if fully set forth herein.

122. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as

defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician 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.

123. Respondent's illegible medical records are not accurate and do not completely document or justify the course of treatment of the care of PH2 because it is impossible to determine if the diagnosis of the patient's condition was appropriate, adequate, accurate, or timely.

124. Respondent's medical records do not justify the course of treatment of the care of PH2.

125. Respondent failed to keep medical records justifying his course of treatment of PH2 in violation of Section 458.331(1)(m), Florida Statutes (2004), in one or more of the following ways:

a. Respondent's medical records are so illegible as to be useless in determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely;

b. the medical records are incomplete because they do not contain documents required by Part I of Chapter 394, Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement; and

c. the medical records contain conflicting statements not conducive to appropriate medical treatment.

COUNT FOURTEEN

126. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) and paragraphs one hundred fourteen (114) through one hundred twenty (120) as if fully set forth herein.

127. Section 458.331(1)(g), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to perform any statutory or legal obligation placed upon a licensed physician.

128. As described in paragraphs five (5) and six (6), Part I of Chapter 394, Florida Statutes (2004), contains "The Florida Mental Health Act," commonly known as "The Baker Act."

129. Patient PH2 was hospitalized without the proper Baker Act procedures being followed for longer than seventy-two (72) hours without a subsequent Petition for Involuntary Placement or required second opinion.

130. Respondent violated Section 458.331(1)(g), Florida Statutes (2004), by failing to perform the statutory and legal obligations placed upon him by Part I of Chapter 394 Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

FACTS RELATED TO PATIENT J.S.

131. On or about November 23, 2004, patient J.S., a then seventy-seven (77) year-old person, was admitted with a diagnosis of Psychosis NOS and noted to be a Baker Act on admission.

132. The Baker Act was signed by Respondent on November 24, 2004.

133. The patient was not discharged until December 22, 2004.

134. The Initial Psychiatric Evaluation done by Respondent on November 24, 2004, is not timed, is illegible and is inadequate. The statement in the Initial Psychiatric Evaluation "The patient is competent to sign for voluntary admission and authorization for treatment" is not checked.

135. Respondent's notes of November 30, and December 1, 6, 5, 11, and 12, 2004, are illegible.

136. An Application for Voluntary Admission is signed by J.S. on December 7, 2004, (fourteen days after admission) and witnessed and timed at 10:00 p.m.

137. Neither Respondent's or Dr. I.P.'s notes, while almost illegible, indicate any change in behavior that would justify allowing the patient to sign a voluntary admission.

138. Although the patient was hospitalized for fourteen days before signing the Application for Voluntary Admission, the record contains no Petition for Involuntary Placement or the required second opinion and the patient's legal status was never clear.

COUNT FIFTEEN

139. Petitioner realleges and incorporates paragraphs one (1) through six (6) and paragraphs one hundred thirty one (131) through one hundred thirty-eight (138) as if fully set forth herein.

140. Section 458.331(1)(m), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician 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.

141. Respondent's illegible medical records are not accurate and do not completely document or justify the course of treatment of the care of J.S. because it is impossible to determine if the diagnosis of the patient's condition was appropriate, adequate, accurate, or timely.

142. Respondent's medical records do not justify the course of treatment of the care of J.S.

143. Respondent failed to keep medical records justifying his course of treatment of J.S. in violation of Section 458.331(1)(m), Florida Statutes (2004), in one or more of the following ways:

a.) Respondent's medical records are so illegible as to be useless in determining the accuracy of the diagnosis, rendering the medical records inadequate, incomplete, inaccurate, and untimely; and

b.) the medical records are incomplete because they do not contain documents required by Part I of Chapter 394, Florida

Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

COUNT SIXTEEN

144. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) and paragraphs one hundred thirty-one (131) through one hundred thirty-eight (138) as if fully set forth herein.

145. Section 458.331(1)(g), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for failing to perform any statutory or legal obligation placed upon a licensed physician.

146. As described in paragraphs five (5) and six (6), Part I of Chapter 394, Florida Statutes (2004), contains "The Florida Mental Health Act," commonly known as "The Baker Act." 159.

147. J.S was hospitalized without the proper Baker Act procedures being followed because he was held for longer than seventy-two (72) hours without a subsequent Petition for Involuntary Placement or a required second opinion. Even if the patient was competent to sign, the Application for Voluntary Admission was not signed until fourteen (14) days after the admission. The patient's legal status was never clear.

148. Respondent violated Section 458.331(1)(g), Florida Statutes (2004), by failing to perform the statutory and legal obligations placed

upon him by Part I of Chapter 394 Florida Statutes (2004), specifically Section 394.467, Florida Statutes (2004), related to involuntary inpatient placement.

FACTS RELATED TO THE SCHEME

149. All of these hospital admissions were made to Florida Medical Center in Ft. Lauderdale, Florida, as part of a scheme to elevate and enhance the patient bed census in the psychiatric unit.

150. Florida Medical Center is a privately owned hospital and its parent company, Tenet Healthcare Corporation (Tenet), on or about February 20, 2006, paid a large fine as part of a settlement of this and other schemes which involved Florida Hospital and other Tenet facilities. Respondent was an active participant in this scheme.

COUNT SEVENTEEN

151. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) and paragraphs one hundred fourty-nine (149) through one hundred fifty (150) as if fully set forth herein.

152. Section 458.331(1)(n), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party ....

153. Respondent exercised influence on many of the patients listed above in violation of Section 458.331(1)(n), Florida Statutes (2004), in such a manner as to exploit those patients by unlawfully keeping them in the psychiatric unit of Florida Medical Center for extended periods of time, thereby increasing the patient census and increasing the financial gain of the facility.

154. Respondent violated Section 458.331(1)(n), Florida Statutes (2004), by for exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party ....

FACTS RELATED TO STANDARD OF CARE

155. On January 30, 2006, a Department expert reviewed the medical records of the patients identified above and determined that Respondent's overall care was both illegal and deprived the patients of their rights.

~~156. For a patient to be kept on involuntary status,~~ the attending physician must request and get a second opinion justifying that status within seventy-two hours and must ensure that a petition for involuntary placement ~~is filed. Because it is unclear that any of these patients~~ had the

capacity to consent to treatment, Respondent failed to meet these requirements.

157. The Department's expert further opined that little or no active or aggressive care was given to these patients. With some patients, such as the elderly or chronically impaired with behavioral problems, such a course of treatment might have been appropriate; however, such a course of treatment was not appropriate for patients admitted for social reasons or for the patient's lack of cooperation in the previous "institutional" placements.

158. The expert further stated that the initial and subsequent notes are so poor as to make it difficult or impossible to determine whether any appropriate treatment regimen was followed.

159. According to the expert, Respondent's notes appear to be written such that they could be generic forms that could be completed without seeing the patients, and many of the notes are so vague or illegible that they appear to be interchangeable.

160. Additionally, the expert opined that while the form for the Initial Psychiatric Evaluation is reasonable, Respondent did not provide enough information to make it meaningful. The substance of the forms

could be used interchangeably amongst all patients due to the absence of legible notes on the forms.

161. As previously indicated by the expert, the medical records of Respondent are almost entirely illegible so as to be virtually useless.

COUNT EIGHTEEN

162. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13) and paragraphs one hundred fifty-five (155) through one hundred sixty-one (161) as if fully set forth herein.

163. Section 458. 331(1)(t), Florida Statutes (2004), subjects a licensee to discipline, including suspension, for 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.

164. According to the Department's expert, the pattern of shoddy care provided to these patients is such that it constitutes the failure to practice medicine within the standard of care.

165. Respondent failed to practice medicine with an acceptable level of care in violation of Section 458.331(1)(t), Florida Statutes (2004), in his treatment of the above-referenced patients, in one or more of the following ways:

a. by failing to perform adequate initial and follow-up psychiatric evaluations and treatments;

b. by failing to follow the requirements of the Baker Act;

c. by failing to ensure that patient's rights under the Baker Act were protected;

d. by failing to maintain legible medical records that justify the course of treatment; and

e. by failing to have proper authorization for treatment of these patients.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 1st **day of** November **, 200__.**

M. Rony François, M.D., M.S.P.H., Ph.D.
Secretary, Department of Health

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FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Alicia Steffen
DATE 11/1/06

DKK
PCP: October 27, 2006
PCP MEMBERS: El-Bahri, Farmer + Dyches

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

AUG 3 0 2005

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v.

CASE NOS.: 2002-18534; 2004-22912; 2004-27542; 2005-02980

BRANISLAV STOJANOVIC, M.D.,

RESPONDENT.

_______________________________/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Branislav Stojanovic, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the state of Florida, having been issued license number 62066.

3. Respondent's address of record is 420 North East 3rd Street, Fort Lauderdale, Florida 33301.

4. At all times material to this Complaint, Dr. Stojanovic practiced neuropsychiatry, but Respondent is not board certified.

FACTS PERTAINING TO CASE NO. 2002-18534

5. On or about June 4, 2002, F.D., a seventy year-old female patient, was brought to Respondent's office after she became uncooperative, resistant, and paranoid. F.D. had been Respondent's patient since 1999 and in 2001 he diagnosed her with Rule Out Senile Dementia. During this visit, Respondent diagnosed F.D. with paranoid schizophrenia and admitted her to Aventura Hospital and Medical Center ("AHMC") to stabilize her condition.

6. Prior to admission to AHMC, F.D. was taking the following psychotropic medications: Prolixin, Cogentin, Aricept and Temazepam. Prior to admission to AHMC, F.D. was self-sufficient in that she was able to

walk, talk, eat, and use the bathroom independently.

7. Prolixin, or fluphenazine hydrochloride, is indicated for the management of manifestations of psychotic disorders.

8. Cogentin, or Benztropine mesylate, is indicated for use as an adjunct in the therapy of all forms of Parkinsonism. It is also useful in the control of extrapyramidal (motor pathways) disorders (except tardive dyskinesia) due to neuroleptic drugs.

9. Aricept, or donepezil hydrochloride, is indicated for the treatment of mild to moderate dementia of the Alzheimer's type.

10. Temazepam, or restoril, a schedule IV controlled substance listed in Chapter 893, Florida Statutes, is indicated for the relief of insomnia. The abuse of temazepam can lead to physical or psychological dependence.

11. On or about June 4, 2002, F.D. was admitted to AHMC for paranoid schizophrenia. Upon her admission, Respondent prescribed the following psychotropic medications: Risperdal 1 milligram ("mg"), Paxil 10 mg, Exelon 1.5 mg, Cogentin 2 mg, Restoril 30 mg, Aricept 5 mg, Ativan 1 mg, and Seroquel 25 mg.

12. Risperdal, or risperidone, is a psychotropic agent belonging to the benzisoxazole derivatives class, and is indicated for the treatment of schizophrenia.

13. Paxil, or paroxetine hydrochloride, has been approved by the U.S. Food and Drug Administration as a safe and effective treatment for these conditions: Depression, Generalized Anxiety Disorder (GAD), Social Anxiety Disorder, Panic Disorder, Obsessive Compulsive Disorder (OCD), and Post-traumatic Stress Disorder (PTSD)

14. Exelon, or rivastigmine tartrate, is a reversible cholinesterase inhibitor, and is indicated for the treatment of mild to moderate dementia of the Alzheimer's type.

15. Ativan, or lorazepam, a schedule IV controlled substance listed in Chapter 893, Florida Statutes, is an anti-anxiety agent indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms.

16. Seroquel, or quetiapine fumarate, is a psychotropic agent belonging to the dibenzothiazepine derivatives class that is indicated for the treatment of acute manic episodes associated with bipolar disorder.

17. On or about June 5, 2002, another physician evaluated F.D. and noted atherosclerotic heart disease, hyperlipidemia, and diabetes.

18. On or about June 15, 2002, Respondent discontinued the Risperdal and replaced it with Haldol.

19. Haldol, or haloperidol, is indicated for the treatment of schizophrenic patients who require prolonged parenteral antipsychotic therapy.

20. On or about June 16, 2002, a floor nurse noted in the 24 Hour Nursing Flow Sheet that, "the patient is deteriorating." Another consulting physician then evaluated F.D. and noted that at admission she was walking, talking, and able to take care of her personal bodily functions but that during the consultation, F.D. was unable to eat, speak, or care for herself. The consulting physician performed a neurological examination and found that F.D. had oral buccal lingual facial dyskinesia with tongue protruding involuntarily. He opined that F.D.'s sudden change of status may have been caused by over medication and recommended that all psychotropic medications be put on hold.

21. Dyskinesia is a syndrome consisting of involuntary movements

of the tongue, lips, face, trunk, and/or extremities. The prevalence of the syndrome appears to be the highest amongst the elderly, especially elderly women.

22. On or about June 18, 2002, Respondent ordered that all of F.D.'s psychotropic medications be held. However, he then called in prescriptions for Seroquel, Ativan, and Cogentin. Therefore, only Paxil, Restoril, and Haldol were held.

23. Then on June 22, 2002, Respondent resumed F.D.'s Restoril prescription and on June 23, 2002, resumed F.D.'s Paxil prescription. Paxil was thereafter held and resumed sporadically until July 5, 2002.

24. On or about June 24, 2002, Respondent discontinued Seroquel and prescribed Clozaril 12.5 mg, twice a day.

25. Clozaril, or clozapine, is an atypical antipsychotic drug. It is indicated for the management of severely ill schizophrenic patients who fail to respond adequately to standard drug treatment for schizophrenia. Clozaril has not been tested in the elderly and has potentially fatal side effects and needs to be monitored closely by the patient.

26. On or about June 25, 2002, Respondent increased the Clozaril

to 25 mg in the morning and 12.5 mg at bedtime and increased the Clozaril to 25 mg, twice a day. F.D. was not competent to self-monitor this medication.

27. On or about June 27, 2002, Respondent increased the Clozaril to 50 mg in the morning and 25 mg at bedtime. On or about June 30, 2002, Respondent increased the Clozaril to 50 mg, twice a day. On or about July 2, 2002, Respondent increased the Clozaril to 75 mg in the morning and 50 mg at bedtime.

28. On or about July 5, 2002, F.D. was lethargic and the nurses could not awaken her. Respondent and the physician who evaluated F.D. at admission were called and the physician ordered the stopping of all psychotropic medications. Respondent ordered an electroencephalogram (EEG) to record the electric activity of F.D.'s brain which was reported on July 6, 2002, as abnormal.

29. Respondent requested a neurological consultation and the specialist noted that F.D.'s diabetes was out of control and diagnosed dehydration and metabolic encephalopathy.

30. Metabolic encephalopathy is a coma or its precursor resulting

from a diffuse abnormality of cerebral neuronal or glial cell metabolism. Primary metabolic encephalopathy is due to any of the degenerative cerebral disorders that culminate in coma. Secondary metabolic encephalopathy results when brain metabolism is disturbed by extracerebral disorders causing intoxication, electrolyte imbalances, or nutritional deficiencies.

31. On or about July 5, 2002, Respondent ordered that F.D. be prepared for discharge from the psychiatric unit with a transfer to the medical floor. According to the discharge summary dictated by another physician, F.D. was being transferred in medically and psychiatrically stable condition to the medical floor for "adult failure to thrive."

32. On or about July 5, 2002, yet another physician evaluated F.D. noting that she was in a coma. Also noting that F.D. did not open her eyes after being intubated, he ordered that she be admitted to intensive care. The physician wrote that F.D. might be over medicated or suffering from sepsis. The physician held all psychotropic medications and ordered hydration through IV's.

33. On or about July 9, 2002, that physician determined that F.D.

was stabilized and ordered her transferred to a psychiatric unit. F.D. was discharged from AHMC and transferred to the psychiatric unit at Parkway Hospital. On the Discharge Summary, the physician noted that F.D., "... appears to have suffered an adverse effect to hypnotic sedatives."

34. Respondent's medical records for F.D. are consistently illegible, inadequate, or not problem-focused and do not accurately document or justify the course of treatment utilized in her care. Respondent's consultants were unable to determine whether or not Respondent had formed an appropriate treatment plan for F.D. nor could they have followed it if he had.

FACTS PERTAINING TO CASE NO. 2004-22912

35. At all times material to this complaint, R.Z., a 95 year-old female, was Respondent's patient at Renaissance Gardens Assisted Living Facility ("Renaissance"). Respondent originally saw R.Z. in or about January 2004, with complaints of depression. Respondent's patient records for this visit do not document R.Z.'s past medical history, family history, past psychiatric history, current medications, or allergies. Respondent prescribed Paxil 30 mg, once a day and Namenda 5 mg, twice

a day for R.Z. Similar prescriptions were written by Respondent on or about February 16, 2004, and again on or about April 19, 2004.

36. On or about May 3, 2004, Respondent visited Renaissance and saw several other patients. At the conclusion of his visit, Respondent prescribed Seroquel 100 mg and Paxil 30 mg to R.Z. R.Z. was to take one-half tablet Seroquel, three times a day.

37. On or about May 5, 2004, R.Z.'s daughter noted that R.Z. was unable to talk, walk, or write and that she was fatigued and sleeping often.

38. On or about May 5, 2004, R.Z.'s daughter took her to R.Z.'s internist. The internist performed a variety of tests in an effort to determine why R.Z.'s condition had deteriorated. He ordered the Namenda discontinued and reduced the Paxil from 30 to 20 mg.

39. And when visiting R.Z.'s at Renaissance, her primary medical provider noted in her medical record that she was unable to write and that she was able to walk on direct command, but only a few steps. He requested that R.Z.'s family keep him apprised of R.Z.'s condition so that he could hospitalize her if she did not improve.

40. On or about May 6, 2004, in recognition of the internist's order,

Renaissance contacted Respondent requesting confirmation of the status of the Seroquel medication. Respondent was advised that R.Z. had received Seroquel 50 mg, three times a day for the last two days. Respondent discontinued the Seroquel.

41. On or about October 26, 2004, Respondent submitted a response to the Department's investigation of his treatment of R.Z. and stated, "(He) takes full responsibility for his error." According to Respondent, he meant to prescribe Seroquel to a different patient, however, he misread his notes and mistakenly wrote the prescription for R.Z. It was inappropriate to prescribe Seroquel for R.Z.

42. Respondent started R.Z. on an inappropriate dosage of Paxil in that the correct way to begin Paxil with an elderly patient is to begin with 10 mg per day, assess the patient's response and mental status, and then increase the dosage in 5 to 10 mg increments.

43. It was inappropriate for Respondent to prescribe Namenda for R.Z. since Namenda is indicated to treat dementia and Respondent did not diagnose her with dementia.

FACTS RELATED TO CASE NO. 2004-27542

44. On or about May 14, 2004, at or about 1:45 p.m., N.H., a 60 year-old female, admitted herself to Florida Medical Center ("FMC"), due to an adverse reaction to Prozac.

45. Prozac, or Fluoxetine, is indicated for the treatment of depression, obsessive-compulsive disorder, and bulimia.

46. N.H. was admitted to the medical floor. After she was medically cleared, she was transferred to the Cares Unit ("Cares") which at FMC is a psychiatric unit. Upon admission to Cares, Respondent was assigned as N.H.'s treating physician. Shortly after admission to Cares, N.H. decided that she wished to leave FMC.

47. N.H. was admitted to Cares at or about 2 pm. N.H. signed an Application for Voluntary Admission ("AVA") form at about 2:15 pm. The AVA form states that it requires a Certification of Patient's Competence to Provide Expressed and Informed Consent within twenty-four hours.

48. A nurse noted in the Patient Assessment Packet that Respondent had been notified of N.H.'s admission at 5:45 p.m. on May 14, 2004. The nursing staff wrote that N.H. had a potential for withdrawal problems, elopement, or going absent without leave and decided to place

her under close observation with nurse checks every 15 minutes.

49. On or about May 15, 2004, at or about 5 p.m., N.H. signed a Notice of Right to Release and an Application for Release. N.H. had still not been seen by Respondent.

50. On or about May 15, 2004, at or about 9 p.m., the nursing notes document that N.H. was asking to see Respondent.

51. On or about May 16, 2004, at or about 10 a.m., Care called Respondent due to N.H.'s insistence. The nursing notes state, "(P)atient very demanding... threatening, wanting to see her psychiatrist. Same was called, Dr. responded that he would come see patient as soon as possible."

52. On or about May 16, 2004, at or about 5 p.m., the nursing notes document that, "(P)atient apprehensive about being discharged. Angry that she cannot leave without seeing (Respondent)."

53. On or about May 16, 2004, at or about 5:20 pm, the nursing staff called Respondent and informed him of N.H.'s request to leave. According to the nursing notes, "(Respondent) called and informed of patient's request to leave the hospital. Will be in to speak to patient."

54. On or about May 16, 2004, at or about 9:30 p.m., Respondent

arrived to evaluate N.H. N.H. told Respondent that she wanted to leave but Respondent did not sign N.H.'s Application for Release and threatened to "Baker Act" her.

55. On or about May 17, 2004, N.H. was evaluated by Respondent's associate and released at about 12:45 p.m.

FACTS RELATED TO CASE NO. 2005-O2980

56. On or about December 7, 2004, at or about 4:00 p.m., C.M., a 76 year-old male, was admitted to Florida Medical Center ("FMC") on a "Baker Act" action, with an admitting diagnosis of Psychotic Disorder, not otherwise specified.

57. Earlier that afternoon, C.M. had been to Respondent's office complaining of nausea and vomiting and Respondent directed him to the hospital for evaluation. C.M. was cleared medically and then admitted involuntarily and without explanation. He was seen daily by Respondent or his associate until December 13, 2004, when he was released to his wife.

58. Based upon the medical records, no active treatment occurred during the six day confinement. Nurse notes indicate C.M. was alert at all relevant times, was always oriented to person (knew who he was), was

sometimes oriented to time and place (sometimes not), and never oriented to his situation.

59. Respondent prescribed for C.M. Paxil CR 12.5 mg, once a day, Risperdal 0.5 mg at bedtime, Exelon 3 mg, twice a day, Restoril 30 mg at bedtime if needed, and Levoxyl 100 mg, daily. During this hospital stay, these medications were not changed except to increase the Paxil CR to 25 mg.

60. Levoxyl, or levothyroxine, is a replacement/substitute agent for diminished thyroid function.

61. Respondent's medical records are consistently illegible, inadequate, or not problem-focused and do not accurately document or justify the course of treatment utilized in the care of C.M.

COUNT ONE

62. Petitioner realleges and incorporates paragraphs one (1) through sixty-one (61) as if fully set forth herein.

63. Section 458.331(1)(g), Florida Statutes (2003), provides that a licensed physician is subject to discipline for failing to perform any statutory or legal obligation. Section 394.4625(1)(f), Florida Statutes

(2003), provides a procedure to which a doctor must adhere upon a voluntary admission of a psychiatric patient, and includes that within 24 hours after admission of a voluntary patient, the admitting physician shall document in the patient's clinical record that the patient is able to give express and informed consent for admission and if the patient is not able, the facility shall either discharge or transfer the patient to involuntary status.

64. Respondent failed to perform a statutory and legal obligation under Section 394.4625, Florida Statutes (2003), in violation of Section 458.331(1)(g) Florida Statutes (2003), by not documenting on May 15, 2004, i.e., within 24 hours after the original admission, that N.H. was able to give express and informed consent for admission, and/or by not transferring N.H. to involuntary status when she requested discharge orally and in writing.

65. Based on the foregoing, Respondent has violated Section 458.331(1)(g), Florida Statutes (2003), that provides that a licensed physician is subject to discipline for failing to perform any statutory or legal obligation by violating Section 394.4625(1)(f), Florida Statutes (2003).

COUNT TWO

66. Petitioner realleges and incorporates paragraphs one (1) through sixty-one (61) as if fully set forth herein.

67. Section 458.331(1)(t), Florida Statutes (2001-2003), provides that 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 are grounds for discipline of a license by the Board of Medicine.

68. Respondent committed gross or repeated malpractice or 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 in one or more of the following ways: a) by failing to adequately evaluate F.D.'s condition including the reduction or elimination of medications to assess how that patient would be affected by the multiple sedating psychotropic drugs; b) by failing to develop a comprehensive, organized, and coherent treatment plan for F.D.; c) by failing to determine whether F.D.'s change in mental status was

due to schizophrenia or dementia; d) by failing to recognize that F.D.'s dyskinesia was caused by inappropriate or excessive medication; e) by medicating F.D. until she was comatose; f) by inadequately evaluating R.Z. initially; g) by prescribing Paxil at an inappropriate dosage; h) by prescribing Namenda and Seroquel to R.Z. when he did not diagnose R.Z. with the disorders Namenda and Seroquel are indicated to treat; i) by waiting over fifty-one hours after N.H.'s admission to evaluate her; j) by performing a cursory, incomplete, and illegibly written evaluation of N.H.; k) by failing to adequately evaluate C.M's condition and provide an appropriate diagnosis; l) by failing to develop a comprehensive, organized, and coherent treatment plan for C.M.; m) by leaving C.M. in involuntary confinement for six days with no active treatment, if treatment was appropriate.

69. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (2001-2003), that provides that 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.

COUNT THREE

70. Petitioner realleges and incorporates paragraphs one (1) through sixty-one (61) as if fully set forth herein.

71. Section 458.331(1)(q), Florida Statutes (2001-2003), provides that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice are grounds for discipline of a license by the Board of Medicine. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

72. Respondent prescribed, dispensed, administered, mixed, or otherwise prepared a legend drug, including any controlled substance, other than in the course of the physician's professional practice in one or more of the following ways: a) by failing to recognize that F.D.'s dyskinesia

was caused by inappropriate or excessive medication after another doctor had recognized and treated the problem; b) by medicating F.D. until she was comatose; c) by prescribing Paxil to R.Z. at an inappropriate dosage; d) by prescribing Namenda and Seroquel to R.Z. when he did not diagnose R.Z. with the disorders Namenda and Seroquel are indicated to treat.

73. Based on the foregoing, Respondent has violated Section 458.331(1)(q), Florida Statutes (2001-2003), by inappropriately and excessively prescribing legend drugs and controlled substances in quantities, combinations, and dosages that were not in the patients' best interest.

COUNT FOUR

74. Petitioner realleges and incorporates paragraphs one (1) through sixty-one (61) as if fully set forth herein.

75. Section 458.331(1)(m), Florida Statutes (2001-2003), provides that failing to keep legible medical records 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 are

ground for discipline of a license by the Board of Medicine.

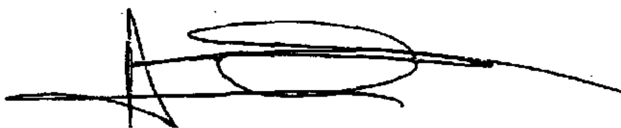
76. Respondent failed to maintain adequate medical records in one or more of the following ways: a) by preparing records for F.D., R.Z., and N.H. that were illegible, inadequate, and/or not problem-focused; b) by failing to adequately document R.Z.'s current medications, past medical history, family history, past psychiatric history, or known allergies; c) by failing to adequately document a treatment plan for N.H.; d) by failing to provide legible records so that consultants for F.D. would be able to determine whether Respondent had formed an appropriate treatment plan and could follow it if he had.

77. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2001-2003), by failing to keep legible medical records that justify the course of treatment of patients, including, but not limited to, patient histories, examination results, test results, or treatment plans.

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

restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

John O. Agwunobi, M.D., M.B.A., M.P.H.
Secretary, Department of Health



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FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Theresa McKown
DATE 8-30-05

Reviewed and approved by: CAG (initials) 7/19/05 (date)

PCP: August 26, 2005

PCP Members: El-Bahri, Farmer, Dyches

Branislav Stojanovic, M..D., DOH Case: 2002-18534 and 3 other

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v.

DOH Case Nos. 2002-18534, 2004-22912, 2004-27542, 2005-02980, & 2005-03228

BRANISLAV M. STOJANOVIC, M.D.,

Respondent,

_______________________________________/

SETTLEMENT AGREEMENT

Branislav M. Stojanovic, M.D., referred to as the "Respondent," and the Department of Health, referred to as "Department, stipulate and agree to the following Agreement and to the entry of a Final Order of the Board of Medicine, referred to as "Board," incorporating the Stipulated Facts and Stipulated Disposition in this matter.

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

STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed physician in the State of Florida having been issued license number ME 62066.

2. The Department charged Respondent with five (5) Administrative Complaints that were filed and properly served upon Respondent with violations of Chapter 458, Florida Statutes, and the rules adopted pursuant thereto. A true and correct copy of the Administrative Complaints is attached hereto as Exhibit A.

3. Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaints for purposes of these proceedings only.

<u>STIPULATED CONCLUSIONS OF LAW</u>

1. Respondent admits that, in his capacity as a licensed physician, he is subject to the provisions of Chapters 456 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the facts alleged in the Administrative Complaints, if proven, would constitute violations of Chapter 458, Florida Statutes, as alleged in the Administrative Complaints.

3. Respondent agrees that the Stipulated Disposition in this case is fair, appropriate and acceptable to Respondent.

<u>STIPULATED DISPOSITION</u>

1. **<u>Reprimand</u>** - The Board shall reprimand the license of Respondent.

2. **<u>Fine</u>** - The Board of Medicine shall impose an administrative fine of twelve thousand five hundred dollars ($12,500.00) against the license of Respondent, to be paid by Respondent to the Department of Health,

HMQAMS/Client Services, Post Office Box 6320, Tallahassee, Florida 32314-6320, Attention: Board of Medicine Compliance Officer, within thirty-days (30) from the date of filing of the Final Order accepting this Agreement. All fines shall be paid by check or money order. The Board office does not have the authority to change the terms of payment of any fine imposed by the Board.

RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE FINE IS HIS LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE FINE IS NOT PAID AS AGREED TO IN THIS SETTLEMENT AGREEMENT, SPECIFICALLY: IF WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER, RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE FINE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD.

3. **Reimbursement Of Costs** - Pursuant to Section 456.072, Florida Statutes, Respondent agrees to pay the Department for any administrative costs incurred in the investigation and prosecution of this case. Such costs exclude the costs of obtaining supervision or monitoring of the practice, the cost of quality assurance reviews, and the Board's administrative cost directly associated with Respondent's probation, if any. The agreed upon amount of Department costs to be paid in this case includes but shall not exceed twenty thousand dollars ($20,000.00). Respondent will pay costs to the Department of Health,

HMQAMS/Client Services, P.O. Box 6320, Tallahassee, Florida 32314-6320, Attention: Board of Medicine Compliance Officer within thirty-days (30) from the date of filing of the Final Order in this cause. Any post-Board costs, such as the costs associated with probation, are not included in this agreement.

RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE COSTS IS HIS LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE COSTS ARE NOT PAID AS AGREED TO IN THIS SETTLEMENT AGREEMENT, SPECIFICALLY: IF WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER, RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE COSTS NOTED ABOVE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD.

4. **Laws And Rules Course** - Respondent shall complete the Laws and Rules Course, administered by the Florida Medical Association, within one (1) year of the date of filing of the Final Order of the Board. In addition, Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical education course within one (1) year of the date of filing of the Final Order incorporating this Agreement. **All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of**

such documentation was previously provided during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education courses shall consist of a live, lecture format.

5. **Drug Course** - Respondent shall complete the course, "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls of Misprescribing," sponsored by the University of South Florida, or a Board-approved equivalent, within one year of the date of filing of the Final Order.

6. **Records Course** - Respondent shall complete the course, "Quality Medical Record Keeping for Health Care Professionals," sponsored by the Florida Medical Association, or a Board-approved equivalent, within one year of the date of filing of the Final Order.

7. **Community Service** - Respondent shall perform one hundred (100) hours of community service, within one year of the date of filing of the Final Order. Community Service shall be defined as the delivery of medical services directly to patients, or the delivery of other volunteer services in the community, without fee or cost to the patient or the entity, for the good of the people of the State of Florida. Community service shall be performed outside the physician's regular practice setting. Respondent shall submit a written plan for performance and completion of the community service to the Probation Committee for approval prior to performance of said community service. Affidavits detailing the completion of

community service requirements shall be filed with the Board as required by the Probation Committee.

8. **Continuing Medical Education** - Within one year of the date of the filing of a Final Order in this cause, Respondent shall attend three (3) hours of Continuing Medical Education (CME) related to the responsibilities of a physician under the Florida Mental Health Act **and** three (3) hours of CME related to management of inpatient psychiatric patients. Respondent shall first submit a written request to the Probation Committee for approval prior to performance of said continuing medical education course(s). Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical course within one (1) year of the date of filing of the Final Order in this matter. All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such documentation was provided previously during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education course(s) shall consist of a formal, live lecture format.

9. **Quality Assurance Consultation/Risk Management Assessment** - An independent, certified risk manager will review Respondent's current practice within sixty (60) days of the date of filing of the Final Order. Specifically, this independent consultant shall review the office procedures employed at

Respondent's practice. This consultant will prepare a report addressing Respondent's practice. This report will include suggested improvements of the quality assurance of Respondent's practice. Respondent will submit this report, as well as documentation that demonstrates compliance with the suggestions enumerated in the report, to the Probation Committee. Respondent shall bear the cost of such consultation and any necessary or appropriate follow-up consultation.

10. **Probation Language** - Effective on the date of the filing of the Final Order incorporating the terms of this Agreement, Respondent's license to practice medicine shall be placed on probation for a period of one (1) year. The purpose of probation is not to prevent Respondent from practicing medicine. Rather, probation is a supervised educational experience designed by the Board to make Respondent aware of certain obligations to Respondent's patients and the profession and to ensure Respondent's continued compliance with the high standards of the profession through interaction with another physician in the appropriate field of expertise. To this end, during the period of probation, Respondent shall comply with the following obligations and requirements:

(A) **Restrictions During Probation** - During the period of probation, Respondent's license shall be restricted as follows:

i. **Indirect Supervision** - Respondent shall practice only under the indirect supervision of a Board-approved physician, hereinafter referred to as the "monitor", whose responsibilities are set by the Board. Indirect

supervision does not require that the monitor practice on the same premises as Respondent, however, the monitor shall practice within a reasonable geographic proximity to Respondent, which shall be within 20 miles unless otherwise provided by the Board and shall be readily available for consultation. The monitor shall be Board Certified in Respondent's specialty area unless otherwise provided by the Board. In this regard, Respondent shall allow the monitor access to Respondent's medical records, calendar, patient logs or other documents necessary for the monitor to supervise Respondent as detailed below.

ii. **Required Supervision:**

a) If the terms of the Settlement Agreement include indirect monitoring of the licensee's practice or direct monitoring of the licensee's practice, Respondent shall not practice medicine without an approved monitor/supervisor, as specified by the Agreement, unless otherwise ordered by the Board.

b) The monitor/supervisor must be a licensee under Chapter 458, Florida Statutes, in good standing and without restriction or limitation on his license. In addition, the Board may reject any proposed monitor/supervisor on the basis that he has previously been subject to any disciplinary action against his medical license in this or any other jurisdiction, is currently under investigation, or is the subject of a pending disciplinary action. The monitor/supervisor must be actively engaged in the same or similar specialty area unless otherwise provided by

the Board and be practicing within a reasonable distance of Respondent's practice, a distance of twenty (20) miles unless otherwise specifically provided for in the Settlement Agreement. The Board may also reject any proposed monitor/supervisor for good cause shown.

iii. **Mechanism For Approval Of Monitor/Supervisor:**

a) **Temporary Approval** - The Board confers authority on the Chairman of the Probation Committee to temporarily approve Respondent's monitor/supervisor. To obtain this temporary approval, Respondent shall submit to the Chairman of the Probation Committee the name and curriculum vitae of the proposed monitor/supervisor at the time this agreement is considered by the Board. **Once a Final Order adopting the Agreement is filed, Respondent shall not practice medicine without an approved monitor/supervisor. Temporary approval shall only remain in effect until the next meeting of the Probation Committee.**

b) **Formal Approval** - Respondent shall have the monitor/supervisor with Respondent at Respondent's first probation appearance before the Probation Committee. Prior to the consideration of the monitor/supervisor by the Probation Committee, Respondent shall provide to the monitor/supervisor a copy of the Administrative Complaint and Final Order in this case. Respondent shall submit a current curriculum vita and a description of current practice from the proposed monitor/supervisor to the Board office no later than fourteen (14) days before Respondent's first scheduled probation appearance.

Respondent's monitor/supervisor shall also appear before the Probation Committee at such other times as directed by the Probation Committee. It shall be Respondent's responsibility to ensure the appearance of the monitor/supervisor as directed. Failure of the monitor/supervisor to appear as directed shall constitute a violation of the terms of this Settlement Agreement and shall subject Respondent to disciplinary action.

iv. **Change In Monitor/Supervisor** - In the event that Respondent's monitor/supervisor is unable or unwilling to fulfill the responsibilities of a monitor/supervisor as described above, Respondent shall immediately advise the Probation Committee of this fact. Respondent shall immediately submit to the Chairman of the Probation Committee the name of a temporary monitor/supervisor for consideration. Respondent shall not practice pending approval of this temporary monitor/supervisor by the Chairman of the Probation Committee. Furthermore, Respondent shall make arrangements with his temporary monitor/supervisor to appear before the Probation Committee at its next regularly scheduled meeting for consideration of the monitor/supervisor by the Probation Committee. Respondent shall only practice under the auspices of the temporary monitor/supervisor (approved by the Chairman) until the next regularly scheduled meeting of the Probation Committee at which the issue of the Probation Committee's approval of Respondent's new monitor/supervisor shall be addressed.

v. **Responsibilities Of The Monitor/Supervisor** - The Monitor shall:

a) Review 25% percent of Respondent's active patient office charts and 5% percent of hospitalization charts. The monitor shall go to Respondent's office once every month and shall review Respondent's calendar or patient log, shall select the records to be reviewed, and shall discuss Respondent's inpatient commitment practices.

1) Maintain contact with Respondent on a frequency of at least once per month. In the event that the monitor is not timely contacted by Respondent, then the monitor shall immediately report this fact in writing to the Probation Committee.

b) Submit reports quarterly, in affidavit form, which shall include:

1) A brief statement of why Respondent is on probation;

2) A description of Respondent's practice (type and composition);

3) A statement addressing Respondent's compliance with the terms of probation;

4) A brief description of the monitor's relationship with Respondent;

5) A statement advising the Probation Committee of any problems which have arisen; and

6) A summary of the dates the monitor went to Respondent's office, the number of records reviewed, and the overall quality of the records reviewed, and the dates Respondent contacted the monitor pursuant to subsection c), 3), above.

c) Report immediately to the Board any violations by Respondent of Chapters 456 or 458, Florida Statutes, and the rules promulgated thereto.

d) Respondent's monitor shall appear before the Probation Committee at the first meeting of said committee following commencement of the probation, and at such other times as directed by the Committee. It shall be Respondent's responsibility to ensure the appearance of Respondent's monitor to appear as requested or directed. If the approved monitor fails to appear as requested or directed by the Probation Committee, **Respondent shall immediately cease practicing medicine until such time as the**

approved monitor or alternate monitor appears before the Probation Committee.

vi. **Reports From Respondent** - Respondent shall submit quarterly reports, in affidavit form, the contents of which may be further specified by the Board, but which shall include:

a) A brief statement of why Respondent is on probation;

b) A description of practice location;

c) A description of current practice (type and composition);

d) A brief statement of compliance with probationary terms;

e) A description of the relationship with monitoring physician;

f) A statement advising the Board of any problems which have arisen; and

g) A statement addressing compliance with any restrictions or requirements imposed.

vii. **Continuity Of Practice:**

a) **Tolling Provisions** - In the event 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 the 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:

1) The time period of probation shall be tolled;

2) The provisions regarding supervision whether direct or indirect by another physician, and required reports from the monitor/supervisor shall be tolled;

3) The provisions regarding preparation of investigative reports detailing compliance with this Settlement Agreement shall be tolled; and

4) Any provisions regarding community service shall be tolled.

b) **Active Practice** - In the event that Respondent leaves the active practice of medicine for a period of one year or more, the Board may require Respondent to appear before the Board and demonstrate his ability to practice medicine with skill and safety to patients prior to resuming the practice of medicine in this State.

(B) **Obligations/Requirements Of Probation** - During the period of probation, Respondent shall comply with the following obligations and requirements:

i. Respondent shall appear before the Probation Committee of the Board of Medicine at the first Committee meeting after probation commences, at the last meeting of the Committee preceding scheduled termination of the probation, and at such other times as requested by the Committee. Respondent shall be noticed by the Board staff of the date, time and place of the Committee meeting at which Respondent's appearance is required. Failure of Respondent to appear as requested or directed or failure of Respondent to comply with **any** of the terms of this agreement shall be considered a violation of the terms of this Agreement, and shall subject Respondent to disciplinary action.

ii. Respondent shall be responsible for ensuring that the monitor submits all required reports.

STANDARD PROVISIONS

1. **Appearance**: Respondent is required to appear before the Board at the meeting of the Board where this Agreement is considered.

2. **No force or effect until final order** - It is expressly understood that this Agreement is subject to the approval of the Board and the Department. In this regard, the foregoing paragraphs (and only the foregoing paragraphs) shall

have no force and effect unless the Board enters a Final Order incorporating the terms of this Agreement.

3. **Addresses** - Respondent must keep current residence and practice addresses on file with the Board. Respondent shall notify the Board within ten (10) days of any changes of said addresses.

4. **Future Conduct** - In the future, Respondent shall not violate Chapter 456, 458 or 893, Florida Statutes, or the rules promulgated pursuant thereto, or any other state or federal law, rule, or regulation relating to the practice or the ability to practice medicine. Prior to signing this agreement, the Respondent shall read Chapters 456, 458 and 893 and the Rules of the Board of Medicine, at Chapter 64B8, Florida Administrative Code.

5. **Violation of terms considered** - It is expressly understood that a violation of the terms of this Agreement shall be considered a violation of a Final Order of the Board, for which disciplinary action may be initiated pursuant to Chapters 456 and 458, Florida Statutes.

6. **Purpose of Agreement** - Respondent, for the purpose of avoiding further administrative action with respect to this cause, executes this Agreement. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to or in conjunction with consideration of the Agreement. Respondent agrees to support this Agreement at the time it is presented to the Board and shall offer no evidence, testimony or argument that disputes or contravenes any stipulated fact or conclusion of law.

Furthermore, should this Agreement not be accepted by the Board, it is agreed that presentation to and consideration of this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration or resolution of these proceedings.

7. **No preclusion of additional proceedings** - Respondent and the Department fully understand that this Agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings by the Board and/or the Department against Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached as Exhibit A.

8. **Waiver of attorney's fees and costs** - Upon the Board's adoption of this Agreement, the parties hereby agree that with the exception of costs noted above, the parties will bear their own attorney's fees and costs resulting from prosecution or defense of this matter. Respondent waives the right to seek any attorney's fees or costs from the Department and the Board in connection with this matter.

9. **Waiver of further procedural steps** - Upon the Board's adoption of this Agreement, Respondent expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to otherwise challenge or contest the validity of the Agreement and the Final Order of the Board incorporating said Agreement.

SIGNED this 22nd day of FEBRUARY 2008.

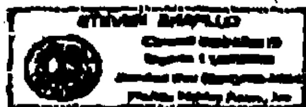
Branislav M. Stojanovic, M.D.

Before me, personally appeared BRANISLAV M. STOJANOVIC whose identity is known to me by PERSONALLY KNOWN (type of identification) and who, under oath, acknowledges that his/her signature appears above.

Sworn to and subscribed before me this 22nd day of FEBRUARY 2008.

NOTARY PUBLIC

My Commission Expires:



APPROVED this 28th day of February, 2008.

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General
Department of Health

By: Diane K. Kiesling
Assistant General Counsel
Department of Health

DKK/sdw