STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF PROFESSIONAL REGULATION, BOARD OF MEDICINE, Petitioner,	)	
vs.	)	CASE NO. 92-5794
	)	CASE NO. 92-5795
RICHARD SAMITIER CARDET, M.D., Respondent.	)	CASE NO. 92-6588

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly designated Hearing Officer, Claude B. Arrington, held a formal hearing in the above-styled case on September 27-29, 1993, in Miami, Florida.

APPEARANCES

For Petitioner: Arthur B. Skafidas, Esquire
Department of Business and Professional Regulation
1940 North Monroe Street
Northwood Centre, Suite 60
Tallahassee, Florida 32399-0792

For Respondent: Richard Samitier-Cardet, M.D., pro se
5831 Southwest 26th Street
Miami, Florida 33155

STATEMENT OF THE ISSUES

Whether disciplinary action should be taken against Respondent's medical license, number ME 0043028, based upon violations of the Medical Practice Act, Chapter 458, Florida Statutes, as alleged in the three Administrative Complaints filed against Respondent in these consolidated proceedings.

PRELIMINARY STATEMENT

Three separate Administrative Complaints were filed against Respondent's license to practice medicine in the State of Florida.

On August 19, 1992, the Petitioner filed an Administrative Complaint against Respondent that contained thirteen separate counts. Following Respondent's challenge to the allegations and conclusions contained in this Administrative Complaint, the matter was referred to the Division of Administrative Hearings (DOAH) and assigned DOAH Case No. 92-5795. Counts 1-3 of DOAH Case No. 92-5795 pertain to Respondent's treatment of a patient who will be referred to as J. M. Counts 4-8 of DOAH Case No. 92-5795 pertain to Respondent's treatment of a patient who will be referred to as A. M. S. Counts

9-11 of DOAH Case No. 92-5795 pertain to Respondent's dealings with an undercover investigator employed by Petitioner who will be referred to as T. M. and to a procedure referred to as CAPE that Respondent performed on male patients. Counts 12 and 13 of DOAH Case No. 92-5795 pertain to certain advertisements of the Respondent that allegedly failed to contain a disclaimer required by section 455.24, Florida Statutes.

Count 1 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(t), Florida Statutes, based on his treatment of J. M.

Count 2 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(m), Florida Statutes, based on his treatment of J. M.

Count 3 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, based on his treatment of J. M.

Count 4 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(t), Florida Statutes, based on his treatment of A. M. S.

Count 5 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(q), Florida Statutes, based on his treatment of A. M. S.

Count 6 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(n), Florida Statutes, based on his treatment of A. M. S.

Count 7 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, based on his treatment of A. M. S.

Count 8 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(m), Florida Statutes, based on his treatment of A. M. S.

Count 9 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(t), Florida Statutes, by performing the CAPE procedure.

Count 10 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, based on his dealings with T. M.

Count 11 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(k), Florida Statutes, based on his dealings with T. M.

Count 12 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(d), Florida Statutes, based on those advertisements.

Count 13 of DOAH Case No. 92-5795 alleges that Respondent violated the provisions of Section 458.331(1)(g), Florida Statutes, based on those advertisements.

On September 10, 1992, the Petitioner filed an Administrative Complaint against Respondent that contained four separate counts and pertained to Respondent's treatment of a patient that will be referred to as C. M. R. Following Respondent's challenge to the allegations and conclusions contained in this Administrative Complaint, the matter was referred to DOAH and assigned DOAH Case No. 92-5794.

Count 1 of DOAH Case No. 92-5794 alleges that Respondent violated the provisions of Section 458.331(1)(t), Florida Statutes, based on his treatment of C. M. R.

Count 2 of DOAH Case No. 92-5794 alleges that Respondent violated the provisions of Section 458.331(1)(m), Florida Statutes, based on his treatment of C. M. R.

Count 3 of DOAH Case No. 92-5794 alleges that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, based on his treatment of C. M. R.

Count 4 of DOAH Case No. 92-5794 alleges that Respondent violated the provisions of Section 458.331(1)(x), Florida Statutes, based on his treatment of C. M. R.

On October 9, 1992, the Petitioner filed an Administrative Complaint against Respondent that contain two separate counts and pertain to certain advertisements of the Respondent that allegedly failed to contain a disclaimer required by section 455.24, Florida Statutes. Following Respondent's challenge to the allegations and conclusions contained in this Administrative Complaint, the matter was referred to DOAH and assigned DOAH Case No. 92-6588.

Count 1 of DOAH Case No. 92-6588 alleges that Respondent violated the provisions of Section 458.331(1)(d), Florida Statutes, based on those advertisements.

Count 2 of DOAH Case No. 92-6588 alleges that Respondent violated the provisions of Section 458.331(1)(g), Florida Statutes, based on those advertisements.

DOAH Case Nos. 92-5794, 92-5795, and 92-6588 were thereafter consolidated and the formal hearing was set to be heard on January 19-21 and 26-29, 1993. On or about January 11, 1993, Respondent moved to continue the formal hearing in this cause because his counsel of record moved for leave to withdraw from the DOAH proceedings. On January 21, 1993, the undersigned granted Respondent's attorneys leave to withdraw and ordered this matter abated until February 19, 1993, to give Respondent sufficient time to secure counsel. The formal hearing was re-noticed for April 13-16 and 19-23, 1993. On or about April 9, 1993, Respondent moved to continue the formal hearing that was scheduled to begin on April 13, 1993, based on his representation that he was incarcerated and unable to attend the hearing. The motion was granted, and the formal hearing was rescheduled for September 20-24, 1993. On May 14, 1993, Petitioner filed its Motion for New Hearing Date, based upon the unavailability of expert witnesses who were expected to testify. Thereafter the formal hearing was rescheduled for

September 27 - October 1, 1993. Respondent was afforded adequate notice of the time and place of the formal hearing that was conducted in this proceeding.

Repeated efforts to secure Respondent's participation for status conferences and motion hearings were unsuccessful. Because Respondent was under house arrest as a result of federal and state criminal charges, his whereabouts were known and he was provided notice as to these efforts to secure his participation in these status conferences and motion hearings. On September 8, 1993, a Notice of Telephone Hearing on Pending Motions, which scheduled a hearing by telephone conference call for September 13, 1993, on all pending motions was served on Respondent. This notice specifically advised that the failure of either party to participate in the telephone hearing may have severe and adverse consequences for the non-attending party. Respondent failed to participate in the conference call despite his known availability and despite repeated efforts to reach him. Respondent asserted at the formal hearing that he was unable to prepare for this case due to his status of being under house arrest for state and federal criminal charges and because he was unable to afford an attorney. Respondent failed to establish any factual basis upon which an indefinite continuance of these serious charges should be granted. Respondent failed to demonstrate that he made any attempt at discovery or that he made any attempt to prepare for the formal hearing. For the reasons stated on the record at the beginning of the formal hearing, the request by the Respondent that the formal hearing be indefinitely continued was denied.

At the onset of formal hearing, the undersigned granted Petitioner's Motion for Costs and Other Remedies, filed on February 22, 1993, but reserved ruling on the amount to be awarded to Petitioner. That amount will be set by separate order.

At the formal hearing, Petitioner offered thirty-one (31) exhibits, all of which were accepted into evidence, and presented the testimony of sixteen (16) witnesses. Respondent did not offer any exhibits into evidence nor call any witnesses to testify.

A transcript of the proceedings has been filed. The proposed findings of fact submitted by Petitioner are adopted in material part by the Recommended Order. Those proposed findings of fact that are not adopted by the Recommended Order are either unnecessary to the findings made and the conclusions reached or are conclusions of law that are inappropriate as findings of fact. The Respondent's post-hearing submittal did not contain proposed findings of fact.

FINDINGS OF FACT

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, and Chapters 455 and 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0043028.

3. Respondent was selected for a residency program in general surgery at Mount Sinai Hospital, which is a five year program. Respondent's participation in the general residency program at Mount Sinai was terminated during his third year of the program. Senior surgical residents in the Mount Sinai program are selected from among fifth year residents. Respondent did not attain the status as a senior surgical resident.

4. Respondent has no formal training in plastic or cosmetic surgery. Respondent is not a plastic surgeon and is not qualified to practice plastic or reconstructive surgery.

FACTS RELATED TO COUNTS 1-3 OF DOAH CASE NO. 92-5795

5. On or about January 23, 1990, patient J. M., a twenty-six (26) year old female, presented to Respondent's office for consultation. Respondent performed a physical examination of J. M. and made a diagnosis of breast hypoplasia. Breast hypoplasia is a general term used to describe small breasts. Respondent failed to obtain a thorough initial medical evaluation and medical history for patient J. M.

6. On or about January 26, 1990, Respondent performed a bilateral augmentation mammoplasty on patient J. M. A bilateral augmentation mammoplasty is a procedure in which the surgeon dissects a pocket behind the breast tissue or behind the muscle that sits under the breast tissue and implants a prosthesis in the pocket in order to augment a patient's breasts. Respondent failed to make a descriptive operative report of the procedure he performed on J. M.

7. Postoperatively, scar tissue developed around the prosthesis that had been implanted in J. M.'s right breast, and her right breast hardened. On March 6, 1990, Respondent performed a closed capsulotomy on patient J. M.'s right breast. A closed capsulotomy is a procedure that exerts pressure on a women's breast that has an implant in it in order to try to fracture the scar around the implant and thereby release the spherical capsular contracture (hard breast). This was an acceptable procedure and resolved J. M.'s complaint.

8. On or about September 4, 1990, Respondent performed a bilateral mastopexy and abdominal liposuction on patient J. M. A mastopexy is a breast lift procedure in which excess skin is removed in order to raise the breast and the nipple areola complex to a preferred position. Respondent failed to make a descriptive operative report of these procedures. Respondent failed to order the appropriate laboratory studies prior to these procedures.

9. On or about October 12, 1990, patient J. M. presented to Respondent complaining of a scab peeling off of her breast with the implant being visibly exposed. Respondent treated patient J. M. with Neosporin ointment and Duricef. Respondent then sutured the wound closed. Neosporin is a local bacterial ointment used to treat local wound infections. Duricef is an oral antibiotic. Respondent should have obtained a culture of the wound, removed patient J. M.'s implant, irrigated the wound, administered antibiotics, and then closed the wound. After a culture was obtained, Respondent should have placed the patient on antibiotics, and then after receiving the culture report, modified the antibiotic as necessary.

10. Respondent failed to practice medicine with an acceptable level of care in regards to patient J. M., in that Respondent failed to recognize that patient J. M. had developed a serious infection and failed to appropriately treat the infection.

11. Respondent is not trained to perform mastopexy, augmentation, or liposuction procedures. Respondent performed breast implantation surgery and liposuction procedures on patient J. M. without having adequate training.

FACTS RELATED TO COUNTS 4-8 OF DOAH CASE NO. 92-5795

12. A. M. S. is a female who was 34 years old at the time of the formal hearing. On or about January 25, 1991, A. M. S. presented to Respondent's office. Patient A. M. S. desired fuller lips. Respondent's medical records lists the "Paris Lips" procedure as the reason for her visit.

13. "Paris Lips" is a procedure performed by Respondent during which liquid silicone is injected into the patient's lips.

14. In the early 1970s, Dow Corning sought a new drug application from the United States Food and Drug Administration (FDA) for use of silicone as an injectable substance for use in human tissue. Silicone occurs in either solid or liquid form. A study was authorized by the FDA which allowed eight physicians, seven plastic surgeons and a dermatologist, to carry out injections in certain types of human subjects, primarily in the face. After these studies, the doctors involved issued a statement which concluded that the risk and dangers of liquid silicone injections far outweighed the benefits, and the new drug application was withdrawn. At the times pertinent to this proceeding, the use of liquid silicone was under FDA control. In 1991, liquid silicone was considered to be an experimental substance. Now it has been banned from use completely.

15. The injection of liquid silicone is not an accepted procedure in the medical community. The use of liquid silicone without an Investigational Device Exemption is a violation of Federal law. Respondent has never had authorization from the FDA for the use of liquid silicone for facial or soft tissue augmentation.

16. Patient A. M. S. paid Respondent $500.00 for the "Paris Lips" procedure.

17. On or about January 31, 1991, Respondent injected 2 cc's of liquid silicone into the lips of patient A. M. S.

18. Neither Respondent nor his staff performed any physical examination on patient A. M. S. prior to the injections.

19. Respondent's medical records indicate that he explained the benefits and risks of silicone to patient A. M. S. and that patient A. M. S. agreed to the procedure. Respondent told patient A. M. S. that there would not be any side effects, just a little swelling and some bruising. The testimony of A. M. S. established that Respondent did not adequately discuss the risks or benefits of liquid silicone injections with patient A. M. S.

20. Following the procedure, patient A. M. S. noted that her lips were very swollen and red. Approximately 2-3 weeks after the procedure, patient A. M. S. presented to Respondent's office complaining that he had placed too much silicone in her lips and that her lips were uneven and appeared deformed.

21. In response to these complaints, Respondent injected additional liquid silicone into patient A. M. S.'s lips on February 8, 1991, and March 4, 1991, in an effort to even out the lips. After these additional injections of silicone, patient A. M. S. felt her appearance was horrendous and it affected her job as a court reporter.

22. Patient A. M. S. expressed her dissatisfaction to Respondent. Subsequently, patient A. M. S. sought additional opinions from other plastic surgeons, including the opinion of Dr. Harold Norman. Dr. Norman took pictures of patient A. M. S. and told her to return in two months. Patient A. M. S. sought the opinion of Dr. Anthony Wolfe. Dr. Wolfe told patient A. M. S. that nothing could be done for her condition, in that there is no easy way to remove liquid silicone.

23. Patient A. M. S. then sought the opinion of Ernest DiGeronimo, M.D. Dr. DiGeronimo performed four surgeries in an effort to correct the effects of Respondent's liquid silicone injections on patient A. M. S. Each surgery by Dr. DiGeronimo cost patient A. M. S. $800.00. Respondent inappropriately injected liquid silicone into the lips of patient A. M. S.

24. Respondent exploited patient A. M. S. for financial gain.

25. Respondent committed gross malpractice in his treatment of patient A. M. S. by injecting her lips with liquid silicone.

FACTS RELATED TO COUNTS 9-11 OF DOAH CASE NO. 92-5795

26. At all times material hereto, on numerous and diverse occasions, Respondent has performed on male patients a procedure he calls the "Circumferential Autologous Penile Engorgement," hereinafter "CAPE". The CAPE procedure is used to enlarge the girth of the penis by taking fat from one part of the body and injecting it into the walls of the patient's penis. The CAPE procedure was developed by Respondent. Respondent is not trained to perform the CAPE procedure, and the procedure is not recognized as being a medically acceptable procedure.

27. On or about November 19, 1991, DPR Investigator Thomas Daniels, presented to Respondent's office in an undercover capacity using an assumed name, that of patient T. M. Mr. Daniels discussed the CAPE procedure surgery with Respondent and scheduled an appointment with Respondent to undergo the CAPE procedure on or about December 3, 1991.

28. Respondent indicated that the CAPE procedure was a very low risk procedure. In fact, the CAPE procedure has potentially serious complications including, but not limited to, hematoma, infection, loss of the patient's penis, necrosis, functional problems, and scar tissue. The statements made by Respondent to Mr. Daniels regarding the CAPE procedure were deceptive, fraudulent, and untrue.

29. On or about December 5, 1991, Petitioner issued subpoena number A023965 to Respondent in order to obtain Respondent's complete medical records of Patient T. M. (Mr. Daniels.) The records of Mr. Daniels' undercover visit of November 19, 1991, state in part the following: "Rectal exam requested by patient, no abnormalities."

30. Neither Respondent, nor his staff, conducted a rectal examination on Mr. Daniels.

FACTS RELATED TO COUNTS 12-13 OF DOAH CASE NO. 92-5795

31. Pursuant to Section 455.24, Florida Statutes, in any advertisement for a free, discounted fee, or reduced fee service, examination, or treatment by a health care provider licensed under Chapter 458, Florida Statutes, the following

statement shall appear in capital letters clearly distinguishable from the rest of the text: THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT WHICH IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT.

32. Around October 1991, Respondent placed an advertisement in The Miami Herald newspaper for a procedure he defined in the advertisement as "The Closed Neck Lift," and described it as "an exciting new procedure" which leaves "no scar." The aforementioned advertisement also offered a free consultation and video imaging. The aforementioned advertisement failed to include the disclaimer noted in Section 455.24, Florida Statutes.

33. In a letter to a DPR investigator dated November 20, 1991, Respondent described the aforementioned closed neck lift procedures as performed by the use of liposuction. The aforementioned procedure has been practiced in the United States for approximately the past ten (10) years and is not "new." The aforementioned procedure leaves a small scar.

34. On or about October 16, 1991, Respondent placed an advertisement in The Fort Lauderdale Sun-Sentinel which offered a free consultation and video imaging session.

35. The October 16, 1991, advertisement failed to include the disclaimer statement required by Section 455.24, Florida Statutes, when free or discounted medical services are being offered.

36. Respondent failed to include the disclaimer required by Section 455.24, Florida Statutes, in regards to the October 1991 Miami Herald and the October 1991 Fort Lauderdale Sun-Sentinel advertisement.

FACTS RELATED TO DOAH CASE NO. 92-5794

37. On or about January 7, 1992, patient C. M. R., a 47 year old male, presented to Respondent's office for a first consultation. Approximately twenty years prior to his visit to Respondent, Patient C. M. R. had undergone aortic valve replacement and the insertion of a pacemaker. He had been on the drug Coumadin for approximately twenty years.

38. Respondent's medical records for patient C. M. R. fail to reflect that patient C. M. R. had a pacemaker. Respondent knew that patient C. M. R. had been taking Coumadin for the past twenty years. Coumadin is an anticoagulant drug used to prevent the development of blood clots. A recognized effect of Coumadin is that it causes patients who are taking it to bleed following any surgical procedure.

39. Respondent's plan for patient C. M. R. included liposuction of the face and neck. Patient C. M. R. was to also undergo a CAPE procedure.

40. Respondent's medical records for patient C. M. R. fail to reflect that Respondent obtained the patient's cardiology records, or as an alternative, obtained a cardiology consult prior to allowing patient C. M. R. to undergo elective cosmetic surgery. Respondent should have obtained medical clearance from a cardiologist or internist prior to patient C. M. R.'s surgery.

41. On April 23, 1992, patient C. M. R. returned to Respondent's office to schedule surgery.

42. Patient C. M. R.'s blood was drawn and pre-operative blood tests included a thyroid test, electrolytes, bone, renal, ferritin studies, a complete blood count, and an HIV test. No protime, prothrombin time, or clotting time was obtained by Respondent. A prothrombin time is a test that measures the level of the blood's anticoagulation.

43. On the evening of May 1, 1992, patient C. M. R. presented to Respondent's clinic for surgery. Patient C. M. R.'s wife, L. M. R., dropped him off at Respondent's clinic at approximately 8:00 p.m. on May 1, 1992.

44. Patient C. M. R. was prepared for surgery. An intravenous solution of 1,000 cc's of lactate of ringers was administered. Papaverine 30 milligrams was injected into the penis, and 3 cc's of Xylocaine 1 percent with Epinephrine (a topical anesthetic) were used for local anesthesia.

45. Respondent extracted 100 cc's of fat from the patient's abdomen and neck. Respondent performed the CAPE procedure using 60 cc's of the fat extracted from the abdomen. Respondent placed a pressure dressing on the neck and placed packing in the buccal space of patient C. M. R.'s cheeks.

46. Respondent's medical records for patient C. M. R. indicated that during the early morning hours on May 2, 1992, C. M. R. began oozing blood from his right cheek while in recovery and was taken back to the operating room.

47. At approximately midnight, Respondent informed L. M. R., who had previously returned to Respondent's clinic, that patient C. M. R. was suffering bleeding complications from one of his cheeks.

48. At approximately 1:30 a.m., Respondent called a Dr. Zufi and requested a consultation. Dr. Zufi arrived at Respondent's clinic at approximately 2:00 a.m. and went directly to the operating room to consult with Respondent. Digital pressure and Epinephrine were used to control the oozing from patient's C. M. R.'s right cheek. Patient C. M. R. was then returned to recovery.

49. L. M. R. asked Respondent if it was necessary to transport C. M. R. to a hospital. Respondent informed L. M. R. that it was not necessary to transport the patient to a hospital, and C. M. R. remained in the recovery room at Respondent's clinic.

50. On May 2, 1992, at 11:30 p.m., a sublingual pill of Nitroglycerin was given because patient C. M. R. complained of midline discomfort.

51. On May 3, 1992, at approximately 1:10 a.m., Respondent was awakened by the monitor alarm with the monitor reading oxygen saturation at 80 percent and the pulse at 90. Respondent found patient C. M. R. unresponsive and his pupils dilated.

52. Respondent called "911" and Dr. Zufi for assistance. The Emergency Medical Technicians (EMTs) arrived at approximately 1:16 a.m. The EMTs entered Respondent's clinic and observed patient C. M. R. The EMTs observed a pulse meter, but did not observe a blood pressure monitor or crash cart. Respondent was attempting to suction the patient when the EMTs arrived.

53. Patient C. M. R. was very discolored, bruised, and was suffering a lot of edema. Patient C. M. R. had bandages wrapped around his face. When questioned about the patient's discoloration, Respondent indicated that the patient had been taking Coumadin.

54. The EMTs placed patient C. M. R. on a cardiac monitor. The cardiac monitor revealed the patient to be in full cardiopulmonary arrest. At this time, patient C. M. R. had a idioventricular rate of approximately 20. An idioventricular rate is an electrical impulse in the ventricles only, where the heart is in the last death stages with no pulse.

55. The EMTs made two unsuccessful attempts to intubate C. M. R. The EMTs eventually successfully intubated the patient with a computube. A computube has two lumens (openings). One lumen is a breathing passage and the other is a blind passage. A computube is a foolproof intubation system. The construction of the computube allows it to function in either the trachea or the esophagus.

56. Patient C. M. R.'s heart rhythm remained idioventricular. The EMTs changed the patient's IV and administered medication to the patient. Patient C. M. R. remained unresponsive despite the medications and other efforts to revive him. Respondent indicated to the EMTs that the patient was hypovolemic and needed to go to the emergency room.

57. Patient C. M. R. was then transported to Mercy Hospital where he was pronounced dead at approximately 1:56 a.m. on May 3, 1992.

58. At approximately 9:15 a.m. on May 3, 1992, J. David Charlesworth, M.D., the Associate Medical Examiner at the Dade County Medical Examiner's Department, performed an autopsy on patient C. M. R. The autopsy report indicates, among other things: extensive purple-red contusions surrounding the incision in the lower abdomen, extending down to, and involving the scrotum; extensive blue-purple contusion covering the right flank and anterior abdominal wall; blue-purple contusion covering the anterior neck up to and including the jaws; contusion extending up to the ear lobes and onto both cheeks; upper eyelids of both eyes suffused with extravasated blood; soft tissues of both sides of the neck suffused with extravasated blood extending from the jaw line down to the prevertebral fascia and down to the clavicles; hemorrhagic and fat globules seen in blood pool collected in the pelvic area; and large abdominal wall hematoma.

59. The cause of death was reported as cardiorespiratory arrest following liposuction and other plastic surgery procedures, with interstitial hemorrhages of the face, neck, abdomen, and legs. The patient suffered interstitial hemorrhages (bleeding into tissues).

60. The computube in patient C. M. R.'s esophagus did not contribute to the patient's death.

61. A cardiac pathological examination of patient C. M. R.'s heart revealed that the heart was slightly larger than normal, had scars covering the heart, and had a prosthetic aortic valve. Neither his prosthetic aortic valve or his pacemaker caused C. M. R.'s death.

62. Respondent failed to adequately assess patient C. M. R.'s condition, in that Respondent failed to obtain a prothrombin time (PT), or a partial thromboplastin time (PTT) preoperatively.

63. Respondent failed to practice medicine with an acceptable level of care in regard to patient C. M. R. in that Respondent should have discontinued the use of Coumadin prior to proceeding with this elective surgery.

64. In general, patients who are anticoagulated with Coumadin who require surgery are admitted to a hospital and weaned off of Coumadin prior to surgery. Surgery is performed with the patient in a normal hemostatic status. Within 24 hours following surgery, anticoagulation medication is reinstituted.

65. Respondent did not have any hospital staff privileges from 1988 to the present. Hospital staff privileges are obtained after an application is made to a hospital following the physician's completion of his training in order to be credentialed by that hospital to practice his specialty at that hospital. Because Respondent did not have hospital privileges, he did not have access to a hospital to admit C. M. R. so that he could continue his treatment after the complications occurred.

66. It is highly unusual for a surgeon to practice his profession without hospital privileges.

67. Despite postoperative bleeding complications, Respondent failed to refer Patient C. M. R. to a hospital emergency room in a timely, and appropriate manner.

68. Even without hospital privileges, Respondent could have referred patient C. M. R. to a hospital emergency room.

69. Respondent's failure to timely refer patient C. M. R. significantly contributed to the patient's death.

70. Respondent failed to practice medicine with an acceptable level of care in regards to patient C. M. R. in that Respondent failed to: perform a thorough initial evaluation and history of the patient; preoperatively obtain a prothrombin time (PT), or a partial thromboplastin time (PTT); discontinue the use of Coumadin and/or take other precautions before proceeding with cosmetic surgery; and failed to refer the patient to a hospital emergency room in a timely and appropriate manner when C. M. R. began to ooze blood immediately after the surgery.

71. Respondent failed to properly diagnose all medical and surgical problems of patient C. M. R. prior to the performance of surgery and failed to properly manage the postsurgical care of patient C. M. R. Respondent committed gross malpractice in regards to patient C. M. R.

FACTS RELATED TO DOAH CASE NO. 92-6588

72. Respondent placed an advertisement in The Miami Herald on or about December 5, 1990, which purportedly offered a new technique in cosmetic surgery, specifically, lip augmentation.

73. Respondent advertised lip augmentation, or "Paris Lips," as a "perfectly safe and painless procedure" which creates fuller, more sensuous lips.

74. The advertisement does not indicate how Respondent's procedure creates fuller lips.

75. Respondent's lip augmentation procedure is performed by injecting silicone into a patient's lips.

76. Respondent's "Paris Lips" advertisement is false, deceptive, or misleading, in that it indicates the "Paris Lips" procedure is a "perfectly safe and painless" procedure.

77. The dangers of silicone injections include infection bleeding, hematomas, permanency, and/or migration of the silicone.

78. The use of liquid silicone for the augmentation of human tissue is tightly regulated by the Food and Drug Administration (FDA) and liquid silicone is only to be used by those physicians under FDA approval.

79. Respondent does not have, nor has he ever had, FDA approval to perform augmentation of human tissue by use of liquid silicone.

80. Respondent's "Paris Lips" advertisement is false, deceptive, or misleading, in that it fails to indicate that the "Paris Lips" procedure is performed by injecting liquid silicone into the patient's lips.

81. Respondent's advertisement further offered the "Paris Lips" augmentation procedure "for a limited time only, for $500.00," and a free consultation and video imaging session.

82. Respondent's "Paris Lips" advertisement fails to include the necessary disclaimer required by Section 455.24, Florida Statutes, when free or discounted services are being offered.

CONCLUSIONS OF LAW

83. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of these proceedings pursuant to Section 120.57(1), Florida Statutes, and Section 455.225, Florida Statutes

84. Petitioner has the burden of proving by clear and convincing evidence the allegations against Respondent. See Section 458.331(3), Florida Statutes, and Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Evans Packing Co. v. Department of Agriculture and Consumer Services, 550 So.2d 112 (Fla. 1st DCA 1989). The nature of clear and convincing evidence has been described as follows in Slomowitz v. Walker, 429 So.2d 797, 800 (Fla. 4th DCA 1983):

> We therefore hold that clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief of conviction, without hesitancy, as to the truth of the allegations sought to be established.

See also, Smith v. Department of Health and Rehabilitative Services, 522 So.2d 956 (Fla. 1st DCA 1988), which, at page 958, quotes with approval the above-quoted language from Slomowitz. The Smith case also includes the following at page 958:

> "Clear and convincing evidence" is an intermediate standard of proof, more than the "preponderance of evidence" standard used in most civil cases, and less than the "beyond a reasonable doubt" standard used in criminal cases. See State v. Graham, 240 So.2d 486 (Fla. 2nd DCA 1970).

85. Section 458.331, Florida Statutes (1991), provides, in pertinent part, as follows:

> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
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> * * *
>
> (d) False, deceptive, or misleading advertising.
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> * * *
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> (g) Failing to perform any statutory duty or legal obligation placed upon a licensed physician.
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> (k) Making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine.
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> * * *
>
> (m) Failing to keep written medical records justifying 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.
>
> (n) 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, which shall include, but not be limited to, the promoting or selling of services, goods, appliances, or drugs.
>
> * * *
>
> (q) 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. . . .
>
> * * *
>
> (t) 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. . . .
>
> * * *
>
> (v) 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 is not competent to perform.

DOAH CASE NUMBER 92-5795

86. Petitioner proved by clear and convincing evidence that Respondent's failure to properly treat J. M.'s infected implant constituted "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" and violated the provisions of Section 458.331(1)(t), Florida Statutes, as alleged in Count 1 of DOAH Case No. 92-5795.

87. Petitioner proved by clear and convincing evidence that Respondent's medical records did not justify his course of treatment of J. M. in violation of Section 458.331(1)(m), Florida Statutes, as alleged in Count 2 of Case No. 92-5795. No separate penalty should be imposed for that failure. As discussed in the foregoing paragraph, Petitioner proved by clear and convincing evidence that Respondent's treatment of J. M. fell below acceptable standards. Consequently, it is concluded that there were no medical records that he could have kept "justifying the course of treatment of the patient" within the meaning of Section 458.331(1)(m), Florida Statutes. It is redundant to charge Respondent with performing an unacceptable procedure and also to charge him with failing to keep records that would justify the unacceptable procedure. Respondent's discipline should result for performing the unacceptable procedure.

88. Petitioner proved by clear and convincing evidence that Respondent's treatment of J. M. was beyond the scope of his training and experience and constituted "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 is not competent to perform" within the meaning of and in violation of Section 458.331(1)(v), Florida Statutes, as alleged in Count 3 of DOAH Case No. 92-5795.

89. Petitioner proved by clear and convincing evidence that Respondent's repeated injection of liquid silicone into the lips of A. M. S. was illegal and constituted "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" and violated the provisions of Section 458.331(1)(t), Florida Statutes, as alleged in Count 4 of DOAH Case No. 92-5795. This conduct should be viewed as being gross malpractice that has resulted in harm to the patient.

90. Petitioner proved by clear and convincing evidence that Respondent's repeated injection of liquid silicone into the lips of A. M. S. was illegal and constituted ". . . administering . . . a legend drug, including any controlled substance, other than in the course of the physician's professional practice" within the meaning of and in violation of the provisions of Section 458.331(1)(q), Florida Statutes, as alleged in Count 5 of DOAH Case No. 92-5795.

91. Petitioner proved by clear and convincing evidence that Respondent encouraged A. M. S. to undergo the Paris lips procedure and charged her a fee for the procedure without explaining to her the risks of the procedure. Consequently, it is concluded that Petitioner proved that Respondent exploited A. M. S. for his financial gain within the meaning of and in violation of Section 458.331(1)(n), Florida Statutes, as alleged in Count 6 of DOAH Case No. 92-5795.

92. Petitioner proved by clear and convincing evidence that Respondent's treatment of A. M. S. was illegal and beyond the scope of his training and experience. Respondent's injection of liquid silicone into the lips of A. M. S. constituted "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 is not competent to perform" within the meaning of and in violation of Section 458.331(1)(v), Florida Statutes, as alleged in Count 7 of DOAH Case No. 92-5795.

93. Petitioner proved by clear and convincing evidence that Respondent's medical records did not justify his course of treatment of A. M. S. in violation of Section 458.331(1)(m), Florida Statutes, as alleged in Count 8 of Case No. 92-5795. No separate penalty should be imposed for that failure. As discussed above, Petitioner proved by clear and convincing evidence that Respondent's treatment of A. M. S. fell below acceptable standards. Consequently, it is concluded that there were no medical records that he could have kept "justifying the course of treatment of the patient" within the meaning of Section 458.331(1)(m), Florida Statutes. It is redundant to charge Respondent with performing an unacceptable procedure and also to charge him with failing to keep records that would justify the unacceptable procedure. Respondent's discipline should result for performing the unacceptable procedure.

94. Petitioner proved by clear and convincing evidence that the CAPE procedure is not a recognized or accepted procedure and that Respondent practiced below the acceptable level of care in violation of Section 458.331(1)(t), Florida Statutes, as alleged in Count 9 of DOAH Case No. 92-5795 by performing this procedure on various male patients.

95. Petitioner proved by clear and convincing evidence that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, as alleged in Count 10 of DOAH Case No. 92-5795, by offering to perform the CAPE procedure on T. M., a procedure that Respondent was not competent to perform and that was not medically acceptable.

96. Petitioner proved by clear and convincing evidence that Respondent violated the provisions of Section 458.331(1)(k), Florida Statutes, as alleged in Count 11 of DOAH Case No. 92-5795, by falsely stating in his medical records that Respondent had performed a rectal examination on T. M.

97. Petitioner proved by clear and convincing evidence that Respondent violated the provisions of Section 458.331(1)(d), Florida Statutes, as alleged in Count 12 of DOAH Case No. 92-5795, by his advertisements that contained false statements as alleged in Count 12 of DOAH Case No. 92-5795.

98. Petitioner proved by clear and convincing evidence that Respondent violated the provisions of Section 458.331(1)(g), Florida Statutes, as alleged in Count 13 of DOAH Case No. 92-5795, by his advertisements that failed to contain the disclaimer required by Section 455.24, Florida Statues.

DOAH CASE NUMBER 92-5794

99. Petitioner proved by clear and convincing evidence that Respondent's preoperative and postoperative care of patient C. R. M. constituted "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" and violated the provisions of Section 458.331(1)(t), Florida Statutes, as alleged in Count 1 of DOAH Case No. 92-5794.

100. Petitioner proved by clear and convincing evidence that Respondent's medical records did not justify his course of treatment of C. R. M.. in violation of Section 458.331(1)(m), Florida Statutes, as alleged in Count 2 of Case No. 92-5794. No separate penalty should be imposed for that failure. As discussed above, Petitioner proved by clear and convincing evidence that Respondent's treatment of C. R. M. fell below acceptable standards. Consequently, it is concluded that there were no medical records that he could have kept "justifying the course of treatment of the patient" within the meaning of Section 458.331(1)(m), Florida Statutes. It is redundant to charge Respondent with performing an unacceptable procedure and also to charge him with failing to keep records that would justify the unacceptable procedure. Respondent's discipline should result for his gross malpractice committed in the treatment of C. R. M.

101. Petitioner proved by clear and convincing evidence that Respondent's treatment of a patient in C. R. M.'s physical condition was beyond the scope of his training and experience and constituted "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 is not competent to perform" within the meaning of and in violation of Section 458.331(1)(v), Florida Statutes, as alleged in Count 3 of DOAH Case No. 92-5794.

102. Rule 21M-20.015, Florida Administrative Code, (which has subsequently been renumbered as Rule 61F6-27.007, Florida Administrative Code) imposes upon a surgeon the ultimate responsibility for the preoperative diagnosis of medical and surgical problems and the responsibility for the management of the patient's postsurgical care. Petitioner proved by clear and convincing evidence that Respondent failed to comply with the responsibilities imposed on a surgeon by this rule in his treatment of C. R. M. in violation of Section 458.331(1)(x), Florida Statutes, as alleged in Count 4 of DOAH Case No. 92-5794.

DOAH CASE NUMBER 92-6588

103. Petitioner proved by clear and convincing evidence that Respondent violated the provisions of Section 458.331(1)(d), Florida Statutes, as alleged in Count 12 of DOAH Case No. 92-5795, by his advertisements that contained false statements as alleged in Count 1 of DOAH Case No. 92-6588.

104. Petitioner proved by clear and convincing evidence that Respondent violated the provisions of Section 458.331(1)(g), Florida Statutes, as alleged in Count 2 of DOAH Case No. 92-6588, by his advertisements that failed to contain the disclaimer required by Section 455.24, Florida Statues.

105. Section 458.331(2), Florida Statutes, authorizes the Petitioner to impose discipline on a licensee who has violated the provisions of Section 458.331(1), Florida Statutes. Rule 21M-20.001, Florida Administrative Code,

(which has been renumbered as Rule 61F6-20.001, Florida Administrative Code) establishes disciplinary guidelines and a recommended range of penalty for violations of the Medical Practice Act. The following recommended penalties are within the authority conferred upon Petitioner by Section 458.331(2), Florida Statutes, and are consistent with the guidelines now found at Rule 61F6-20.001, Florida Administrative Code.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner enter a Final Order which adopts the findings of fact and conclusions of law contained in this Recommended Order and which:

Finds that Respondent violated the provisions of Section 458.331(1)(t), Florida Statutes, as alleged in Count 1 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $5,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(m), Florida Statutes, as alleged in Count 2 of DOAH Case No. 92-5795. It is recommended that no separate penalty be imposed for this violation.

Finds that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, as alleged in Count 3 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $5,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(t), Florida Statutes, as alleged in Count 4 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $5,000 and the revocation of Respondent's licensure.

Finds that Respondent violated the provisions of Section 458.331(1)(q), Florida Statutes, as alleged in Count 5 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $5,000 and the revocation of Respondent's licensure.

Finds that Respondent violated the provisions of Section 458.331(1)(n), Florida Statutes, as alleged in Count 6 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $1,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, as alleged in Count 7 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $1,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(m), Florida Statutes, as alleged in Count 8 of DOAH Case No. 92-5795. It is recommended that no separate penalty be imposed for this violation.

Finds that Respondent violated the provisions of Section 458.331(1)(t), Florida Statutes, as alleged in Count 9 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $5,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, as alleged in Count 10 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $1,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(k), Florida Statutes, as alleged in Count 11 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $1,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(d), Florida Statutes, as alleged in Count 12 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $1,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(g), Florida Statutes, as alleged in Count 13 of DOAH Case No. 92-5795. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $1,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(t), Florida Statutes, as alleged in Count 1 of DOAH Case No. 92-5794. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $5,000 and the revocation of Respondent's licensure.

Finds that Respondent violated the provisions of Section 458.331(1)(m), Florida Statutes, as alleged in Count 1 of DOAH Case No. 92-5794. It is recommended that no separate penalty be imposed for this violation.

Finds that Respondent violated the provisions of Section 458.331(1)(v), Florida Statutes, as alleged in Count 3 of DOAH Case No. 92-5794. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $5,000 and the revocation of Respondent's licensure.

Finds that Respondent violated the provisions of Section 458.331(1)(x), Florida Statutes, as alleged in Count 4 of DOAH Case No. 92-5794. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $5,000 and the revocation of Respondent's licensure.

Finds that Respondent violated the provisions of Section 458.331(1)(d), Florida Statutes, as alleged in Count 1 of DOAH Case No. 92-6588. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $1,000 and the suspension of Respondent's licensure for a period of one year.

Finds that Respondent violated the provisions of Section 458.331(1)(g), Florida Statutes, as alleged in Count 2 of DOAH Case No. 92-6588. It is recommended that the penalty for this violation be the imposition of an administrative fine in the amount of $1,000 and the suspension of Respondent's licensure for a period of one year.

DONE AND ENTERED in Tallahassee, Leon County, Florida, this 7th day of December 1993.

CLAUDE B. ARRINGTON
Hearing Officer
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-1550
(904) 488-9675 SC 278-9675

Filed with the Clerk of the
Division of Administrative Hearings
this 7th day of December, 1993.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions to this recommended order. All agencies allow each party at least ten days in which to submit written exceptions. Some agencies allow a larger period within which to submit written exceptions. You should contact the agency that will issue the final

order in this case concerning agency rules on the deadline for filing exceptions to this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF PROFESSIONAL REGULATION, BOARD OF MEDICINE, Petitioner, vs. RICHARD SAMITIER CARDET, M.D., Respondent.	)	CASE NO. 92-5794
DEPARTMENT OF PROFESSIONAL REGULATION, BOARD OF MEDICINE, Petitioner, vs. RICHARD SAMITIER CARDET, M.D., Respondent.	)	CASE NO. 92-5795
DEPARTMENT OF PROFESSIONAL REGULATION, BOARD OF MEDICINE, Petitioner, vs. RICHARD SAMITIER CARDET, M.D., Respondent.	)	CASE NO. 92-6588

FINAL ORDER AWARDING COSTS AND FEES

This cause came to be heard on the "Motion for Costs and Other Remedies" filed by Petitioner on February 22, 1993. The parties were given the opportunity to argue the motion at the beginning of the formal hearing that was conducted in these consolidated proceedings. Respondent failed to appear at his deposition that was duly noticed by Petitioner. As a result of Respondent's failure to appear, Petitioner incurred costs in the amount of $2,744.49. Rule 60Q-2.019(4), Florida Administrative Code, authorizes DOAH Hearing Officers to impose sanctions pursuant to the Florida Rules of Civil Procedure to enforce discovery. Pursuant to Rule 1.380(d), Florida Rules of Civil Procedure, Petitioner is entitled to an award of its costs, including reasonable attorney's

fees, for Respondent's failure to attend the scheduled deposition. The premises considered, it is ORDERED that the motion is GRANTED and that costs and fees are hereby awarded to Petitioner and assessed against Respondent in the amount of $2,744.49.

DONE AND ORDERED this 7th day of December, 1993, in Tallahassee, Leon County, Florida.

_____
CLAUDE B. ARRINGTON
Hearing Officer
Division of Administrative Hearings
The Oakland Building
2009 Apalachee Parkway
Tallahassee, Florida 32399-1550
(904) 488-9675

Filed with the Clerk of the
Division of Administrative Hearings
this 7th day of December, 1993.

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NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this final order is entitled to judicial review pursuant to Section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing one copy of a Notice of Appeal with the Agency Clerk of the Division of Administrative Hearings and a second copy, accompanied by filing fees prescribed by law, with the District Court of Appeal, First District, or with the District Court of Appeal in the appellate district where the party resides. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.