9. Patient M.S.'s liposuction procedure was associated and directly related to the fat graft procedure and was, therefore, a Level II surgery.

10. The liposuction and fat graft procedures for which Patient M.S. was scheduled had a maximum planned duration of greater than five minutes.

11. Prior to the procedures, Respondent administered, or ordered the administration of, lidocaine as the local anesthetic for the procedures.

12. Respondent was not assisted during the procedures by an anesthesiologist, certified registered nurse anesthesist, a physician assistant qualified under Rule 64B8-30.012(2)(b)6, Florida Administrative Code, or a registered nurse.

13. Respondent did not use a cardiac monitor during the procedures, nor did he have personnel monitor the patient's cardiac rhythm, blood pressure, or respiration.

14. Respondent did not have a crash cart in the room when the procedures commenced.

15. Respondent did not adequately monitor Patient M.S. or have the patient adequately monitored during the procedures.

16. During the liposuction procedure, Respondent removed approximately 500 cc of fat from Patient M.S.'s back.

17. During the fat graft procedure, Respondent injected approximately 500 cc of fat into M.S.'s buttocks.

18. Respondent did not aspirate the injection cannula prior to the injection of fat into M.S.'s buttocks during the fat graft procedure to assure that he was not in the vascular space.

19. During the fat graft procedure, Respondent erroneously injected fat tissue into Patient M.S.'s vascular system.

20. During the fat graft procedure, Patient M.S. had difficulty breathing, was unresponsive, and went into full cardiopulmonary arrest.

21. Respondent failed to adequately diagnose and treat Patient M.S. when she went into cardiopulmonary arrest.

22. Respondent failed to initiate ACLS procedures, including assessing or diagnosing the patient's heart rhythms, establishing an airway, establishing intravenous ("IV") access to provide fluids and medication, and attempting to diagnose the patient's condition.

23. Respondent and his staff initiated cardiopulmonary resuscitation ("CPR").

24. Respondent instructed his staff to bring a crash cart into the procedure room and to call 9-1-1.

25. Patient M.S. was in cardiopulmonary arrest for approximately ten (10) minutes when Emergency Medical Services ("EMS") arrived and instituted ACLS.

26. Patient M.S. subsequently expired due to a pulmonary artery adipose tissue embolism (a clot in the pulmonary artery).

27. The artery adipose tissue embolism which caused Patient M.S.'s death resulted from Respondent's injection of fat into M.S.'s vascular system during the fat graft procedure.

28. A reasonably prudent physician would have taken measures to ensure that fat was not injected into the patient's vascular system.

29. A reasonably prudent physician would have taken measures to adequately monitor the patient during the liposuction and fat graft procedures.

30. A reasonably prudent physician would have initiated ACLS procedures, including assessing or diagnosing the patient's heart rhythms, establishing an airway, establishing IV access, and/or attempting to diagnose the patient's condition.

31. Respondent failed to keep legible medical records by failing to adequately document the resuscitative efforts or course of treatment after Patient M.S. went into cardiopulmonary arrest and ultimately expired.

COUNT I

32. Petitioner realleges and incorporates paragraphs 1 through 31 as if fully set forth herein.

33. Section 458.331(1)(t), Florida Statutes (2010-2011), subjects a physician to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes (2010-2011).

34. Section 456.50(1)(g), Florida Statutes (2010-2011), defines medical malpractice as "the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure."

35. Section 456.50(1)(e), Florida Statutes (2010-2011), defines the level of care, skill, and treatment recognized in general law related to

health care licensure as the standard of care specified in Section 766.102, Florida Statutes (2010-2011).

36. Section 766.102(1), Florida Statutes (2010-2011), defines the "prevailing professional standard of care for a given health care provider" as "that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."

37. Respondent failed to meet the prevailing standard of care in his treatment of Patient M.S. In one or more of the following ways:

a. Respondent failed to take precautions to ensure that fat tissue was not injected into the Patient M.S.'s vascular system;

b. Respondent injected fat tissue into Patient M.S.'s vascular system;

c. Respondent failed to establish an airway when Patient M.S. went into cardiopulmonary arrest;

d. Respondent failed to establish IV access when Patient M.S. went into cardiopulmonary arrest;

e. Respondent failed to assess or diagnose Patient M.S.'s cardiac rhythm;

f. Respondent failed to use a cardiac monitor during the procedures;

g. Respondent failed to have personnel monitor Patient M.S.'s vital signs; and/or

h. Respondent failed to have personnel monitor Patient M.S.'s respiration.

38. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes (2010-2011), by committing medical malpractice with respect to his treatment of Patient M.S.

COUNT II

39. Petitioner realleges and incorporates paragraphs 1 through 31 as if fully set forth herein.

40. Section 458.331(1)(nn), Florida Statutes (2010-2011), subjects a physician to discipline for violating any provision of Chapters 456 or 458, Florida Statutes, or any rules adopted pursuant thereto.

41. Rule 64B8-9.009(4), Florida Administrative Code, sets forth the standards for office surgeries, in part, as follows:

(b) Standards for Level II Office Surgery.

3. Equipment and Supplies Required.

a. Full and current crash cart at the location the anesthetizing is being carried out. The crash cart must include, at a minimum, the following resuscitative medications:

* * *

4. Assistance of Other Personnel Required. The surgeon must be assisted by a qualified anesthesia provider as follows: An Anesthesiologist, Certified Registered Nurse Anesthesist, or Physician Assistant qualified as set forth in subparagraph 64B8-30.012(2)(b)6., F.A.C., or a registered nurse may be utilized to assist with the anesthesia, if the surgeon is ACLS certified. An assisting anesthesia provider cannot function in any other capacity during the procedure. If additional assistance is required by the specific procedure or patient circumstances, such assistance must be provided by a physician, osteopathic physician, registered nurse, licensed practical nurse, or operating room technician. A physician licensed under Chapter 458 or 459, F.S., a licensed physician assistant, a licensed registered nurse with post-anesthesia care unit experience or the equivalent, credentialed in Advanced Cardiac Life Support or, in the case of pediatric patients, Pediatric Advanced Life Support, must be available to monitor the patient in the recovery room until the patient is recovered from anesthesia.

* * *

42. Respondent performed a Level II surgery on Patient M.S.

43. Respondent failed to meet the standards for Level II office surgeries in one or more of the following ways:

a. Respondent failed to have a full and current crash cart at the location the anesthetizing was being carried out; and/or

b. Respondent failed to have adequate assistance from an anesthesia provider during Patient M.S.'s procedures.

44. Based on the foregoing, Respondent violated Section 458.331(1)(nn), Florida Statutes (2010-2011), by violating Rule 64B8-9.009(4), Florida Administrative Code.

COUNT III

45. Petitioner realleges and incorporates paragraphs 1 through 31 as if fully set forth herein.

46. Section 458.331(1)(nn), Florida Statutes (2010-2011), subjects a physician to discipline for violating any provision of Chapters 456 or 458, Florida Statutes, or any rules adopted pursuant thereto.

47. Rule 64B8-9.0091(1)(a), Florida Administrative Code, sets forth the requirements for the registration of office surgery clinics, in part, as follows:

> Every licensed physician who holds an active Florida license and performs Level II surgical procedures in Florida with a maximum planned duration of more than five (5) minutes or any Level III office surgery, as fully defined in Rule 64B8-9.009, F.A.C., shall register the office with the Department of Health. It is the physician's responsibility to ensure that every office in which he or she performs Levels II or III surgical procedures as described above is registered, regardless of whether other physicians are practicing in the same office or whether the office is non-physician owned.

48. Respondent is a licensed physician in the State of Florida.

49. Respondent performed a Level II surgical procedure with a planned maximum duration greater than five minutes on Patient M.S. at Alyne.

50. Respondent failed to register Alyne with the Department of Health.

51. Based on the foregoing, Respondent violated Section 458.331(1)(nn), Florida Statutes (2010-2011), by violating Rule 64B8-9.0091(1)(a), Florida Administrative Code.

COUNT IV

52. Petitioner realleges and incorporates paragraphs 1 through 31 as If fully set forth herein.

53. Section 458.331(1)(m), Florida Statutes (2010-2011), subjects a physician to discipline 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. Rule 64B8-9.003(3), Florida Administrative Code, sets forth standards for adequacy of medical records, in part, as follows:

> The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

55. Respondent failed to keep legible medical records in one or more of the following ways:

a. By failing to adequately document the amount of fat removed from each section of Patient M.S.'s body; and/or

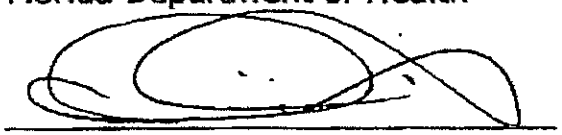
b. By failing to adequately document the resuscitative efforts or course of treatment of Patient M.S. once the patient went into cardiopulmonary arrest and ultimately expired.

56. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2010-2011), by failing to keep legible medical records.

WHEREFORE, 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 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 25 **day of** May, **2012.**

JOHN H. ARMSTRONG, MD
State Surgeon General and Secretary of Health
Florida Department of Health



Alicia E. Adams
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, FL 32399-3265
Florida Bar No. 0065248
(850) 245-4640 Phone
(850) 245-4662 Fax

PCP: May 25, 2012
PCP Members: Dr. Miguel, Dr. Stringer, Mr. Levine

33541

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.