STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2023-51255**

BENJAMIN JACOB BROWN, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

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

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

2. At all times material to this Complaint, Respondent was licensed to practice as a medical doctor within the State of Florida, having been issued license number ME 122557.

3. At all times material to this Complaint, Respondent's address of record was 1645 Nantahala Beach Road, Gulf Breeze, Florida 32563.

4. At all times material to this Order, Respondent owned and operated Restore Plastic Surgery in Pensacola, Florida.

5. Restore Plastic Surgery is not registered with the Department as an office surgery registrant.

Facts Relating to Patient B.F.

6. On or about August 24, 2021, Patient B.F., a 40-year-old woman, met with Respondent to discuss undergoing a breast implant replacement, tummy tuck, liposuction, and fat injection into her hips.

7. During the consultation, Respondent recommended Patient B.F. also receive gluteal fat injections, also known as a Brazilian Butt Lift (BBL). Patient B.F. did not want a BBL and specifically stated she did not authorize Respondent to inject fat into her buttocks.

8. Respondent inaccurately documented in Patient B.F.'s records that she wished to have gluteal fat injections to improve the lateral contour of her buttocks.

9. On or about October 25, 2021, Patient B.F. presented to Baptist Hospital for the first phase of her procedures, which included liposuction, abdominoplasty, and breast implant replacement.

10. In addition to the consented procedures, Respondent also

performed gluteal fat transfer. Respondent injected 1,100 mL of fat into Patient B.F.'s right buttock and 1,100 mL of fat into her left buttock.

11. The gluteal fat transfer was an unauthorized procedure.

12. On or about December 7, 2021, Patient B.F. presented to Respondent for a wound debridement.

13. Respondent failed to document a description of Patient B.F.'s wound, including size, shape, and appearance.

14. On or about February 7, 2023, Patient B.F. presented to Restore Plastic Surgery for laser treatment on her abdomen, navel, and breast.

15. Laser therapy constitutes the practice of medicine and may not be performed by unlicensed individuals.

16. H.R.[1] is not a licensed health care provider in the state of Florida.

17. H.R. performed an Erbium ProFractional laser treatment on Patient B.F.

18. On or about March 9, 2023, Patient B.F. presented to Restore Plastic Surgery for a scar revision procedure.

19. Injections constitute the practice of medicine and may not be performed by unlicensed individuals.

[1] Also known as H.B.

20. H.R. injected Patient B.F. with Kenalog and 5-fluorouracil (5-FU).[2]

21. Respondent knew that H.R. performed laser treatment and gave injections to Patient B.F. and aided, assisted, procured, or advised her to do so.

Facts Relating to Patient J.H.

22. On or about September 9, 2022, Patient J.H., a 55-year-old woman presented to Respondent at Restore Plastic Surgery to discuss undergoing cosmetic surgery, including the removal of her breast implants.

23. Patient J.H. specifically stated that she did not want to have fat transferred to her buttocks.

24. Despite Patient J.H.'s decision not to receive a BBL, Respondent inaccurately documented in Patient B.F.'s records that she wished to have fat transferred to her buttocks.

25. On or about November 18, 2022, Patient J.H. presented to

[2] Kenalog and 5-FU are injections that target keloid (benign, dermal growths related to previous skin trauma or inflammation) formation. 5-FU works by inhibiting the growth of new blood vessels, which helps to reduce the size of the keloid. Kenalog works by reducing inflammation and shrinking the size of the keloid.

Baptist Hospital for her procedure.

26. Respondent performed liposuction of her back, flanks, and abdomen; an abdominoplasty; a breast implant removal; and fat grafting to her breasts and buttocks.

27. In the beginning of December 2022, Patient J.H.'s abdominal incision opened and began leaking fluid.

28. On or about December 5, 2022, Patient J.H. presented to Respondent's office for a check-up. During the check-up Patient J.H. had abdominal bloating and Respondent provided her with a new garment.

29. Respondent failed to create or maintain a medical record documenting the December 5, 2022, appointment. Respondent failed to create or maintain a medical record documenting Patient J.H.'s abdominal bloating.

30. On or about December 7, 2022, Patient J.H. presented to Respondent's office for a check-up. During the check-up Patient J.H. had a large area of skin necrosis.[3]

31. Respondent failed to create or maintain a medical record

[3] Necrosis is the death of the cells in your body tissues. Skin necrosis (gangrene) occurs when blood flow to your body tissues or internal organs is blocked.

documenting the December 7, 2022, appointment.

32. Respondent failed to create or maintain a medical record documenting Patient J.H.'s necrotic wound, including a description of the size, shape, or appearance of the wound.

33. On or about December 20, 2022, Patient J.H. presented to Respondent's office to undergo a "procedure."

34. Respondent failed to create, or maintain, a medical record documenting what occurred during the December 20, 2022, appointment, including what procedure was completed, who performed the procedure, the results of the procedure, or any description of Patient J.H.'s wound.

35. On or about December 27, 2022, and January 3, 2023, Patient J.H. presented to Respondent's office for an evaluation of her open abdominal wound.

36. During the January 3, 2023, appointment, Respondent trimmed excess fat from Patient J.H.'s wound and changed the dressing.

37. Respondent failed to create or maintain a medical record documenting Patient J.H.'s open, necrotic wound, including a description of the size, shape, or appearance of the wound during the December 27, 2022, and January 3, 2023, appointments.

Facts Relating to H.R. (aka H.B.)

38. On or about November 21, 2023, H.R. was scheduled to undergo cosmetic surgeries with Respondent at the Restore Plastic Surgery office.

39. H.R. was scheduled to undergo a miniature muscle plication/abdominal scar revision, bilateral arm liposuction, lip injections, and ear adjustment procedures.

40. The morning of the procedure, H.R. prepared her own tumescent solution,[4] which includes diluted lidocaine, epinephrine, and sodium bicarbonate. She filled one-to-two I.V. bags with the solution.

41. The preparation of H.R.'s tumescent solution was not supervised by Respondent or any other licensed health care practitioner.

42. At around 11:00 a.m., H.R. ingested a "handful" of multi-colored pills, which included Valium.[5]

43. After consuming this medication, H.R. began to exhibit effects of sedation.

[4] Tumescent local anesthesia is a form of local anesthesia, which is a technique in which a dilute local anesthetic solution is injected into the subcutaneous tissue until it becomes firm and tense.
[5] Valium is the brand name for diazepam. Diazepam is a benzodiazepine, which are depressants that produce sedation and hypnosis.

44. Respondent documented that H.R. ingested Valium 5 mg, Tramadol[6] 50 mg, Cefadroxil[7] 500 mg, Zofran[8] 8 mg, and Versed[9] 2 mg, at 12:00 p.m.

45. There is no documentation of the "handful" of pills that H.R. ingested at 11:00 a.m.

46. Prior to beginning the procedure, a medical assistant gave H.R. another dose of Versed.

47. Respondent documented that the tumescent solution that he used was "1000 mg lidocaine (100 mL of 1% lidocaine), 10 mL 8.4% sodium bicarbonate, 2 mg epinephrine, 888 mL normal saline)."

48. However, H.R. prepared the tumescent solution and did not create any documentation of the solution, so Respondent could not have ensured the concentration of the tumescent solution that he used.

49. The minimum prevailing professional standard of care requires physicians to ensure that medications injected into a patient are prepared

[6] Tramadol is a strong pain medication used to treat moderate to severe pain that is not being relieved by other types of pain medicines. Tramadol is a synthetic opioid and acts in the brain and spine (central nervous system) to reduce the amount of pain you feel.
[7] Cefadroxil is an antibiotic used to treat a wide variety of bacterial infections.
[8] Zofran (ondansetron) is a medication that prevents nausea and vomiting caused by chemotherapy, radiation or surgery.
[9] Versed is the brand name for midazolam. Midazolam is a benzodiazepine that is used before surgery or a procedure. It helps to cause drowsiness, decrease anxiety, and to decrease your memory of the surgery or procedure.

by an appropriately licensed health care practitioner or are prepared under the supervision of an appropriately licensed health care practitioner.

50. The minimum prevailing professional standard of care requires that physicians not permit a patient to prepare medications for use in their own surgery.

51. Respondent fell below the minimum prevailing professional standard of care by permitting H.R. to prepare the tumescent solution for her own surgery.

52. Respondent fell below the minimum prevailing professional standard of care by injecting tumescent solution into H.R. that she had prepared without any supervision.

53. Respondent injected 600 mL of the tumescent solution into H.R.'s abdomen and 200 mL into each of H.R.'s arms.

54. Respondent used all of the contents of the one or two I.V. bags, and requested staff bring him Xylocaine.[10]

55. Respondent instructed an assistant to pour the Xylocaine into a bowl and then drew the fluid into a needle and injected undiluted Xylocaine into H.R.'s arms.

[10] Xylocaine (lidocaine HCl) Injection is a local anesthetic used for local or regional anesthesia.

56. Respondent did not document injecting undiluted Xylocaine into H.R.'s arms.

57. Respondent performed the scar revision and muscle plication procedures.

58. H.R. assisted in her own procedure by suturing the skin back together.

59. During this portion of the procedure, H.R. became restless and her feet began twitching.

60. Respondent then performed liposuction of H.R.'s arms and her twitching worsened.

61. Respondent inject undiluted lidocaine and/or Xylocaine into H.R.'s face.

62. Respondent documented that he injected a "more concentrated" solution of lidocaine into H.R.'s face and lips containing "20 mL of saline, 20 mL 1% lidocaine with epinephrine and 20 mL 0.5% Bupivacaine.[11]"

63. Respondent failed to accurately record the anesthetic medication and/or dosage given to H.R. during her procedure.

---

[11] Bupivacaine injection is used to numb an area of your body during or after surgery or other procedures, childbirth, or dental work.

64. H.R. stated that her vision started to blur, and she told Respondent that she saw "orange."

65. Respondent injected more lidocaine and/or Xylocaine in H.R.'s face.

66. During the procedure, H.R. became unresponsive and began to have a seizure.[12]

67. A seizure can be a medical emergency and requires immediate transfer to a higher level of care for assessment and triage.

68. When a patient experiences a seizure during a medical procedure, the minimum prevailing professional standard of care requires a physician to immediately initiate emergency transfer to a higher level of care.

69. A medical assistant asked Respondent if they should call 911 and Respondent said "no." Over the next 10-20 minutes, a medical assistant asked Respondent if they should call 911 and Respondent said "no," or "wait."

[12] A seizure is a sudden, uncontrolled burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of consciousness. Lidocaine-induced seizures are a warning sign for subsequent cardiac toxicity which can be lethal. Conservative management is the best option for treatment of lidocaine-induced seizure.

70. Respondent fell below the minimum prevailing professional standard of care by failing to immediately initiate emergency transfer to a higher level of care when H.R. experienced a seizure.

71. Following the seizure, H.R. experienced hypotension and oxygen desaturation.

72. When a patient experiences hypotension and oxygen desaturation following a seizure, the minimum prevailing professional standard of care requires a physician to immediately initiate emergency transfer to a higher level of care.

73. Respondent failed to immediately initiate emergency transfer to a higher level of care when H.R.'s vitals declined.

74. Respondent fell below the minimum prevailing professional standard of care by failing to immediately initiate emergency transfer of H.R. to the hospital when her vitals declined.

75. Respondent asked the staff "what medication did she take, what did she take?"

76. The minimum prevailing professional standard of care requires physicians to be aware of the medications a patient ingests prior to a procedure.

77. Respondent fell below the minimum prevailing professional standard of care by permitting H.R. to administer her own medications without supervision, and therefore failing know which medications H.R. ingested prior to the procedure.

78. After approximately 10-20 minutes, H.R.'s breaths were shallow, and her pulse and blood oxygen levels were low.

79. Respondent asked the assistants to call 911 and began performing CPR.[13]

80. At 4:13 p.m., an assistant called 911 and requested an ambulance.

81. First responders arrived shortly after that and began CPR and intubated H.R.

82. EMS transported H.R. to the Ascension Sacred Heart Emergency Department in cardiac arrest with an elevated lactic acid level and suspected lidocaine toxicity.

[13] Cardiopulmonary resuscitation (CPR) is an emergency procedure consisting of chest compressions often combined with artificial ventilation, or mouth to mouth in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing in a person who is in cardiac arrest.

83. H.R. did not regain consciousness and after several days in the hospital, H.R. passed away on November 28, 2023.

Count I

84. Petitioner realleges and incorporates paragraphs 1-83 as if fully set forth herein.

85. Section 458.331(1)(t), Florida Statutes (2023), authorizes discipline against a medical doctor for committing medical malpractice as defined in section 456.50, Florida Statutes (2023).

86. Section 456.50(1)(g), 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.

87. Respondent violated section 458.331(1)(t) by falling below the minimum standard of care by:

a. Being unaware of the medications H.R. ingested prior to her procedure;

b. Permitting H.R. to prepare the tumescent solution for her own procedure;

c. Injecting a tumescent solution prepared by an unlicensed and unsupervised individual;

d. Failing to initiate an emergency transfer for H.R. immediately after she suffered a seizure; and/or

e. Failing to initiate an emergency transfer for H.R. after her vitals began to decline.

88. Based on the forgoing, Respondent violated section 458.331(1)(t).

Count II

89. Petitioner realleges and incorporates paragraphs 1-83 as if fully set forth herein.

90. Section 458.331(1)(m), Florida Statutes (2021-2023), authorizes discipline for failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

91. Section 458.331(1)(nn), Florida Statutes (2021-2023), authorizes discipline for violating any provision of chapter 458 or chapter 456, or any rules adopted pursuant thereto.

92. 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.

93. Respondent violated section 458.331(1)(m), and/or section 458.331(1)(nn) through a violation of Rule 64B8-9.003, by failing to keep legible medical records by:

a. Inaccurately recording that Patients B.F. and J.H. requested gluteal fat injections;

b. Failing to create or maintain documentation of Patient B.F.'s wound complications, including the size, shape, and appearance of the wound on December 7, 2021;

c. Failing to create or maintain documentation of Patient J.H.'s December 5, 2022, appointment;

d. Failing to create or maintain documentation of Patient J.H.'s December 7, 2022, appointment;

e. Failing to create or maintain documentation of Patient J.H.'s wound complications, including the size, shape, and appearance of the wound on December 5, 7, and/or 27, 2022;

f. Failing to document what procedure was completed, who performed the procedure, the results of the procedure, and/or any description of Patient J.H.'s wound during Patient J.H.'s appointment on December 20, 2022;

g. Failing to accurately document the medications H.R. consumed prior to her procedure on November 21, 2023; and/or

h. Failing to accurately document the type and dosage/concentration of anesthetic used during H.R.'s procedure.

94. Based on the foregoing, Respondent violated section 458.331(1)(m) and/or section 458.331(1)(nn), through a violation of Rule 64B8-9.003.

Count III

95. Petitioner realleges and incorporates paragraphs 1-83 as if fully set forth herein.

96. Section 458.331(1)(f), Florida Statutes (2022-2023), authorizes discipline for aiding, assisting, procuring, or advising any unlicensed person to practice medicine contrary to this chapter or to a rule of the department or the board.

97. Respondent violated section 458.331(1)(f) by aiding, assisting, procuring, or advising H.R. to perform actions that constitute the practice of medicine, including:

a. Performing laser treatment on B.F. on February 7, 2023;

b. Injecting Kenalog and/or 5-FU into B.F.'s abdominal scar on March 9, 2023;

c. Preparing tumescent solution for her own procedure on November 21, 2023; and/or

d. Suturing her own surgical wound during her own procedure on November 21, 2023.

98. Based on the foregoing, Respondent violated section 458.331(1)(f).

Count IV

99. Petitioner realleges and incorporates paragraphs 1-83 as if fully set forth herein.

100. Section 458.331(1)(bb), Florida Statutes (2021-2022), authorizes discipline for performing or attempting to perform health care services on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition. For the purposes of this paragraph, performing or attempting to perform health care services includes the preparation of the patient.

101. Respondent violated section 456.072(1)(bb) by:

a. Performing gluteal fat transfer on Patient B.F. without her consent; and/or

b. Performing gluteal fat transfer on Patient J.H. without her consent.

102. Based on the foregoing, Respondent violated section 458.331(1)(bb).

[Remainder of Page Intentionally Left Blank]

WHEREFORE, Petitioner respectfully requests that the Board enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 17th day of May, 2024.

Joseph A. Ladapo, MD, PhD
Surgeon General and Secretary

Kristen Summers
Chief Legal Counsel
Florida Bar No. 112206
Prosecution Services Unit
Florida Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265
P: 850-558-9909
F: 850-245-4662
Kristen.Summers@flhealth.gov

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Elizabeth Eubanks
DATE: May 20, 2024

PCP Date: May 17, 2023
PCP Members: Dr. El-Bahri and Dr. Wasylik

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested. A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.

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

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition any other discipline imposed.