STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NOS. 2022-20963; 2022-20968; 2022-20978**

CHRISTOPHER SAPUTA, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

Petitioner Department of Health (Department) files this Administrative Complaint before the Board of Medicine (Board) against Christopher Saputa, M.D., and in support thereof alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to section 20.43, Florida Statutes (2022); and chapters 456 and 458, Florida Statutes (2022).

2. At all times material to this Complaint, Respondent was licensed to practice medicine within the State of Florida, having been issued license number ME 121890.

3. At all times material to this Complaint, Respondent's address of

record was 90 South Highland Avenue, Suite 123, Tarpon Springs, Florida 34689.

4. At all times material to this Complaint, Respondent worked at Integrity Medical Care, LLC d/b/a American Family Planning, (AFP) an abortion clinic, license number 932, located at 6115 Village Oaks Drive, Pensacola, Florida 32504.

5. At all times material to this Complaint, AFP maintained a transfer agreement with Florida West Hospital (FWH), in Pensacola, Florida.

6. Respondent is not board certified by any medical specialty recognized by the American Board of Medical Specialties.

7. Respondent has not completed a residency or fellowship in obstetrics and gynecology, surgery, or family planning.

8. Respondent's training in obstetrics and gynecological procedures includes a rotation during his one-year medical internship in the 1980s and informal shadowing and instruction at abortion clinics in or around 2012 to 2015.

9. Respondent does not have adequate education, training, or experience to perform surgical abortions.

10. S.S. is the Office Manager for AFP. S.S. does not maintain a

healthcare license in the State of Florida.

11. The standard of care requires a reasonably prudent physician to use the level of care and skill, and exercise appropriate level of caution, to protect his patients from injury.

Facts Related to Patient K.J.[1]

12. On or about March 23, 2022, at around 11:15 a.m., Patient K.J., a 27-year-old woman, who was 20-weeks pregnant, presented to Respondent at AFP for a termination procedure.

13. Patient K.J.'s procedure was scheduled for two days. The first day, Respondent planned to insert Laminaria[2] into Patient K.J.'s vagina. The Laminaria is used to slowly expand and dilate the cervix, at which point Patient K.J. would return to AFP to complete the termination procedure.

14. Upon Patient K.J.'s presentation to AFP, S.S. performed an ultrasound and prepared an Obstetrical Sonogram Report. S.S. did not document the fetus' measurements for crown rump length (CRL), femur length (FL), or gestational sac.

[1] Facts related to Patient K.J. are contained in Department case number 2022-20968.
[2] Laminaria is a type of seaweed kelp. A laminaria stick is a dried bundle of laminaria that's been compressed into a stick. When inserted into the vagina, a laminaria stick absorbs the moisture and expands. This gently opens (dilates) the cervix.

15. Respondent failed to document the fetus' measurements for CRL, FL, or gestational sac in Patient K.J.'s medical records.

16. S.S. did not save or print the ultrasound image.

17. Respondent reviewed the incomplete sonogram report. Respondent did not review an image of Patient K.J.'s sonogram to determine gestational age.

18. Respondent failed to keep original pictures of each ultrasound examination of Patient K.J. in her medical history file.

19. Respondent did not perform or legibly document performing a pelvic examination on Patient K.J. prior to initiating the insertion of Laminaria.

20. Respondent inserted Laminaria into Patient K.J.'s vagina. However, clear liquid started leaking from Patient K.J.'s vagina, indicating that Patient K.J.'s amniotic sac ruptured. This necessitated her to switch to a one-day procedure.

21. Respondent failed to perform or document performing a pause prior to starting the procedure to confirm Patient K.J.'s name and the procedure.

22. Respondent failed to legibly document complete operative notes for Patient K.J. including start and stop times of the procedure, intra-operative vitals, any surgical preparation or aseptic technique utilized, what parts of the procedure, if any, were performed under ultrasound guidance, and/or sufficient legible detail of the course of treatment and outcome of the procedure.

23. Prior to initiating the procedure, Respondent administered a paracervical block.[3] Respondent failed to document the location of where he injected the paracervical block.

24. Patient K.J. received Ketamine, a sedative, to sedate her for the procedure. Patient K.J. was in a twilight state of sedation during the procedure. Patient K.J. could hear what was happening during the procedure.

25. During the procedure, Respondent rapidly dilated Patient K.J.'s cervix. Respondent lacerated Patient K.J.'s cervix one or more times and/or perforated or tore Patient K.J.'s uterus one or more times.

26. At some time during or immediately after the procedure, Patient

[3] A paracervical block is a local anesthetic used for pain management during gynecological surgeries. Paracervical blocks are administered by injecting a lidocaine solution into the cervix.

K.J. experienced vaginal bleeding, which was treated with Pitocin[4] and Methergine.[5]

27. The bleeding stopped momentarily, and AFP staff began transitioning Patient K.J. to the recovery room. However, Patient K.J. started bleeding vaginally again. Respondent failed to document the intervals or severity of Patient K.J.'s bleeding.

28. After Patient K.J. started bleeding again, the standard of care required Respondent to physically examine Patient K.J., including a manual examination of her uterus, to determine the cause of her vaginal bleeding and whether further medication was indicated.

29. Respondent failed to examine, or legibly document examining, Patient K.J.'s uterus.

30. Respondent failed to have, or document having, adequate medical justification to continue treatment with more Pitocin and Methergine.

31. Patient K.J.'s bleeding stopped again.

32. AFP staff moved Patient K.J. into the recovery room. Patient K.J.

[4] Pitocin (oxytocin injection) is a natural hormone that causes the uterus to contract. Pitocin is used to induce labor, strengthen labor contractions during childbirth, control bleeding after childbirth, or to induce an abortion.
[5] Methergine is used to treat severe bleeding from the uterus after childbirth.

began to experience vaginal bleeding again.

33. AFP staff brought Patient K.J. back to the procedure room and started an IV fluid infusion.

34. If Respondent had timely performed a physical examination of Patient K.J.'s uterus, Respondent would have had reason to know that Patient K.J. had an injury requiring medical treatment. In that scenario, the standard of care requires a reasonably prudent physician to immediately initiate emergency transfer.

35. Respondent failed to immediately initiate Patient K.J.'s transportation to the hospital, due to his failure to appropriately and timely assess the cause of Patient K.J.'s bleeding.

36. Respondent failed to identify a designated scribe to record information about K.J.'s emergency management. As a result, there were no vital signs recorded during the time that she was bleeding after the procedure.

37. At some point during this emergency situation, a staff member took Patient K.J.'s blood pressure and observed that it was "low." However, this was not documented in Patient K.J.'s records.

38. Respondent initiated emergency transport and called 911 at or

around 11:11 p.m.

39. Patient K.J. continued to bleed profusely.

40. Escambia County Emergency Medical Services (EMS) arrived at approximately 11:26 p.m.

41. When EMS arrived, they observed Patient K.J. laying on the exam room bed. The bed was saturated with blood and there were several pools of blood on the exam room floor.

42. At the time of EMS's arrival, Patient K.J. lacked radial pulses on both sides and was only responsive to painful stimuli. Patient K.J. was pale and cold.

43. Respondent reported to EMS that Patient K.J. lost an estimated 750 mL of blood. This was an inaccurate estimation of the amount of blood that Patient K.J. lost

44. EMS transported Patient K.J. to FWH.

45. The standard of care requires physicians to provide a complete copy of all available records to the receiving hospital upon transfer.

46. Respondent only provided EMS and FWH with Patient K.J.'s demographic information. Respondent failed to provide a copy of the clinical records, procedure notes, or physician comments to EMS and failed to

arrange for a copy of these records to be sent to FWH.

47. The standard of care requires physicians to provide an accurate report to EMS and/or the receiving hospital when transferring a patient.

48. Respondent called FWH and provided a report to an Emergency Room physician. Respondent minimized Patient K.J.'s medical condition.

49. Upon arrival to FWH, Patient K.J. was cool, pale, and diaphoretic, and her blood pressure was 74/35.

50. EMS reported to the hospital staff that Respondent told them that Patient K.J. had lost 750 mL of blood; but that they believed this was underestimated. Patient K.J. ultimately received a total of 10 units of blood while at the hospital.

51. FWH staff immediately intubated Patient K.J. to assist with breathing and determined that she was in hemorrhagic shock and respiratory failure.

52. Patient K.J was taken to the operating room for an emergency procedure.

53. During the emergency surgery, FWH surgeons observed two cervical lacerations, a lower uterine perforation that opened into the abdomen, and a large tear in the left lower uterine segment.

54. Due to the extensive damage, the surgeons had to perform a total abdominal hysterectomy with bilateral salpingectomy.

55. Patient K.J. continues to physically and emotionally suffer from her experience with Respondent at AFP.

Facts Relating to Patient D.W.[6]

56. On or about April 28, 2022, Patient D.W., a 22-year-old woman who was 12.6 weeks pregnant, presented to Respondent at AFP to terminate her pregnancy.

57. Upon Patient D.W.'s presentation to AFP, S.S. performed an ultrasound and prepared an Obstetrical Sonogram Report. S.S. did not document the measurements of the fetus' CRL, FL, gestational sac, placenta, fluid, heartbeat, or movement.

58. Respondent failed to document the measurements of the fetus' CRL, FL, gestational sac, placenta, fluid, heartbeat, or movement in Patient D.W.'s medical record.

59. Respondent failed to keep original pictures of each ultrasound examination of Patient D.W. in her medical history file.

[6] Facts related to Patient D.W. are contained in Department of Health Case Number 2022-20978.

60. Respondent reviewed the incomplete sonogram report. Respondent did not review an ultrasound image prior to beginning the procedure or confirm the gestational age via ultrasound.

61. Respondent failed to perform or document performing a pause prior to starting the procedure to verbally confirm the patient's identification, the intended procedure and the correct surgical/procedure site.

62. Respondent failed to legibly document complete operative notes for Patient D.W. including start and stop times of the procedure, intra-operative vitals, any surgical preparation or aseptic technique utilized, and/or what parts of the procedure were performed under ultrasound guidance.

63. Respondent did not observe or document observing a 5 cm x 6 cm teratoma[7] located on Patient D.W.'s ovary during the procedure.

64. During the procedure, Respondent perforated, or damaged, Patient D.W.'s uterus, and in the process, punctured, or damaged the teratoma.

65. On or about May 5, 2022, Patient D.W. presented to USA Children's and Women's Hospital (USAH), in Mobile, Alabama. Patient D.W. was in septic shock.

[7] A teratoma is a type of germ cell tumor that may contain several types of body tissue.

66. The hospital physicians performed an emergency abdominal laparoscopy and discovered the teratoma leaking a purulent fluid from a small circular defect.

67. The damaged teratoma caused extensive infection throughout Patient D.W.'s uterus and abdomen.

68. The surgeon observed "mild possible defects" in the right corner of Patient D.W.'s rectouterine pouch.

69. As a result of the spread of the infection, Patient D.W. underwent a hysterectomy and appendectomy.

Facts Relating to Patient D.C.[8]

70. On or about May 5, 2022, at approximately 9:30 – 10:00 a.m., Patient D.C., a 36-year-old woman who was 19.6 weeks pregnant, presented to Respondent at AFP to terminate her pregnancy.

71. Patient D.C.'s obstetrical history includes two cesarean sections.[9]

72. Respondent did not assess, evaluate, or examine, or document assessing, evaluating, or examining, Patient D.C. until her procedure began approximately thirteen hours after she arrived.

[8] Facts related to Patient D.C. are contained in Department of Health Case Number 2022-20963.
[9] Caesarean section, also known as C-section or caesarean delivery, is the surgical procedure by which one or more babies are delivered through an incision in the mother's abdomen.

73. Respondent did not perform, or document performing, a physical examination and/or pelvic examination of Patient D.C. prior to starting the procedure.

74. When Patient D.C. arrived at AFP, S.S. performed an ultrasound on Patient D.C.

75. S.S. interpreted the ultrasound and prepared an Obstetrical Sonogram Report. S.S. did not document the measurements of the fetus' CRL, FL, or gestational sac.

76. Respondent failed to document the measurements of the fetus' CRL, FL, or gestational sac in Patient D.C.'s medical record.

77. Respondent failed to keep original pictures of each ultrasound examination of Patient D.C. in her medical history file.

78. Respondent reviewed the incomplete sonogram report. Respondent did not review an image of Patient D.C.'s sonogram to determine gestational age.

79. Respondent ordered AWP staff to administer 4 tablets of 200 µg of misoprostol[10] (800 µg total) to Patient D.C., followed by another 800 µg

[10] Misoprostol is a drug used to soften the cervix and empty the uterus by causing cramping and bleeding.

every hour thereafter. A nurse administered the loading dose to Patient D.C. at 11:20 a.m.

80. Patient D.C. received between six and seven 800 µg doses of misoprostol between 11:20 and 5:30 p.m.

81. Misoprostol is contraindicated for patients who have previously undergone a cesarean section because it increases risk of uterine rupture.

82. The standard of care requires a physician to not exceed the maximum recommended dosage of misoprostol. The maximum recommended dose is as follows: a loading dose of 600-800 µg followed by 400 µg every three hours, up to five doses total (maximum dose of 2,800 µg in 12 hours).

83. Respondent ordered 4,800 - 5,600 µg of misoprostol to be administered to Patient D.C. in approximately a six-hour and ten-minute period of time despite Patient D.C.'s two prior cesarean sections.

84. Respondent failed to have, or document having, adequate medical justification to order 4,800 to 5,600 µg of misoprostol for Patient D.C.

85. After Respondent ordered Patient D.C. receive misoprostol, the standard of care required Respondent to examine or assess Patient D.C.'s

symptoms and dilation progression in between doses to determine whether an additional dose of misoprostol was medically indicated.

86. Respondent failed to examine or assess Patient D.C.'s symptoms and/or dilation progression in between doses to determine whether additional doses were necessary.

87. At some time on May 5, 2022, Patient D.C.'s uterus ruptured. Uterine rupture is a medical emergency.

88. At around 1:20 – 1:30 p.m., Patient D.C. experienced a sharp, intense pain in her abdomen. Patient D.C. felt as if something in her stomach had turned upside down and felt the pain radiate to her right side. Patient D.C. was unable to walk and required assistance. Patient D.C. reported her pain to AFP staff.

89. After 3:00 p.m., Patient D.C. became weak, fatigued, hot, and her breathing slowed.

90. Patient D.C. waited in the waiting room until approximately 11:00 p.m.

91. While Patient D.C. waited, AFP staff repeatedly measured her blood pressure but kept receiving an error message on the machine.

92. Patient D.C. reported that she was weak, dizzy, tired, sweaty,

and not able to move.

93. Patient D.C. went to the bathroom assisted by AFP staff. Patient D.C. observed that she was bleeding vaginally when she went to the bathroom. Patient D.C. reported this to staff.

94. After Patient D.C. returned from the bathroom, AFP staff attempted to take her blood pressure again and either got another error message or a low reading.

95. Respondent instructed AFP staff to bring Patient D.C. to the examination room to start the procedure because she was "not progressing."

96. Patient D.C. was a patient with a history of cesarean sections and received 4,800-5,600 µg of misoprostol. The standard of care required Respondent to assess Patient D.C. or obtain a report of her symptoms during her approximately 13-hour wait.

97. Respondent failed to evaluate or assess Patient D.C. during her approximate 13-hour wait and/or failed to obtain a status report on Patient D.C.

98. Patient D.C. was brought into the examination room at or around 11:00 p.m. S.S. performed an ultrasound of Patient D.C. but observed that it was "cloudy" and that she could not see the fetus.

99. Prior to beginning the procedure, S.S. reported her findings to Respondent.

100. Based on Patient D.C.'s current symptoms, medical history, and ultrasound imaging, the standard of care would require a reasonably prudent physician to suspect a uterine rupture and evaluate the patient to confirm or rule out the diagnosis. Upon confirmation of a uterine rupture, the standard of care requires emergency transfer to a hospital within reasonable proximity.

101. Respondent failed to appropriately evaluate Patient D.C. and failed to timely diagnose a uterine rupture. Based on the delayed diagnosis, Respondent failed to timely transfer Patient D.C. to the hospital.

102. Respondent failed to perform or document performing a pause prior to starting the procedure to verbally confirm the patient's identification, the intended procedure and the correct surgical/procedure site.

103. Respondent failed to legibly document complete operative notes for Patient D.C. including start and stop times of the procedure, intra-operative vitals, any surgical preparation or aseptic technique utilized, and/or what parts of the procedure, if any, were performed under ultrasound guidance.

104. Respondent administered a paracervical block.

105. The standard of care requires physicians to avoid injecting paracervical blocks into the three and nine o'clock positions of the cervix.[11]

106. Respondent injected the anesthetic at the three and nine o'clock positions on Patient D.C.'s cervix.

107. Respondent began the procedure and manually dilated Patient D.C.'s cervix from 13 mm to 51 mm French.[12] Respondent then rapidly jumped to 73 mm French. This is atypical and increases the risk of cervical laceration. Respondent then instrumented Patient D.C.'s cervix with an 86 mm French dilator. Respondent stopped the dilation.

108. Respondent lacerated Patient D.C.'s cervix.

109. During the procedure, S.S. assisted Respondent with the sonogram and interpreted the findings. S.S. told Respondent that she saw a shadow on the ultrasound. Respondent discussed the significance of the ultrasound with S.S.

110. Respondent suctioned Patient D.C.'s uterus for clots.

[11] The uterine artery courses along the cervix at the lateral points (three and nine o'clock). Injecting local anesthetic into an artery can cause cardiac arrhythmias and seizures.
[12] Dilators are measured in millimeters of diameter (Hagar) or "French" circumference in millimeters (Pratt).

111. Respondent documented that the fetus was "too far up" for him to reach and elected to terminate the procedure.

112. Respondent completed notes under "Physician's Comments" on Patient D.C.'s Abortion Procedure Record. The notes are mostly illegible.

113. Respondent documented that Patient D.C. had a "possible silent uterine rupture" and required an "exploratory lap and c-section."

114. Respondent documented that a "silent rupture" occurred because he did not know that Patient D.C. exhibited symptoms of uterine rupture leading up to the procedure.

115. Whenever Respondent suspected Patient D.C. experienced a uterine rupture, the standard of care required Respondent to immediately initiate emergency transfer to a hospital within reasonable proximity to the clinic.

116. Respondent failed to initiate emergency transfer to a hospital within reasonable proximity to the clinic, despite documenting that he suspected a uterine rupture.

117. Respondent discharged Patient D.C. around midnight.

118. Respondent failed to create, or maintain, a legible discharge summary for Patient D.C. or document her time of discharge.

119. Respondent advised Patient D.C. to go to the hospital to complete the procedure and told her husband that there was a possible uterine rupture.

120. FWH is approximately 2.3 miles from AFP. USA Children's and Women's Hospital (USAH) is approximately 60 miles from AFP.

121. Respondent advised Patient D.C. and/or her husband that it was okay for her to go to the hospital in Mobile, Alabama.

122. Patient D.C.'s husband asked if they should go to a hospital in Pensacola, Florida, and Respondent indicated that it was not necessary because she was stable.

123. Respondent failed to initiate emergency transport or hospitalization by allowing Patient D.C. to travel to a hospital approximately 60 miles away in a personal vehicle without access to medical care.

124. If a patient chooses to forgo emergency care and travel to a distant hospital, the standard of care requires the physician to educate the patient of the risks involved with delayed treatment.

125. Respondent did not inform, or legibly document informing, Patient D.C. of the risks of delayed treatment. Respondent minimized the medical emergency that Patient D.C. was experiencing and told her that she

was "stable."

126. Respondent failed to document in the medical records that Patient D.C. declined treatment at a hospital within reasonable proximity against medical advice.

127. Respondent did not legibly document his discussion with Patient D.C. or C.C. to sufficiently explain the justification for Patient D.C. to transfer to Mobile, Alabama for treatment.

128. The standard of care required Respondent to contact the hospital to provide a verbal report or communicate Patient D.C.'s condition in advance of her admission.

129. Respondent did not contact the hospital to provide a verbal report or communicate her condition in advance of her admission.

130. Patient D.C. presented to USAH approximately one hour later.

131. When Patient D.C. arrived at USAH, she was tachycardic with a blood pressure of 60/20. USAH emergency physicians determined that Patient D.C. was in critical condition due to her blood loss.

132. Patient D.C. was emergently taken to the operating room for an exploratory laparotomy. The surgeons observed that Patient D.C. had sustained a mid-transverse uterine rupture, likely secondary to the excessive

dosing of misoprostol.

133. The surgeons observed that there was approximately three liters of blood and blood clots, and a free-floating fetus in her abdomen. The surgeons estimated that Patient D.C. was minutes away from death.

134. Due to Patient D.C.'s uterine rupture, the USAH physicians advised her to not get pregnant in the future. Patient D.C. still suffers from the complications from her abortion.

Standard of Care
Counts I-III

135. Section 458.331(1)(t)1-3, Florida Statutes (2021), authorizes the Board to impose discipline against medical doctors for committing medical malpractice, gross medical malpractice, or repeated medical malpractice as defined in section 456.50, Florida Statutes (2021).

136. Section 456.50 defines medical malpractice to mean the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

137. Section 458.331(1)(t)3 provides that a person found by the board to have committed repeated medical malpractice based on section 456.50 may not be licensed or continue to be licensed by this state to provide

health care services as a medical doctor in this state.

Count I

138. Petitioner re-alleges and incorporates paragraphs 1-137 as if fully set forth herein.

139. Respondent committed medical malpractice by falling below the standard of care in his treatment of Patient K.J. in one or more of the following ways:

a. Failing to physically examine Patient K.J., including a manual examination of her uterus, to determine the cause of her vaginal bleeding and whether further medication was indicated,

b. Failing to timely initiate emergency transfer to the hospital due to his failure to appropriately and timely assess the cause of Patient K.J.'s bleeding,

c. Failing to provide an accurate report to EMS and/or FWH, and/or

d. Failing to provide Patient K.J.'s complete medical records to EMS and/or FWH at the time of transfer.

140. Based on the foregoing, Respondent violated section

458.331(1)(t).

Count II

141. Petitioner re-alleges and incorporates paragraphs 1-137 as if fully set forth herein.

142. Respondent committed medical malpractice by failing to take reasonable care and skill and exercising appropriate caution, to avoid injuring his patients during treatment in one or more of the following ways:

a. Lacerating Patient K.J.'s cervix one or more times,

b. Tearing Patient K.J.'s uterus one or more times,

c. Causing a defect, possible perforation, in Patient D.W.'s uterus and resultant puncture in her teratoma,

d. Lacerating Patient D.C.'s cervix one or more times, and

e. Causing Patient D.C.'s uterus to rupture.

143. Based on the foregoing, Respondent violated section 458.331(1)(t).

Count III

144. Petitioner re-alleges and incorporates paragraphs 1-137 as if fully set forth herein.

145. Respondent committed medical malpractice by falling below the

standard of care in his treatment of Patient D.C. in one or more of the following ways:

a. Ordering Patient D.C. receive more than the recommended maximum dosage of misoprostol without adequate medical justification,
b. Ordering Patient D.C. receive additional doses of misoprostol without determining whether they were medically indicated,
c. Failing to assess Patient D.C. or obtain a status report on her prior to initiating the procedure,
d. Injecting the paracervical block at the three and nine o'clock positions of Patient D.C.'s cervix,
e. Failing to timely diagnose Patient D.C.'s uterine rupture,
f. Failing to timely terminate the procedure and immediately initiate emergency transfer procedures and/or arrange hospitalization for Patient D.C. at a hospital within reasonable proximity to the clinic,
g. Failing to inform Patient D.C. of the risks related to delayed treatment of a uterine rupture, and/or
h. Failing to call the hospital to provide a verbal report in

advance of Patient D.C.'s arrival.

146. Based on the foregoing, Respondent violated section 458.331(1)(t).

Medical Records
Counts IV-VI

147. Section 458.331(1)(m), Florida Statutes, authorizes 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.

148. Rule 64B8-9.003, Florida Administrative Code, provides:

> (2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
> (3) 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.

Count IV

149. Petitioner realleges and incorporates paragraphs 1-134 and 147-148 as if fully set forth herein.

150. Respondent failed to keep legible medical records for Patient K.J. in one or more of the following ways:

a. Failing to document the measurements of the fetus' CRL, FL, and gestational sac, on the Obstetrical Sonogram Report,

b. Failing to keep original pictures of each ultrasound examination of Patient K.J. in her medical history file,

c. Failing to legibly document performing a pelvic examination on Patient K.J. prior to inserting Laminaria,

d. Failing to legibly document the justification for the course of treatment for Patient K.J. on the Laminaria Insertion & Induction of Intrauterine Fetal Demise,

e. Failing to document that a pause and verbal confirmation were completed prior to the initiation of Patient K.J.'s procedure,

f. Failing to legibly document complete operative notes for Patient K.J. including start and stop times of the procedure, intra-operative vital signs, any surgical preparation or aseptic technique utilized, and what parts of the procedure, if any, were performed under ultrasound guidance,

g. Failing to legibly document the location of where he injected the paracervical block for Patient K.J.,

h. Failing to document performing an assessment of Patient K.J.'s uterus to determine the cause of her vaginal bleeding,

i. Failing to document adequate medical justification for administering Patient K.J. a second dose of Pitocin and Methergine, and/or

j. Failing to document Patient K.J.'s vital signs during recovery.

151. Based on the foregoing, Respondent violated section 458.331(1)(m).

Count V

152. Petitioner realleges and incorporates paragraphs 1-134 and 147-148 as if fully set forth herein.

153. Respondent failed to keep legible medical records for Patient D.W. in one or more of the following ways:

a. Failing to document the measurements of the fetus' CRL, FL, gestational sac, placenta, fluid, heartbeat, or movement on the Obstetrical Sonogram Report,

b. Failing to keep original pictures of each ultrasound examination of Patient D.W. in her medical history file.

c. Failing to document that a pause and verbal confirmation were completed prior to the initiation of Patient D.W.'s procedure,

d. Failing to legibly document complete operative notes for Patient D.W. including start and stop times of the procedure, intra-operative vital signs, any surgical preparation or aseptic techniques utilized, and/or what parts of the procedure, if any, were performed under ultrasound guidance, and/or,

e. Failing to legibly document the location of where he injected

the paracervical block for Patient D.W.,

154. Based on the foregoing, Respondent violated section 458.331(1)(m).

Count VI

155. Petitioner realleges and incorporates paragraphs 1-134 and 147-148 as if fully set forth herein.

156. Respondent failed to keep legible medical records for Patient D.C. in one or more of the following ways:

a. Failing to document the measurements of the fetus' CRL, FL, and gestational sac, on the Obstetrical Sonogram Report,
b. Failing to keep original pictures of each ultrasound examination of Patient D.C. in her medical history file,
c. Failing to legibly document performing a pelvic examination on, or a physical examination of, Patient D.C.,
d. Failing to legibly document adequate medical justification for ordering more than the maximum recommended dosage of misoprostol to Patient D.C.,
e. Failing to legibly document assessing Patient D.C.'s current symptoms, and/or obtaining a status report, prior to initiating

the procedure,

f. Failing to document that a pause and verbal confirmation were completed prior to the initiation of Patient D.C.'s procedure,

g. Failing to legibly document complete operative notes for Patient D.C. including start and stop times of the procedure, intra-operative vital signs, any surgical preparation or aseptic technique utilized, and/or what parts of the procedure, if any, were performed under ultrasound guidance, and/or,

h. Failing to legibly document the justification for the course of post-procedure care of Patient D.C.,

i. Failing to write legibly in Patient D.C.'s medical record

j. Failing to legibly document his discussion with Patient D.C. and/or C.C. regarding transfer to the hospital, including sufficient medical justification to support transport to Mobile, Alabama, and/or discussing the risks associated with delaying treatment, and/or

k. Failing to document a discharge note or Patient D.C.'s discharge time.

157. Based on the foregoing, Respondent violated section 458.331(1)(m).

Laws & Rules
Counts VII-IX

158. Section 458.331(1)(g), Florida Statutes (2021), authorizes the Board to impose discipline against a medical doctor for failing to perform any statutory or legal obligation placed upon a licensed physician.

159. Rule 59A-9.025(1)(c)2, Florida Administrative Code, provides that the physician shall keep original pictures of each ultrasound examination of a patient in the patient's medical history file.

160. Rule 64B8-9.007, Florida Administrative Code, provides:

> Except in life-threatening emergencies requiring immediate resuscitative measures, once the patient has been prepared for the elective surgery/procedure and the team has been gathered and immediately prior to the initiation of any procedure, the team will pause and the physician(s) or physican assistant(s) performing the procedure will verbally confirm the patient's identification, the intended procedure and the correct surgical/procedure site. The operating physician or physican assistant(s) shall not make any incision or perform any surgery or procedure prior to performing this required confirmation. If the surgery/procedure is performed in a facility licensed pursuant to Chapter 395, F.S., or a level II or III surgery/procedure is performed in an office surgery setting, the physician(s) or physican assistant(s) performing the procedure and another Florida licensed health care

> practitioner shall verbally and simultaneously confirm the patient's identification, the intended procedure and the correct surgical/procedure site prior to making any incision or initiating the procedure. The medical record shall specifically reflect when this confirmation procedure was completed and which personnel on the team confirmed each item.

Count VII

161. Petitioner realleges and incorporates paragraphs 1-134 and 158-160 as if fully set forth herein.

162. Respondent failed to keep original pictures of each ultrasound examination of Patient K.J. in her medical history file.

163. Respondent failed to pause prior to Patient K.J.'s procedure to verbally confirm her identification, the intended procedure and the correct surgical/procedure site, and/or document performing the pause.

164. Based on the foregoing, Respondent violated section 458.331(1)(g) through a violation of Rule 59A-9.025(1)(c)2, and/or Rule 64B8-9.007.

Count VIII

165. Petitioner realleges and incorporates paragraphs 1-134 and 158-160 as if fully set forth herein.

166. Respondent failed to keep original pictures of each ultrasound examination of Patient D.W. in her medical history file.

167. Respondent failed to pause prior to Patient D.W.'s procedure to verbally confirm her identification, the intended procedure and the correct surgical/procedure site, and/or document performing the pause.

168. Based on the foregoing, Respondent violated section 458.331(1)(g) through a violation of Rule 59A-9.025(1)(c)2, and/or Rule 64B8-9.007.

Count IX

169. Petitioner realleges and incorporates paragraphs 1-134 and 158-160 as if fully set forth herein.

170. Respondent failed to keep original pictures of each ultrasound examination of Patient D.C. in her medical history file.

171. Respondent failed to pause prior to Patient D.C.'s procedure to verbally confirm her identification, the intended procedure and the correct surgical/procedure site, and/or document performing the pause.

172. Based on the foregoing, Respondent violated section 458.331(1)(g) through a violation of Rule 59A-9.025(1)(c)2, and/or Rule 64B8-9.007.

Competency of Practice
Counts X-XII

173. Section 458.331(1)(v), Florida Statutes (2021), authorizes the Board to impose discipline against a medical doctor for practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform.

Count X

174. Petitioner re-alleges and incorporates paragraphs 1-134 and 173 as if fully set forth herein.

175. Respondent accepted and performed professional responsibilities which he knew or has reason to know that he was not competent to perform by performing an abortion on Patient K.J. without completing the appropriate education or training to perform this procedure.

176. Based on the forgoing, Respondent violated section 458.331(1)(v).

Count XI

177. Petitioner re-alleges and incorporates paragraphs 1-134 and 173 as if fully set forth herein.

178. Respondent accepted and performed professional responsibilities which he knew or has reason to know that he was not competent to perform by performing an abortion on Patient D.W. without completing the appropriate education or training to perform this procedure.

179. Based on the forgoing, Respondent violated section 458.331(1)(v).

Count XII

180. Petitioner re-alleges and incorporates paragraphs 1-134 and 173 as if fully set forth herein.

181. Respondent accepted and performed professional responsibilities which he knew or has reason to know that he was not competent to perform by performing an abortion on Patient D.C. without completing the appropriate education or training to perform this procedure.

182. Based on the forgoing, Respondent violated section 458.331(1)(v).

WHEREFORE, Petitioner respectfully requests that the Board 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 1st day of August, 2022.

Joseph A. Ladapo, MD, PhD
State Surgeon General

/s/ Kristen Summers

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DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Elizabeth Eubanks
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PCP: July 29, 2022
PCP Members: Falcone & Wasylik

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with sections 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. A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.

Mediation under Section 120.573, Florida Statutes, is not available to resolve this Administrative Complaint.

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 any other discipline imposed.