Final Order No. DOH-22-0919-ESG-MQA

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Department of Health
By Bridget Coates
Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

In Re: Emergency Suspension of the License of
Christopher Saputa, M.D.
License No: ME 47402
Case Numbers: 2022-20963; 2022-20968; 2022-20978

ORDER OF EMERGENCY SUSPENSION OF LICENSE

Joseph A. Ladapo, MD, PhD, State Surgeon General, ORDERS the emergency suspension of the medical license of Christopher Saputa, M.D., (Dr. Saputa) in the State of Florida. Dr. Saputa is licensed as a medical doctor in the State of Florida, having been issued license number ME 47402. Dr. Saputa's address of record is 90 South Highland Avenue, Suite 123, Tarpon Springs, Florida 34689. The following Findings of Fact and Conclusions of Law support the emergency suspension of Dr. Saputa's license to practice medicine in the State of Florida.

FINDINGS OF FACT

1. The Department of Health (Department) is the state agency charged with regulating the practice of medicine pursuant to chapters 20, 456, and 458, Florida Statutes (2022). Section 456.073(8), Florida Statutes (2022), authorizes the State Surgeon General to summarily suspend Dr. Saputa's medical license, in accordance with section 120.60(6), Florida Statutes (2022).

2. At all times material to this order, Dr. Saputa was licensed as a medical doctor, having been issued license number ME 47402.

3. Dr. Saputa is a general practitioner and does not maintain any board certifications.

4. Dr. Saputa has not completed any gynecological surgical residencies or other intensive clinical training to perform gynecological surgeries or procedures.

5. At all times material to this Order, Dr. Saputa 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.

6. At all times material to this Order, AFP maintained a transfer agreement with West Florida Hospital, a hospital located approximately two miles away.

7. The Agency for Health Care Administration (AHCA) is the state agency responsible for regulating abortion clinics pursuant to chapter 390, Florida Statutes, and Rule 59A-9, Florida Administrative Code.

8. On May 20, 2022, AHCA filed an Emergency Suspension Order against AFP, suspending its ability to operate in the State of Florida.

Facts Relating to Patient K.J.[1]

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

10. Dr. Saputa did not meet with Patient K.J. in person at least 24 hours before the procedure and did not determine whether Patient K.J. had met with her referring physician at least 24 hours before the procedure to discuss the nature and risks of the procedure.

11. Patient K.J.'s procedure was supposed to last two days. The first day, Dr. Saputa 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.

12. Upon Patient K.J.'s presentation to AFP, the Office Manager, who is non-clinical personnel, performed an ultrasound and prepared an Obstetrical Sonogram Report. The Office Manager 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 DOH Case Number 2022-20968.
[2] Laminaria is a sterile, dried seaweed that absorbs fluid from the vagina and slowly expands to dilate the cervix.

13. Pursuant to AHCA's rules, abortion clinics are required to save an image of the ultrasound used to determine gestational age. The Office Manager did not save or print the ultrasound image.

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

15. Dr. Saputa did not perform or document performing a pelvic examination on Patient K.J. prior to initiating the insertion of Laminaria.

16. Dr. Saputa 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[3] ruptured. This necessitated her to switch to a one-day procedure.

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

18. Dr. Saputa failed to document the start and end times of the procedure and failed to ensure that Patient K.J.'s vitals were documented during the procedure.

19. Prior to initiating the procedure, Dr. Saputa administered a paracervical block.

[3] The amniotic sac, also referred to as membranes, is the fluid-filled sac that contains and protects a fetus in the womb.

20. 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. The American College of Obstetricians and Gynecologists (ACOG) recommends that the injections occur at the 2:00, 5:00, 8:00, and 10:00 locations on the cervix. Clinicians are trained to avoid the 3:00 and 9:00 positions of the cervix because of the concentration of vessels located at the 3:00 and 9:00 positions. The injection of an anesthetic into a vessel can cause seizures or cardiac arrest.

21. Dr. Saputa failed to document the location of where he injected the anesthetic.

22. Patient K.J. received Ketamine, a sedative, to sedate her for the procedure. Prior to the procedure, Patient K.J. signed an informed consent to receive fentanyl citrate or midazolam as a sedative. Patient K.J. did not consent to the use of Ketamine as a sedative. Patient K.J. was in a twilight state of sedation during the procedure. Patient K.J. could hear what was happening during the procedure.

23. During the procedure, Patient K.J. heard Dr. Saputa ask the person operating the ultrasound if he was in the right place and the person replied "no."

24. There were no vital signs documented during Patient K.J.'s procedure.

25. At some time during or immediately after the procedure, Patient K.J. experienced vaginal bleeding, which was treated with Pitocin[4] and Methergine.[5]

26. The bleeding stopped momentarily, and AFP staff began transitioning Patient K.J. to the recovery room. However, Patient K.J. started bleeding vaginally again. Dr. Saputa administered more Pitocin and Methergine.

27. Dr. Saputa did not contact EMS after K.J. started bleeding a second time, despite previous medical intervention and the suspicion of uterine perforation.

28. AFP staff moved Patient K.J. into the recovery room; however, Patient K.J. began to experience heavy vaginal bleeding again. The blood was mostly bright red, with some clots.

29. AFP staff brought Patient K.J. back to the procedure room and started an IV fluid infusion. Patient K.J. continued to bleed heavily, with the blood spilling onto the floor.

[4] Pitocin is natural hormone that causes the uterus to contract and can be 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.

30. Dr. Saputa failed to document the administration of Pitocin and Methergine and the IV fluid infusion that were administered on Patient K.J.'s Patient Medication Log.

31. Dr. Saputa suspected that Patient K.J.'s bleeding was caused by a uterine perforation. [6]

32. Dr. Saputa knew, or should have known, that treatment of Patient K.J.'s suspected uterine perforation was beyond the medical capability of the AFP staff.

33. The minimum standard of care required Dr. Saputa to immediately contact emergency medical services and arrange for emergency transport to the hospital once he realized that Patient K.J. started bleeding again despite medicinal intervention.

34. However, Dr. Saputa delayed transfer, while Patient K.J. was thrashing in pain in the recovery room. Patient K.J. was bleeding profusely and AFP staff were continually changing heavy pads that were saturated with blood.

35. Dr. Saputa 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.

[6] Uterine perforation and associated complications can result in hemorrhage or sepsis.

36. 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.

37. Dr. Saputa described the situation as "hectic" because Patient K.J. was being combative. However, Patient K.J. denies that she was being combative.

38. Dr. Saputa finally initiated emergency transport and called 911 at 11:11 p.m. An AFP nurse reported that Dr. Saputa should have initiated emergency transport sooner based on the amount of blood Patient K.J. had lost.

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

40. Escambia County Emergency Medical Services (EMS) arrived at approximately 11:28 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. EMS observed an employee throwing away a pad saturated with blood. EMS instructed Dr. Saputa to replace the pad.

43. At the time of EMS's arrival, Patient K.J. lacked radial pulses[7] on both sides and was only responsive to painful stimuli.

[7] Radial pulses are measured on a patient's wrist. A weak or absent pulse is a medical emergency.

44. Dr. Saputa reported to EMS that Patient K.J. lost an estimated 750 mL of blood. However, Dr. Saputa based this on a visual estimation and did not utilize any form of quantitative measurement, resulting in him grossly underestimating the amount of blood loss.[8]

45. EMS transported Patient K.J. to West Florida Hospital (WFH).

46. Dr. Saputa only provided EMS and WFH with Patient K.J.'s demographic information. Dr. Saputa 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 WFH.

47. Upon arrival to WFH, Patient K.J. was cool, pale, and diaphoretic,[9] and her blood pressure was 74/35.[10]

48. EMS reported to the hospital staff that Dr. Saputa told them that Patient K.J. had lost 750 mL of blood; however, EMS suspected that this was underestimated based on Patient K.J.'s condition when they arrived and the

[8] Postpartum hemorrhage causes approximately 11% of maternal deaths in the United States and is the leading cause of death that occurs on the day of birth. Importantly, 54–93% of maternal deaths due to obstetric hemorrhage may be preventable. Studies that have evaluated factors associated with identification and treatment of postpartum hemorrhage have found that imprecise health care provider estimation of actual blood loss during birth and the immediate postpartum period is a leading cause of delayed response to hemorrhage. American College of Obstetrics and Gynecologist, Quantitative Blood Loss in Obstetric Hemorrhage, Committee Opinion, December 2019.

[9] Sweating heavily.

[10] Low blood pressure (hypotension) is generally considered a reading lower than 90/60. Large drops in blood pressure can be life-threatening.

amount of blood they saw. Patient K.J. ultimately received a total of 10 units of blood while at the hospital.[11]

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

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

51. During the emergency surgery, WFH surgeons observed two cervical lacerations, a lower uterine perforation that opened into the abdomen, and a large tear in the left lower uterine segment. The surgeon was troubled by the fact that there were two large tears on opposite sides of the uterus, both near vessels.

52. Due to the extensive damage, the surgeons had to perform a total abdominal hysterectomy with bilateral salpingectomy.[12]

53. Dr. Saputa did not follow up with Patient K.J. after her emergency transfer to the hospital.

54. Dr. Saputa did not report this complication to AHCA.

[11] Approximately 10 pints.
[12] Removal of the uterus and both fallopian tubes.

55. Patient K.J. continues to suffer from her experience with Dr. Saputa at AFP.

Facts Relating to Patient D.W.[13]

56. On or about April 28, 2022, Patient D.W., a 22-year-old woman who was an estimated 12 weeks and 6 days pregnant, presented to Dr. Saputa at AFP to terminate her pregnancy.

57. Dr. Saputa did not meet with Patient D.W. in person at least 24 hours before the procedure and did not determine whether Patient D.W. had met with her referring physician at least 24 hours before the procedure to discuss the nature and risks of the procedure.

58. Upon Patient D.W.'s presentation to AFP, a staff member performed an ultrasound and prepared an Obstetrical Sonogram Report. The staff member did not document the measurements of the fetus' CRL, FL, gestational sac, placenta, fluid, heartbeat, or movement. The only measurement the staff member reported was the biparietal diameter (BPD), or the diameter of the fetus' head. The staff member did not print an image of the ultrasound to be reviewed by Dr. Saputa.

[13] Facts related to Patient D.W. are contained in DOH Case Number 2022-20978.

59. Dr. Saputa reviewed the incomplete report. Dr. Saputa did not review an ultrasound image prior to beginning the procedure.

60. Dr. Saputa failed to perform or document performing a pause prior to starting the procedure to confirm Patient D.W.'s name and the procedure.

61. Dr. Saputa failed to document the start and end times of the procedure and failed to ensure that Patient D.W.'s vitals were documented during the procedure.

62. Dr. Saputa did not observe or document observing a large (5 cm x 6 cm) teratoma located on Patient D.W.'s ovary during the procedure.

63. Patient D.W. received documentation that instructed her to contact the facility if she experienced any symptoms or complications and to not contact a hospital unless she first contacted the facility.

64. Dr. Saputa did not follow up with Patient D.W. after her procedure.

65. On or about May 3, 2022, Patient D.W. contacted the AFP call center and reported that she was experiencing pain and fever. The call center informed Patient D.W. that she should return to AFP for her previously scheduled follow-up appointment, which was a couple days later.

66. On or about May 5, 2022, Patient D.W. contacted AFP call center again and reported that she was still experiencing severe symptoms, including fever.

67. Patient D.W. decided to go to the hospital.

68. Patient D.W. presented to the hospital in septic shock.

69. The hospital physicians performed an emergency abdominal laparoscopy and discovered the teratoma. The surgeon observed that the teratoma appeared intact until they noticed that it was leaking a purulent fluid from a small circular defect. The fluid was leaking throughout her abdomen and pelvis.

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

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

72. An independent expert reviewed this case and opined that teratomas do not spontaneously rupture and that the only reasonable medical conclusion is that Dr. Saputa punctured Patient D.W.'s uterus during either the cervical insertion or evacuation procedure, and then also punctured the teratoma, resulting in inflammation, followed by sepsis.

Facts Relating to Patient D.C.[14]

73. On or about May 5, 2022, Patient D.C., a 36-year-old woman who was 19-weeks and 6-days pregnant, presented to Dr. Saputa at AFP to terminate her pregnancy at approximately 10:00 a.m.

74. Dr. Saputa did not meet with Patient D.C. in person at least 24 hours before the procedure and did not determine whether Patient D.C. had met with her referring physician at least 24 hours before the procedure to discuss the nature and risks of the procedure.

75. Upon Patient D.C.'s presentation to AFP, a staff member performed an ultrasound and prepared an Obstetrical Sonogram Report. The staff member did not document the measurements of the fetus' CRL, FL, or gestational sac. The staff member did not print an image of the ultrasound to be reviewed by Dr. Saputa.

76. Dr. Saputa did not perform a physical examination prior to starting the procedure.

77. At approximately 11:20 a.m., Dr. Saputa ordered the administration of 4 tablets of 200 µg of misoprostol[15] (800 µg total).

[14] Facts related to Patient D.C. are contained in DOH Case Number 2022-20963.
[15] Misoprostol (brand name: Cytotec) is an oral medication this is commonly used to induce labor in women and works by softening the cervix to allow easier dilation (known as "ripening") and producing contractions.

78. Misoprostol is a drug used to soften the cervix and empty the uterus by causing cramping and bleeding. The standard dosing for misoprostol is 400-600 µg followed by 400 µg every hour, as needed. ACOG recommends that patients should not receive more than 2,400 µg of misoprostol in 24 hours. Misoprostol is generally contraindicated for patients who had prior c-sections because it increases the chance for uterine rupture. Patient D.C. had two prior c-sections and was contraindicated for high doses of misoprostol.[16]

79. Dr. Saputa prescribed or administered six more doses of 800 µg of misoprostol between 12:20 p.m. and 5:30 p.m., resulting in Patient D.C. receiving a total of 5,600 µg of misoprostol in six hours. Dr. Saputa ordered over two-times the recommended daily dose in a quarter of the time.

80. At around 1:30 p.m. Patient D.C. experienced a sharp, intense pain. AFP staff measured her blood pressure repeatedly but kept receiving an error message on the machine. This was not documented in Patient D.C.'s records.

81. Prior to the procedure, a staff member reported that Patient D.C.'s blood pressure was in the low 80s, but this was not documented in Patient D.C.'s records.

[16] Uterine rupture is a catastrophic tearing of the uterus that may result in the fetus being expelled into the peritoneal cavity. Uterine rupture is rare. Uterine rupture occurs most often along healed scar lines in women who have had prior cesarean deliveries.

82. Dr. Saputa failed to perform or document performing a pause prior to starting the procedure to confirm Patient D.C.'s name and the procedure.

83. Dr. Saputa failed to document the start and end times of the procedure and failed to ensure that Patient D.C.'s vitals were documented during the procedure.

84. Dr. Saputa administered a paracervical block. Dr. Saputa injected the lidocaine at the 9:00, 2:00, 3:00, and 5:00 locations on Patient D.C.'s cervix. Dr. Saputa fell below the minimum standard of care by injecting an anesthetic at the 3:00 and 9:00 positions on Patient D.C.'s cervix based on the presence of vessels at this location. The procedure commenced sometime after 5:30 p.m.

85. At some point during Patient D.C.'s procedure, AFP staff administered Patient D.C. IV fluids, however this was not documented in her medical records.

86. During the procedure, the AFP Office Manager assisted Dr. Saputa with the sonogram and reported that she saw clots on the ultrasound. The clots indicated that there was bleeding in the abdomen and possible uterine rupture.

87. Dr. Saputa observed that the fetus was "too far up" for him to reach and elected to terminate the procedure.

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

89. Dr. Saputa discharged Patient D.C. around midnight.

90. Dr. Saputa told Patient D.C.'s husband, C.C., to not go to any hospital in Pensacola, that Patient D.C. was "fine", and that he could take her to a hospital in Mobile, Alabama.

91. Dr. Saputa stated that Patient D.C.'s transport to a hospital in Mobile via her personal vehicle "wouldn't be that different" than if he had called emergency services because it would have taken emergency services 10-20 minutes to get onsite, 10-15 minutes to get Patient D.C. on the ambulance, and another 10-15 minutes to get her to the hospital.[17]

92. Dr. Saputa did not complete a discharge order or discharge note upon Patient D.C.'s discharge.

93. While C.C. drove Patient D.C. to the hospital, Patient D.C. passed out in the car and made "gurgling" sounds.

94. Dr. Saputa did not contact the hospital to provide a report or communicate her condition in advance of her admission.

[17] Dr. Saputa made this assertion despite the fact that Patient K.J. had just been transported to the hospital in 30 minutes in March. Transport to Mobile, Alabama would have taken over two-times as long.

95. Patient D.C. presented to USA Children's and Women's Hospital, (UCW) a hospital located in Mobile, Alabama, approximately one hour and fifteen minutes away from AFP.

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

97. Patient D.C. was emergently taken to the operating room for an exploratory laparotomy.[18] The surgeons observed that Patient D.C. had sustained a mid-transverse uterine rupture, likely secondary to the excessive dosing of misoprostol.

98. 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.

99. The surgeons estimated that Patient D.C. lost 3,500 mL of blood.

100. Due to Patient D.C.'s uterine rupture, the UCW physicians advised her to not get pregnant in the future.

[18] An exploratory laparotomy is a general surgical operation where the abdomen is opened and the abdominal organs are examined for injury or disease.

101. The Department interviewed Dr. Saputa about his care of the patients. Dr. Saputa denied wrongdoing and refused to accept that his practice of medicine was responsible for the harm that occurred. Instead, Dr. Saputa shifted blame to the facility.

102. AHCA also interviewed Dr. Saputa. Dr. Saputa informed AHCA that although he was aware that the facility had policies and procedures, including for emergency management, he had not read them. He blamed the facility for this, as well.

103. In the course of their practice, physicians are responsible for performing medical procedures in a manner that is correct and safe. Gynecological surgeries and procedures require the physician to be able to safely enter the uterus through the cervix and skillfully manipulate instruments without damaging any of the sensitive tissue of the vagina, cervix, or uterus. Learning how to safely enter the uterus without causing harm to patients is a skill developed through rigorous training and education, usually through a residency or fellowship.

104. Dr. Saputa is not a trained gynecological surgeon. In fact, in his response to the Department's investigation, the only training history he provided was a "GYN surgical month" during his rotating surgical internship in the 1980s.

An independent medical expert reviewed Dr. Saputa's curriculum vitae and determined that Dr. Saputa does not have the education, training, or experience to be competent to perform gynecological surgeries or procedures and that his continued performance of these surgeries is a public safety hazard.

105. Despite being woefully underqualified to perform gynecological surgeries, Dr. Saputa accepted a position at AFP where he was responsible to be the primary physician for performing complex, dangerous procedures on people seeking abortions. Many of these patients, especially those seeking second trimester terminations, are a vulnerable population with limited availability of options of physicians to assist them, and a limited timeline to undergo the procedure. This resulted in a grossly underqualified physician performing surgeries that caused catastrophic results for at least three women over the course of two months. Uterine rupture, uterine perforation, and cervical lacerations are all known complications of abortion. However, the instances of these complications are very rare. The fact that Dr. Saputa experienced all three of these complications within weeks of each other indicates that he lacks the technical skill to be able to safely practice gynecological procedures.

106. Outside of Dr. Saputa's poor technical skill when instrumenting a patient's cervix and uterus, Dr. Saputa exhibited extraordinarily poor judgment in

the emergency care of his patients. Dr. Saputa's decision to permit Patient D.C. to travel out of state, rather than to the hospital two miles away, nearly cost her life, not to mention the emotional scarring of her husband who unwittingly transported his dying wife across state lines in search of treatment. Dr. Saputa made this disastrous decision despite having arranged for emergency transport for Patient K.J. only five weeks earlier. This indicates that Dr. Saputa knew how to correctly follow emergency management procedures, but simply chose not to, at the expense of his patient.

107. Additionally, Dr. Saputa demonstrated a significant deficit in understanding appropriate dosing when he prescribed Patient D.C. an extraordinary amount of misoprostol. This kind of oversight can lead to uterine rupture, a possibly preventable complication. This significant misjudgment signifies that Dr. Saputa lacks the clinical judgment to be able to prescribe medication to patients in a manner that is correct and safe.

108. Dr. Saputa's oversight and judgment exhibited during these procedures also signify a great public danger. Dr. Saputa's record keeping was grossly inadequate, with entire sections of operative reports left blank. Dr. Saputa failed to comply with even the simplest laws and rules, like keeping a photograph of an ultrasound in his patients' medical file or performing a pause prior to the

start of a procedure. Medical records are important tools for being able to provide continuity of care in case of emergency. Dr. Saputa failed to create, and also failed to transmit, his records when these emergencies occurred.

109. Taken as a whole, the facts outlined in this Order show that Dr. Saputa lacks the clinical judgment to administer medications and respond to medical emergencies, lacks the technical skill to be able to safely perform surgeries, and lacks the good judgment and personal insight to be able to self-regulate to only perform tasks that he is competent to perform.

110. The practice of medicine involves applying appropriate clinical judgment, skill, and technique to the real-world treatment of patients. At every level of the practice of medicine, a physician needs to exercise this good judgment, and failure to do so can result in patient harm, and even death.

111. An independent medical expert has determined that Dr. Saputa's treatment of the patients was an egregious violation of the standard of care. However, when faced with the investigation, Dr. Saputa denied wrongdoing and blamed the facility instead. Dr. Saputa's lack of insight and remorse for performing procedures that he is not competent to perform indicates that there is a significant likelihood that Dr. Saputa's reckless behavior will continue.

Therefore, Dr. Saputa's continued practice as a medical doctor presents an immediate, serious danger to the health, welfare, and safety of the public.

112. The Department considered various restrictions on Dr. Saputa's license short of a summary suspension but found that due to the scope of issues with Dr. Saputa's treatment of the patients in this Order, these restrictions would be inadequate to protect the public.

113. First, the Department considered a restriction prohibiting Dr. Saputa from performing gynecological surgeries and procedures based on demonstrated failure to safely perform these low-risk procedures. However, this would not address Dr. Saputa's failure to provide appropriate emergency care to patients. Dr. Saputa's poor judgment in not treating the findings that he saw on Patient D.C.'s ultrasound which indicated a possible uterine rupture or perforation as a medical emergency is equally likely to occur in any situation in which Dr. Saputa would be required to render emergency care to a patient. This is especially true considering the fact that despite experiencing Patient K.J.'s "hectic" emergency care and transfer, Dr. Saputa failed to then read AFP's emergency management policies and procedures to be better prepared for a subsequent emergency. Instead, Dr. Saputa placed a patient with a suspected uterine rupture in a civilian vehicle and permitted her to be driven an hour away. Therefore, any restriction

tailored to protect the public must also include a restriction from practicing in scenarios that may require the physician to perform emergency care.

114. However, that restriction would not address Dr. Saputa's severe misjudgment when prescribing or ordering medications for patients, as seen in his decision to order 5,600 µg of misoprostol for Patient D.C. Misoprostol is a very common medication used in abortions. As a physician working at an abortion clinic, Dr. Saputa should have a complete understanding of proper dosing for this commonplace medication. However, Dr. Saputa did not adhere to the proper dosing for misoprostol, and he dangerously ignored the fact that Patient D.C. was contraindicated for such high dosing to begin with. In any scenario where Dr. Saputa is responsible for ordering patients' medication, this danger of Dr. Saputa's medication mismanagement is present. Therefore, any restriction tailored to protect the public must also include a restriction from practicing in scenarios that may require the physician to order medicine for patients.

115. However, that restriction would still be insufficient to protect the public from harm, because ultimately all of the incidents of misconduct in this case are a result of Dr. Saputa's poor judgment and lack of insight resulting in him performing services that have a low probability of complications that he was not competent to perform. There is no restriction that will be able to effectively

require Dr. Saputa to self-regulate and only perform duties that he is competent to perform. Dr. Saputa has demonstrated an unwillingness to limit his professional services to areas of medicine that he is proficient or skilled. There is no restriction that can protect the public from this severe lack of judgment.

116. Based on the facts in this Order, there is no restriction, outside of suspension, that would be able to adequately protect the public from Dr. Saputa's overestimation of his own skill. As a result, there are no less restrictive means, other than the terms of this Order, that will adequately protect the public from Dr. Saputa's continued unrestricted practice as a medical doctor.

117. Based on the forgoing, Dr. Saputa's continued unrestricted practice as a medical doctor constitutes an immediate, serious danger to the health, safety, or welfare of the citizens of the State of Florida, and this summary procedure is fair under the circumstances to adequately protect the public.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the State Surgeon General concludes as follows:

1. The State Surgeon General has jurisdiction over this matter pursuant to sections 20.43 and 456.073(8) and chapter 458 as set forth above.

2. Section 458.331(1)(t), Florida Statutes (2021), authorizes discipline, including suspension, for committing medical malpractice as defined in section 456.50.

3. Section 458.331(1)(t)3, Florida Statutes (2021), further 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. Repeated medical malpractice is defined as three of more incidents of medical malpractice found to have been committed by a medical doctor.

4. Section 456.50(1)(g), Florida Statutes (2021), 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.

5. Dr. Saputa violated section 458.331(1)(t) by falling below the minimum standard of care:

a. By failing to promptly initiate emergency transportation procedures after suspecting that Patient K.J. had a uterine perforation,

b. By failing to provide EMS and WFH with Patient K.J.'s complete patient records,

c. By inappropriately or excessively prescribing 5,600 µg of misoprostol to Patient D.C. in a six-hour timeframe,

d. By injecting the paracervical block at the 3:00 and 9:00 locations on Patient D.C.'s cervix,

e. By failing to arrange for Patient D.C.'s emergency transportation to a hospital within reasonable proximity to AFP immediately after suspecting a uterine rupture or perforation,

f. By permitting, or instructing, Patient D.C. to go to a hospital in Mobile, Alabama, via personal vehicle, instead of one within reasonable proximity to AFP,

g. By failing to contact the hospital to provide a verbal report for Patient D.C.'s transfer, and

h. By perforating Patient D.W.'s uterus; perforating Patient D.C.'s uterus, or causing her uterus to rupture; lacerating Patient K.J.'s cervix; and tearing and puncturing Patient K.J.'s uterus, within the course of two months.

6. Section 458.331(1)(g), Florida Statutes (2021), authorizes discipline, including suspension, for failing to perform any statutory or legal obligation placed upon a licensed physician.

7. Section 390.011(3), Florida Statutes (2021), provides that a termination of pregnancy may not be performed or induced except with the voluntary and informed consent of the pregnant woman.

8. Section 390.011(3)(a) provides in pertinent part that consent to a termination of pregnancy is voluntary and informed only if:

> 1. The physician who is to perform the procedure, or the referring physician, has, at a minimum, orally, while physically present in the same room, and at least 24 hours before the procedure, informed the woman of:
> a. The nature and risks of undergoing or not undergoing the proposed procedure that a reasonable patient would consider material to making a knowing and willful decision of whether to terminate a pregnancy.
> b. The probable gestational age of the fetus, verified by an ultrasound, at the time the termination of pregnancy is to be performed.
> (I) The ultrasound must be performed by the physician who is to perform the abortion or by a person having documented evidence that he or she has completed a course in the operation of ultrasound equipment as prescribed by rule and who is working in conjunction with the physician.

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

10. 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.

11. Dr. Saputa violated section 458.331(1)(g) by failing to perform the following statutory or legal obligations placed upon licensed physicians:

a. Performing abortions on Patients K.J., D.W., and D.C. without meeting with them while physically present in the same room at least 24 hours before the procedure to discuss the nature and risks of the procedure and the gestational age of the fetus or confirming that Patients K.J., D.W., and D.C. met with their referring physician

at least 24 hours before the procedure to discuss the nature and risks of the procedure and the gestational age of the fetus,

b. Failing to keep an original print of each ultrasound examination performed on Patients K.J., D.W., and D.C. in their medical history file, and

c. Failing to pause prior to Patients K.J., D.W., and D.C.'s procedures to verbally confirm their identification, the intended procedure and the correct surgical/procedure site, and/or document performing the pause.

12. Section 458.331(1)(m), Florida Statutes (2021), authorizes discipline, including suspension, for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

13. 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.

14. Rule 59A-9.031(1)(a), Florida Administrative Code, provides that clinical records shall contain a printed image of the ultrasound used to determine the period of gestation.

15. Dr. Saputa violated section 458.331(1)(m) and Rule 64B8-9.003 by failing to keep legible medical records by:

a. Failing to legibly document performing a pelvic examination of Patient K.J. prior to Laminaria insertion,

b. Failing to legibly document Patient K.J.'s course of treatment on the Laminaria Insertion & Induction of Intrauterine Fetal Demise,

c. Failing to document the location of the injections for Patient K.J.'s paracervical block,

d. Failing to legibly document performing an examination of Patient D.C. prior to starting the procedure,

e. Failing to legibly document his notes in the "physician's comments" section of Patients K.J.'s, D.W.'s and D.C.'s Abortion Procedure Record,

f. Failing to legibly document his notes in the "physician's comments" comments section of Patients K.J.'s and D.W.'s Examination of Products of Conception report,

g. Failing to create or maintain a printed image of the ultrasound used to determine the period of gestation for Patients K.J., D.W., and D.C.,

h. Failing to document the procedure start and end time in Patients K.J.'s, D.W.'s, and D.C.'s Abortion Procedure Report,

i. Failing to document the time-out performed in Patients K.J.'s, D.W.'s, and D.C.'s Abortion Procedure Report,

j. Failing to document Patients K.J.'s, D.W.'s, and D.C.'s intra-operative vitals in their Abortion Procedure Report,

k. Failing to document the fetal position, placenta location, fluid, fetal heartbeat, and fetal movement in Patient D.W.'s Obstetrical Sonogram Report;

l. Failing to document measurements of the fetus' CRL, FL, and gestational sac, and the weeks by date, in Patients K.J.'s and D.C.'s Obstetrical Sonogram Report,

m. Failing to document a discharge note or discharge instructions in Patients K.J.'s and D.C.'s medical file.

16. Section 458.331(1)(v), Florida Statutes (2021), authorizes discipline, including suspension, 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.

17. Dr. Saputa violated section 458.331(1)(v) by performing, or offering to perform, second trimester abortions on Patients K.J. and D.C., and a first trimester abortion on Patient D.W., when he knew or should have known that he was not competent to perform these procedures.

WHEREFORE, in accordance with section 120.60(6), it is **ORDERED THAT**:

1. The medical license for Christopher Saputa, M.D., ME 47402, is immediately suspended.

2. A proceeding seeking formal discipline of the medical license of Christopher Saputa, M.D., will be promptly instituted and acted upon in compliance with sections 120.569 and 120.60(6), Florida Statutes (2022).

DONE and ORDERED this 13 day of July, 2022.

Joseph A. Ladapo, MD, PhD
State Surgeon General

PREPARED BY:

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In Re: Emergency Suspension of the License of
Christopher Saputa, M.D.
License Nos.: ME 47402
Case Numbers: 2022-20963; 2022-20968; 2022-20978

NOTICE OF RIGHT TO JUDICIAL REVIEW

Pursuant to sections 120.60(6), and 120.68, Florida Statutes (2021), the Department's findings of immediate danger, necessity, and procedural fairness shall be judicially reviewable. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing a Petition for Review, in accordance with Florida Rule of Appellate Procedure 9.100, and accompanied by a filing fee prescribed by law with the District Court of Appeal, and providing a copy of that Petition to the Department of Health within thirty (30) days of the date this Order is filed.