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# Regulation of Healthcare Professionals in Florida

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#### IV. REGULATION OF HEALTHCARE PROFESSIONALS IN FLORIDA

**TIM RAVICH:** I am pleased to introduce our next guest, **SEAN ELLSWORTH**. Mr. Ellsworth is a member of the law firm of Dresnick & Ellsworth, P.A. Mr. Ellsworth's health law practice involves the representation of physicians and hospitals in licensure matters involving the Agency for Health Care Administration. Mr. Ellsworth also provides representation in matters involving hospital/medical staff privileges. Mr. Ellsworth received his undergraduate degree from Flagler College and his law degree from Nova Southeastern University. Mr. Ellsworth has presented numerous lectures to physicians regarding their rights and investigations commenced by the Agency for Health Care Administration, including Continuing Medical Education seminars at the University of Miami School of Medicine. Mr. Ellsworth is a member of the National Health Board Association and Health Law Section of the Florida Bar. Sean, thanks so much for being here . . . I'll give you our attention.

**SEAN ELLSWORTH:** Thank you. I just want to take a second and introduce another lawyer at our firm who is here today. We are going to talk a lot about AHCA, Agency for Health Care Administration, and we have another lawyer at our firm who is a former prosecutor with the Agency for Health Care Administration. So she prosecuted doctors, she tried to take the licenses away from doctors. Now she jumped over to our side; but in addition to prosecuting doctors she served as the attorney for the Board of Podiatry, the Board of Nursing Home Administrators, the Board of Psychology and the Board of Opticians. Her name is Monica Felder and she is sitting right over here. [. . .]

Generally my firm practices, our real area that we focus on is representing doctors, nurses, health care professionals, who [must respond] when the State of Florida comes in and tries to sanction their license. So basically I'm going to break this down . . . and talk about three things: (1) Who does this regulation? (2) How is this regulation accomplished? (3) Why is it now, in 1999, [that the regulations] have a much more dramatic affect on health care practitioners than it [did] say 5 years ago or 6 years ago when I started practice?

The agency or the body that regulates doctors and health care professionals in the state of Florida is now called the Department of Health. When I started practicing law in Florida it was called the Department of Professional Regulation or DPR. It was then changed to the DBPR, then just to the DPR, then it was changed to the Agency for Health Care Administration; now it's the Department of Health. . . . So, the Department of Health is the regulatory agency in the state of Florida that regulates

physicians, regulates nurses, regulates chiropractors, regulates psychologists, regulates podiatrists, on and on — any health care licensee is regulated by the Health Department. Hospitals are still regulated by the Agency of Health Care Administration.

What is the Department of Health looking for and how do they begin and how do they undertake regulation? On page 2 of the outline, I have about a seven page outline that I'm going [. . .] through and if you have it I'm going to stay in order. The most common way that a doctor would get a visit or undergo regulation by the Department of Health is from a medical malpractice case. If a doctor in Florida is sued for medical malpractice, the plaintiff's attorney is required to send notification to the State that this lawsuit is taking place. Two, three, sometimes even four years down the road when the doctor thinks that the civil case is over, that it either [has] been dismissed, settled, or it's gone to trial, — when the doctor thinks it's all said and done, they [then] get a letter from the state saying "We are investigating you for this conduct." O.K., that's the most common way a doctor or a nurse would be subject to regulation under Florida law. Now an interesting note on this is that under the licensure area the doctor is not, — [it has] not [been] established that the patient was in any way harmed. In a civil case, — understand that a patient has to allege damages to collect money in front of a jury. That is not the case in the licensure or the AHCA or the Department of Health area. In other words, we use examples when we give lectures to physicians a lot of the time.

And say you misread an EKG and the patient walks outside your door and gets hit by a bus. The patient can't sue you for medical malpractice because you didn't cause his death. However, AHCA can come in and find that misread EKG and cite you for medical malpractice. Down the line, medical records is another common area when AHCA will come in or the Department of Health will come in and investigate a doctor. They will review medical records often in coordination or in conjunction with a medical malpractice case. And we will generally see [that] these medical records do not come to state standards and a physician can be cited for that.

Under section C we have sexual misconduct. That's another area. Sexual misconduct and fraud, — and we are going to have a presentation after I go on Fraud.<sup>1</sup> Those are the both two, I call them "death penalty cases to health care professionals in Florida." Generally speaking if you are a physician, a nurse, or a health care professional and you are involved in an isolated case of medical malpractice it's going to be understandable because doctors like lawyers, — all of us are human beings. And fellow doctors and everyone understands that somewhere along the line a mistake is going to be made and

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<sup>1</sup> See Section V, Fraud and Abuse, *infra* p. 438.

we can accept that. You'll get a fine, you'll get some Continuing Medical Education requirements, you'll get maybe probation or supervision. But generally speaking, a one-time mistake is not going to cause a doctor tremendous amount of trouble. Any time a doctor or nurse, any kind of licensee gets involved with either fraud or sexual misconduct — those are really two good cases where the state will try to take away your medical license or your nursing license or whatever license you may hold. Those are the two I call "death penalty"-type cases because there's really a zero tolerance for that type thing in the state of Florida. [ . . . ]

Supervision — and that really ties into the first presentation when we talked about the fact nurses and ARNPs are getting more active roles in patient care. The physicians are being held accountable for supervising those people, the PAs, ARNPs. There is a protocol requirement right now for those type of people so if a physician has a PA working in his practice there has to be a written protocol that has to be on file with Tallahassee[, Florida]. And the physician is being held accountable if the PA makes a mistake — if it's supposed to be under his supervision. So that's another one we are finding to be a much more common way of regulation.

Now how does the state find out about any of this information? How does the state find out that they need to go investigate a doctor or investigate a nurse? Under section three we have sources of complaints. And again to touch on the medical malpractice that's the primary area where the plaintiff's attorney sends that case to Tallahassee and says, "I'm going to sue Dr. X." The state gets that and the state starts an investigation almost every time.

Disgruntled patients have become a real common area where the state starts an investigation. It's amazing and a real sense of frustration to physicians because I generally give this type of presentation to physicians and they get very upset because a patient in Florida can literally put pen to paper and make a sweeping allegation against a physician, many times completely false and that's going to cause a physician a tremendous amount of trouble. Because even though ultimately, at the end of the road, that complaint is unsubstantiated, it [has] cost that doctor a tremendous amount of time, a lot of money, and a lot of aggravation out of his or her life. And it's amazing to these doctors. The first thing they say to me when they come to my office with this patient complaint which is often times handwritten, poorly written, — and making these accusations. The doctors say, "Can they do that? Can they cause me this much trouble just one patient writing this down?" And the answer unfortunately is "Yes." And the second question the doctor generally asks is, "Can I sue this patient when this is all over?" And the answer is generally "No." For a variety of reasons, one of which is — you explain to the doctor it's going to take a lot of time to sue this patient and the odds are they don't have much to take if we ever win [the] case. So I've never seen a

case where the doctor has gone back and done that. I have seen many cases where a disgruntled patient who sometimes writes a letter because they were upset with how long they were in the doctor's waiting room, the way the receptionist treated them, the fact they thought the doctor's examination was to cursory, will write an elaborate detailed allegation against the doctor which subsequently turns out to be untrue and it has cost the physician tremendously — [in terms of] money, time and aggravation.

"Code 15 Reports" and "One Day Reports" — these are reports hospital risk managers are required to file with the state if there is any kind of untoward or adverse incident that occurs in a hospital setting. For example, unfortunately one of the most common cases we're getting this year are "wrong site surgery" — in other words wrong eye surgery, [performance of] surgery on the incorrect eye — wrong knee surgery, performs surgery on the incorrect knee. When that occurs, if that occurs, the hospital risk manager is under an obligation to notify the state immediately. Those reports get sent up to Tallahassee[, Florida] and an investigation is opened as to the people, the doctors, [and] nurses involved with those incidents. Now, the risk manager, who also holds a professional license, is under an obligation under their license to make sure these events are reported. And this oftentimes causes some friction in the hospital setting where the doctor will come storming down to the risk management office and say, "How could you have ratted on me to the state? I thought we all worked together here." And unfortunately the response the risk manager needs to give is, "I have my own license and I'm under an obligation to report this and if I don't, — not only do I get in trouble but the hospital gets in trouble."

Skip down to F [of outline being presented], "Reporting by Fellow Doctors and Nurses." Again this is something that we do see. Oftentimes this comes up where there is an advertising regulation and we've gotten a number of cases where a competing physician has disliked the advertisement of his competing physician and has reported that to the state. We've had a number of cases where nurses who don't get along with doctors report doctors to the state; and doctors who don't get along with nurses report nurses. That's another way that the state would start an investigation as to a professional.

Discipline in other states. Many doctors, especially many Florida doctors hold licenses in others states, most commonly New York, New Jersey, — places up north. Any time their licenses [are] disciplined in another state, there's two things that occur. One is they're subject to discipline in Florida. And two is they have an obligation, an affirmative obligation to report to the state that they were disciplined in another state. If they do not notify the state that they were disciplined in another state, Florida is going to find out anyway because there's a network of state medical boards that talk to each other and send reports to each other. And the doctor will most likely be subject to an

investigation on the underlying conduct in the other state as well as the failure to report the fact that he or she was disciplined in another state.

[Let's] talk about CME and the financial responsibility audits. That's one that applies to lawyers as well. . . . Every now and again the Board of Medicine or the Department of Health will go in and just kind of make sure everyone is up to date on their continuing education and, if not, will get cited. [. . .]

What should a physician do in the event of a Department of Health investigation? I can tell you this — it's a very traumatic event in a doctor or nurse's life when they receive notification that says generally "Dear Doctor, we are now investigating you, investigating your license for the following conduct." It's a letter that really causes a lot of anguish and turmoil because when they come into my office with that letter they're very upset. This is their license; this is something very personal to them. It's something they care very deeply about and this becomes a traumatic event. Now what do you do when you get this letter? And how do we generally handle these investigations? Nine times out of 10 we exercise the doctor's right to remain silent. The investigators are trained to try to interview doctors. What they want to do is they want to come to your office, sit down, talk to you, get your side of the story, generally that's how they phrase it. "We will work this whole thing out. I'll come down to your office. We'll sit down, we'll have coffee, we'll get this whole thing squared away." Our advice, almost across the board, is that we do not permit our clients to do that. And the reason for that is the investigator, at this stage, really does not have the decision-making authority on this case. This doctor can sit down with this investigator and convince this investigator that he or she is the greatest doctor in the world, that they have done nothing wrong, that this is the most frivolous case the investigator has ever seen. However, the investigator cannot stop the investigation. The investigation can only stop up in Tallahassee. The investigator's responsibility in the case is to package up the material and send it to someone who will ultimately become the decision-maker. So it's our policy that we will submit the response on behalf of the doctor. That way we can kind of shape the response the way we want it primarily. Secondly, we often see investigators go to doctor's offices to discuss the particular case with the doctor and walk out opening up three or four more cases because of violations they have seen while they're in the doctor's office. So that's a couple of reasons why we generally do not allow doctors to be interviewed by investigators.

The doctor has a right to view and examine the generating document. In other words, if a patient, a disgruntled patient writes a complaint, the state has to provide the doctor with that actual document at the initiation of the investigation. Now that's the only thing the state, at this point and time, is

required to provide that doctor. The state's investigation is considered confidential — confidential to the standpoint that even the doctor who is the subject of investigation is not entitled to review any of that material. [ . . . ]

Oftentimes in the hospital setting the best thing for the nurse or the doctor to do is to go to their risk manager when they get one of these letters. Because the hospital oftentimes will work with the doctor or nurse to take care of that problem. Now another interesting point is that a lot of times these investigators will come and say "Well, you need to give me the medical records for the patient that's making this complaint." Well, the doctor is not permitted to do that unless the investigator has a subpoena or patient authorization. Those are really the only two times a physician is allowed to release medical records from his office, — with an authorization from the patient or a subpoena from the agency.

[ . . . ] Under Section 6 [of the outline being presented]: Procedural Stages during the Investigation. What happens is that doctor gets a letter from the investigator saying, "We are investigating you for this." The doctor has 45 days to respond. During that period of time we will gather materials, we will get expert witnesses, we will do whatever we can to refute whatever allegations have been made against this physician. The investigator will get that material, get any other material that's deemed relevant, — if it's interviewing witnesses, if it's interviewing the subject who made the complaint, — and package that up and send it to Tallahassee, where, unfortunately, it tends to sit. And this is a real area of frustration for physicians because, as we were talking earlier with **STEVE STARK** [a Miami healthcare attorney for Fowler, White, Burnett, et al.], who's also here and does a bit of this work — Steve [Stark] has a case up there that's been up there for almost two years. I have a case that's been up there for almost three years and no one's done anything on it. So the cases tend to sit at this stage and it's a real point of frustration because, as you can imagine, this is hanging over the doctor's head for this period of time.

At some point in time the state will present the case to the Probable Cause Panel of the Board of Medicine or Board of Nursing or the Board of Psychology, whatever the licenser is and basically that probable cause panel is made up of three members of the Board of Medicine: generally two doctor members and one lay person. They will vote and generally what they do is they adopt for the most part the attorney's recommendation, — the prosecuting attorney's recommendations on the case. There are three things that [the] Probable Cause Panel can do. One, they can vote to dismiss the case; if that occurs, the case remains confidential and that's a really important point; if the case is dismissed, the investigation is confidential. It does not become part of the physician's licensure file, it does not go on the internet, — like we're going to talk about in the end, it does not become a public record and

no one can find out about the fact that even an investigation took place. The second thing that the Probable Cause Panel can do is they can vote to issue what's called a "Confidential Letter of Guidance." What a Letter of Guidance is is basically a letter saying, "We could have found probable cause against you, but this doesn't rise to the level of something we want to pursue, so we're not going to do that." Doctors generally don't like to get those because they're really not appealable, there's nothing you can do and especially a doctor who doesn't think they've done anything wrong. But under the law, and technically, it's equivalent to a dismissal. Because with that letter that remains confidential and all the confidentiality things that I just said apply. It's not public record, it doesn't go on the internet, on and on, and on. Third thing that the Panel can do is they can issue what's called a "Formal Administrative Complaint." And what that is basically, — it's a charging document. And it says, "We believe you've done the following things wrong and we're going to go prove it." Once the physician gets that complaint, the physician can then require the state to prove its case against him or her. The physician has the right to undergo a formal hearing, which is not done in front of a jury, but in front of administrative law judge, — which is covered by Section 120, which is the Administrative Procedures Act. Most physicians do not do this. And there are a variety of reasons why. Probably the most important reason why is because most of the time, when administrative complaints are issued, the physician has concededly done something that they think is wrong, and that happens.

We talked about the wrong site surgeries that are in our office right now that we're handling. There's no defense to those. You can't really go to formal hearing. Say the left eye was scheduled to be performed or done a surgery on and the doctor did it on the right, — it wouldn't be a long trial. So generally speaking, you don't take that course when that type of situation occurs. Secondly, and really, unfortunately, another reason why a doctor would not pursue a formal hearing is because of the time and expense incurred in going forward with the formal hearing. They take a long time, it's under the Administrative Procedures Act, it involves hiring expert witnesses and all kinds of things like that. And that's a factor to a lot of people because they just simply can't afford to go forward like that. So, when a doctor or nurse or any kind of licensee doesn't want to go that direction, regardless of the reason, they enter into what's called a "Consent Agreement."

Basically [a consent agreement] is a negotiated agreement between the prosecuting attorney and the defense attorney, — hopefully getting the physician something they can live with. I'll use the wrong site surgery again as an example because that's the case Monica [Feldman] and I just handled before the Board. This [involved] a physician who has an unblemished record, who is an excellent physician, high qualifications, very well trained,



— never had another problem in his career but performed surgery on the wrong part of the body. What we had negotiated for that doctor was a fine of I think \$5,000, some extra Continuing Medical Education credits in the area of risk management. I think ultimately the Board decided not to impose and a quality assurance review of his practice. We negotiated that with the state. We got the doctor to sign it. And then we were required to appear before the full Board of Medicine and present that consent agreement and really kind of advocate before the Board that they adopt this consent agreement, — which is oftentimes the most difficult part of the case because the Board of Medicine does not rubberstamp consent agreements that [are] worked out between the attorneys. The Board of Medicine is made up of 15 individuals, 12 of which are physicians, three of which are lay members. They do not rubberstamp consent agreements.

A lot of our anxiety in representing physicians comes when we have to appear before the Board with the physician who has to go under oath and answer questions directed to the physician by Board members. And a lot of the times they will let the attorney make the opening speech. They'll understand what the attorney is saying, but these are doctors and they want to hear from doctors. And it really is an uncomfortable situation for the attorneys because the doctors ask some tough questions. A lot of the times what happens is, — if [, for example,] it involves an O.B. case, there'll be an obstetrician on the Board — [s/he] will have the chart and know the chart and really grill the doctor in areas of minute specificity in the patients chart. And the doctor really has to be prepared and answer the questions. And we have to advocate the Board adopts that consent agreement. The Board does not have to adopt that consent agreement. And generally what happens is if they have a problem with that, and they often times do, their policy is: "We don't care what you lawyers have worked out, we are doctors and we understand this case better than you do and we're not comfortable with what you have worked out." They will reject the consent agreement and most of the time say "We're not happy with this. However if you add in a probation, if you add in indirect supervision, if you add in an extra \$5,000 to the fine," — then [they] will accept it. Then, the doctor is given an opportunity to go back and talk to his lawyer and make a decision at that point if they want to accept the that or not. The doctor is only bound by the consent agreement the doctor signs. If the doctor signs a consent agreement and the Board says "No way, but we will take this, this, and this," the doctor can then say, "I'm only bound by what I signed, I want to go back and I'll elect my right to take a formal hearing."

Page 6 [of the presented outline] on "Penalties," . . . Now the important thing about a reprimand is — a reprimand . . . is really just a written document . . . is important because that's the threshold area of when something is reported to the National Practitioners Databank. So we will really try hard in

representing our physician clients so that we do not get reprimands. We will take any amount of fine as opposed to a reprimand because the doctors are very concerned with the National Practitioners Databank. Administrative fine, community service, probation, you have suspension and revocation are sometimes used in the harsh cases.

In the last two or three minutes that I have here I want to talk about why this has become such an important area for physicians. In July of this year they are going to create this huge database on the internet that's going to have a profile on every physician in Florida.<sup>2</sup> And doctors are starting to get their forms now. Our office has been inundated with telephone calls about what are called, if you look on page 8 of the outline, "Physician Profiling Forms." And this is going to give all kinds of information about the physician's training, qualifications, and discipline. There was a time in Florida when it was very, very difficult for a patient or anybody to find out about a doctor's qualifications, doctor's background, or a doctor's disciplinary history. The only way it could be done was really a public request to the State of Florida requesting that kind of information. And most patients were not and are not sophisticated enough to know what to ask for. Now everybody is on the internet and all you need to find out all kinds of dirt about doctors and really everybody is a computer and a modem. Doctors are very concerned. Years ago one of the most common things doctors used to say to me in my office was — there's this newsletter generated and sent to all doctors and once a year they list all doctors who have been disciplined in the state. And I used to get the question "Am I going to be in the newsletter," and my answer was, "Yeah, you're going to be in the newsletter." Now the first thing people are asking me, "Is this going to be on the internet?" And they are really, really concerned about that because this is going to give everyone access to that information.

Secondly, we talked about managed care this morning. We had representatives from hospitals here this morning. That type of information is considered by the managed care entities. In other words if Dr. X wants to be on Av-Med's plan and wants to get paid by Av-Med, he has to apply and Av-Med has to do some credentialing. What's happening is if a doctor has a significant disciplinary problem, Av-Med may say, "We don't want you on our panel." If enough managed care entities say we don't want you on our panel, it's going to be difficult to practice medicine. Because the reality of it is there aren't too many doctors who don't take insurance, who take private pay, almost all of them have arrangements with some kind of managed care entity. Same goes with hospitals. If a hospital has a physician on staff who

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<sup>2</sup> Florida Department of Health, *Physician Profiling*, <<http://www.doh.state.fl.us/mga/Profiling/home.htm>>; see also FLA. STAT. §§ 455.565, 455.5651-.5656 (1999); see also <[http://www.healthcarechoices.org/profiling/profile\\_fl.htm](http://www.healthcarechoices.org/profiling/profile_fl.htm)>.

has just been disciplined by the Florida Board of Medicine, the hospital can take action against that doctor and can take that doctor off their medical staff. If you don't have staff privileges at hospitals, it becomes very difficult to practice. This is why physicians are becoming much, much, much more attuned and really upset about what's happening with this regulatory process.

As I've alluded to you before, I've given this lecture a lot to doctors. In fact that's my primary audience, is to physicians and at the end of the lecture you can see the steam coming out of their heads. Because the situation is really bleak for doctors right now. And an argument can be made, I think a good argument can be made, that Florida physicians are among the most regulated individuals in the country. They are really practicing under a microscope. With the conversations we were having this morning, as Mr. [Fred] Messing, working harder and really making less. So with that said, and with what Mr. [Fred] Messing said about the stress, it's become a real stressful environment for physicians. And I know Monica [Feldman] and I have spoken to many physicians within just this year [who have] said, "I don't even want to be a doctor anymore. I don't want to practice medicine anymore. I'm just going to go back to doing something else because I'm not making as much money, everybody's looking over my shoulder, everybody's climbing over my back, it's too stressful and that's not why I became a doctor. I wanted to help people and not practice defensive medicine — not worry about my policies and procedures to the point where I can't take care of my patients."

... Yes

*(From the Audience):* You seem to give the opinion that sticking up for the doctor and being confident when he comes and tells you, "I did something wrong and I'm going to be held accountable for it." To me it seems if a doctor does something wrong he should be held accountable for it. It should be posted on the internet and people should be aware.

**SEAN ELLSWORTH:** I don't disagree at all. In fact, most of the time when you see me before the Board of Medicine I am with a physician who is really undergoing a humbling experience of saying, "I screwed up, I'm sorry. I am here to accept this punishment." What I'm telling you is that there are a large number of cases out there. And of course everybody here is advocating for something or has a perspective of something.

I happen to like doctors. I work closely with doctors. I've come to really respect doctors. Am I going to tell you that there aren't some bad apples out there? Of course there are. Am I going to tell you that I don't represent bad apples? Of course I do. O.K., but I think the majority of doctors out there are really special people in my opinion. And again to reiterate, most of the time you see me before the Board, most of the time you see doctors before the

Board, they are there to say, "Yeah I'm a human being, I made a mistake." And I can tell you this from someone who interacts a lot with doctors, when they make a mistake that hurts a patient the thing that bothers them the least is the discipline they have to take; the thing that bothers them the most is they have to think about the effect that that's going to have on the patient and that really troubles them. I'm not an apologist for physicians by any means, but I will say 90 percent of them, in my estimation, are good people. Some of them do make mistakes. You know I'm not going to get into the intentional acts of people. That's going to be the subject of our next topic. . . .

Thank You.

*(Applause).*