

**STATE OF FLORIDA
DEPARTMENT OF HEALTH**

In Re: Emergency Restriction of the License of
Benjamin Jacob Brown, M.D.
License No: ME 122557
Case Numbers: 2023-51255

ORDER OF EMERGENCY RESTRICTION OF LICENSE

Joseph A. Ladapo, MD, PhD, State Surgeon General, ORDERS the emergency restriction of the medical license of Benjamin Jacob Brown, M.D., (Dr. Brown) in the State of Florida. Dr. Brown is licensed as a medical doctor in the state of Florida, having been issued license number ME 122557. Dr. Brown's address of record is 1645 Nantahala Beach Road, Gulf Breeze, Florida 32563. The following Findings of Fact and Conclusions of Law support the emergency restriction of Dr. Brown'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 (2023). Section 456.074(6), Florida Statutes (2023), authorizes the State Surgeon General to summarily restrict Dr. Brown's medical license, in accordance with section 120.60(6), Florida Statutes (2023).
2. At all times material to this order, Dr. Brown was licensed as a medical doctor, having been issued license number ME 122557.

3. Dr. Brown is board certified by the American Board of Plastic Surgery.
4. At all times material to this Order, Dr. Brown owned and operated Restore Plastic Surgery in Pensacola, Florida.
5. Any office where the doctor performs Level II and III procedures must be registered with the Department of Health and submit to annual inspections. Dr. Brown only performs Level I office surgeries at Restore Plastic Surgery and is therefore not registered, or inspected, by the Department.
6. In or around 2021, a medical assistant that worked at Restore Plastic Surgery observed that Dr. Brown's practice began to decline. The medical assistant observed that Dr. Brown began delegating more and more to his physician assistant, Sean Kirby, and his unlicensed wife, H.R.
7. H.R. was not a licensed health care practitioner, was not qualified to practice medicine, including performing cosmetic procedures, and was not legally permitted to perform cosmetic procedures at Restore Plastic Surgery.
8. The medical assistant observed that Restore Plastic Surgery was dirty and poorly maintained.

9. Dr. Brown stored medication, including controlled substances, in an unlocked cabinet. Witnesses reported that staff would ingest Versed¹ from the inventory "to take the edge off."

10. Additionally, staff observed that the administration of Restore Plastic Surgery was tumultuous, poorly managed, and that Dr. Brown could be vindictive.

Facts Relating to Patient B.F.

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

12. During the consultation, Dr. Brown 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 Dr. Brown to inject fat into her buttocks.

13. Despite Patient B.F.'s decision not to receive a BBL, Dr. Brown inaccurately documented in Patient B.F.'s records that she wished to have gluteal fat injections to improve the lateral contour of her buttocks.

¹ Versed is the brand name for the drug midazolam, a sedative commonly prescribed to provide sedation prior to a medical procedure. According to section 893.03(4), Florida Statutes (2023), midazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of midazolam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

14. 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.

15. In addition to the consented procedures, Dr. Brown also performed gluteal fat transfer. Dr. Brown injected 1,100 mL of fat into Patient B.F.'s right buttock and 1,100 mL of fat into her left buttock.

16. The gluteal fat transfer was an unauthorized procedure.

17. After the procedure, Patient B.F. experienced severe pain, blurred vision, and swelling.

18. Additionally, Patient B.F.'s incision began to open and leak.

19. On or about November 23, 2021, Patient B.F. presented to Restore Plastic Surgery to undergo a scar revision surgery which Dr. Brown delegated to physician assistant Sean Kirby to perform.

20. During the procedure, Patient B.F. was crying and in excruciating pain. Patient B.F. described it as "pure torture."

21. Mr. Kirby excised a large portion of skin and fat, creating a large open wound across Patient B.F.'s abdomen.

22. During the procedure, there were several issues with sterility. Neither Mr. Kirby nor the other assistants wore surgical face masks despite Patient B.F.'s

large open abdominal wound. Surgical face masks are essential during any procedure in which the patient has an exposed wound to avoid contamination and increased risk of infection.

23. Mr. Kirby and the assistants wore watches and jewelry under their gloves, which are not sterile.

24. The medical assistants also repeatedly placed gauze on Patient B.F.'s exposed stomach and then used the gauze to stop bleeding in her wound.

25. On December 2, 2021, Patient B.F. removed the bandage from the wound and observed a deep hole in her stomach.

26. On or about December 7, 2021, Patient B.F. presented to Restore Plastic Surgery for a wound debridement.

27. Dr. Brown failed to document a description, including size, shape, and appearance, of Patient B.F.'s wound.

28. On or about April 4, 2022, Patient B.F. presented to Restore Plastic Surgery to undergo abdominal liposuction and abdominal scar revision.

29. During the liposuction and abdominal scar revision procedures, Dr. Brown was assisted by Mr. Kirby. Mr. Kirby was still not wearing a surgical face mask while suturing Patient B.F.

30. As Mr. Kirby's supervising physician, Dr. Brown is responsible for ensuring that Mr. Kirby adheres to appropriate safety practices. The minimum prevailing professional standard of care requires practitioners to maintain a sterile field when performing procedures on patients, which includes wearing a surgical face mask.

31. Dr. Brown failed to meet the minimum prevailing professional standard of care by permitting Mr. Kirby to perform, or assist in performing, procedures involving an open wound without a surgical face mask.

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

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

34. H.R. is Dr. Brown's wife and not a licensed health care provider in the state of Florida.

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

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

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

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

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

40. On February 14, 2024, Patient B.F. was interviewed by the Department. Patient B.F. reported that her body is disfigured from the treatment she received from Dr. Brown and his employees between 2021 and 2023.

Facts Relating to Patient J.H.

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

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

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

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.

44. On or about November 18, 2022, Patient J.H. presented to Baptist Hospital for her procedure.

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

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

47. At this point in time, Patient J.H. presented to Dr. Brown's office for a follow-up appointment to discuss her leaking abdominal incision.

48. Patient J.H. confronted Dr. Brown about her enlarged buttocks and Dr. Brown stated that he performed a BBL and thought that she would "love it."

49. Dr. Brown told Patient J.H. that he was concerned about her abdominal bloating and placed her in a compression garment.

50. On or about December 5, 2022, Patient J.H. presented to Dr. Brown's office for a check-up. Dr. Brown failed to create or maintain a medical record documenting the December 5, 2022, appointment. Dr. Brown failed to create or maintain a medical record documenting Patient J.H.'s abdominal bloating.

51. On or about December 6, 2022, Patient J.H. advised that she was physically unable to remove the garment, so she returned to Dr. Brown's office the following day.

52. On or about December 7, 2022, Patient J.H. presented to Dr. Brown's office for a check-up. Dr. Brown failed to create or maintain a medical record documenting the December 7, 2022, appointment.

53. A medical assistant removed the garment and Patient J.H. had a large area of skin necrosis³ on her abdomen.

54. Dr. Brown 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.

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

56. Dr. Brown 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.

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.

57. Dr. Brown observed Patient J.H.'s necrotic skin and advised that it would need to be excised. Dr. Brown cut a hole in her abdomen that was approximately seven inches long, four inches wide, and half an inch deep.

58. Dr. Brown attempted to re-suture the area but the sutures split open. Dr. Brown packed Patient J.H.'s open wound with acetic acid and gauze and sent her home.

59. The open wound on Patient J.H.'s abdomen did not heal.

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

61. During January 3, 2022, appointment, Dr. Brown trimmed excess fat from Patient J.H.'s wound and changed the dressing.

62. Dr. Brown 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.

63. On January 4, 2023, Patient J.H. returned to Dr. Brown's office for an attempted wound closure procedure.

64. Dr. Brown attempted to stitch the edges of her wound, but Patient J.H. felt that he made the wound worse.

65. Dr. Brown told Patient J.H. that his office does not handle wound care and offered to pay for the procedures to fix her issues.

66. Dr. Brown broke down and told Patient J.H. that "everything was a mess."

67. Patient J.H. continued to decompensate until her friend who is nurse came to help her. The friend immediately took Patient J.H. to the Emergency Department.

68. The consulting surgeon observed Patient J.H.'s wound and stated that it was "horrific" and that she had never seen anything like it.

69. To this day, Patient J.H. still has constant pain in her diaphragm, abdomen, and hips.

Facts Relating to H.R.

70. On or about November 21, 2023, H.R. was scheduled to undergo cosmetic surgeries with her husband, Dr. Brown, at the Restore Plastic Surgery office.

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

72. The morning of the procedure, H.R. prepared her own tumescent solution⁴ which includes diluted lidocaine, epinephrine, and sodium bicarbonate. She filled one-to-two I.V. bags with the solution.

73. At around 11:00 a.m., H.R. ingested a “handful” of multi-colored pills, which included Valium.⁵

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

75. Dr. Brown documented that H.R. ingested Valium 5 mg, Tramadol⁶ 50 mg, Cefadroxil⁷ 500 mg, Zofran⁸ 8 mg, and Versed⁹ 2 mg, at 12:00 p.m.

76. There is no documentation of the “handful” of pills that H.R. ingested at 11:00 a.m.

77. H.R. then went into another patient’s room and removed their stitches.

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.

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.

78. At around noon or 1:00 p.m., a medical assistant began to prepare the procedure room for H.R.'s procedures and Dr. Brown closed the office to the public.

79. Dr. Brown marked H.R. for surgery and H.R. returned to the procedure room approximately 30 minutes later.

80. A medical assistant gave H.R. another dose of Versed.

81. Dr. Brown 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)." However, H.R. prepared the tumescent solution and did not create any documentation of the solution, so Dr. Brown could not have ensured the concentration of the tumescent solution that he used.

82. The minimum prevailing professional standard of care requires physicians to ensure that fluids injected into a patient are properly prepared.

83. Dr. Brown fell below the minimum prevailing professional standard of care by permitting H.R. to prepare the tumescent solution and then using tumescent solution prepared by the patient without being able to ensure that it was the correct concentration or solution.

84. Dr. Brown injected 600 mL of the tumescent solution into H.R.'s abdomen and 200 mL into each of H.R.'s arms.

85. Dr. Brown used all of the contents of the one-to-two I.V. bags, and requested staff bring him Xylocaine.¹⁰

86. Dr. Brown 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.

87. Dr. Brown did not document injecting undiluted Xylocaine into H.R.'s arms.

88. Dr. Brown performed the scar revision and muscle plication procedures.

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

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

91. Dr. Brown then performed liposuction of H.R.'s arms and her twitching worsened.

92. Dr. Brown took a break after completing H.R.'s arm liposuction.

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

93. Dr. Brown 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

94. However, witnesses observed Dr. Brown inject undiluted Xylocaine into H.R.'s face.

95. Dr. Brown failed to accurately record the anesthetic medication and/or dosage given to H.R. during her procedure.

96. H.R. stated that her vision started to blur, and she told Dr. Brown that she saw "orange."

97. Restlessness, muscle twitches, and blurred vision are all early signs of lidocaine toxicity.¹²

98. Dr. Brown continued injecting lidocaine/Xylocaine in H.R.'s face.

99. During the procedure, H.R. became unresponsive and began to have a seizure.¹³

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

¹² Lidocaine toxicity is the rapid onset of severe central nervous system (CNS) depression, seizures and cardiac arrhythmias following local anesthetic administration. <https://www.ncbi.nlm.nih.gov/books/NBK482479/>

¹³ 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.

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

101. 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.

102. A medical assistant asked Dr. Brown if they should call 911 and Dr. Brown said "no." Over the next 10-20 minutes, a medical assistant asked Dr. Brown if they should call 911 and Dr. Brown said "no," or "wait." The medical assistant was scared and a new employee, so she did as Dr. Brown instructed.

103. Dr. Brown failed to immediately initiate emergency transfer to a higher level of care when H.R. experienced a seizure.

104. Dr. Brown instructed staff to retrieve a pulse oximeter, blood pressure cuff, stethoscope, oxygen tanks, and EKG leads.

105. One assistant brought back the pulse oximeter and blood pressure cuff. H.R.'s blood oxygen saturation and blood pressure were low.

106. The other assistants went around the office trying to find the other supplies but did not know where they were or if they were even at the office. The assistants did not know if the office had a crash cart or AED.¹⁴

107. When a patient's vitals decline following a seizure, the minimum prevailing professional standard of care requires a physician to immediately initiate emergency transfer to a higher level of care.

108. Dr. Brown failed to immediately initiate emergency transfer to a higher level of care when H.R.'s vitals declined.

109. Dr. Brown 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.

110. Two assistants went to look for the oxygen tank and found a machine but did not know if it was the right machine.

111. Dr. Brown asked for someone to bring him his stethoscope, but no one could find it.

112. Dr. Brown also shouted at the staff asking them "what medication did she take, what did she take?"

¹⁴ AED stands for automated external defibrillator. It is important to know how to use an AED because a victim's chance of survival decreases by 10% every minute after a sudden cardiac arrest.

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

114. Dr. Brown fell below the minimum prevailing professional standard of care by permitting H.R. to administer her own medications, and therefore failing know which medications H.R. ingested prior to the procedure, in addition to her pre-operative medications.

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

116. Dr. Brown asked the assistants to call 911 and began performing CPR.¹⁵

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

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

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

¹⁵ 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.

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

121. In the course of their practice, medical doctors are entrusted to assess and diagnose patients, order diagnostic testing, prescribe medications, and render treatment in a manner that is correct and safe. Medical doctors are responsible for performing medical procedures in a manner that is correct and safe by using their best judgment when assessing patients during complications or emergency situations and ensuring that the care that they provide to patients is documented accurately. Additionally, medical doctors are placed in a position of trust; therefore, medical doctors must possess good judgment and moral character.

122. Performing procedures and surgeries poses an inherent risk to patients. Performing procedures in an unregulated office setting, without the stringent standards for sterility or access to emergency lifesaving devices, exposes patients to a greater amount of inherent risk. It is the physician's responsibility to minimize this risk, including by implementing requirements that their staff maintain sterile environments when performing or assisting in procedures. Physicians must have good judgment to ensure that procedures are performed by qualified personnel and with appropriate emergency equipment.

123. In or around 2021, Dr. Brown's attention to his practice declined, resulting in an unsafe environment for procedures to be performed. When Patient B.F. presented to Restore Plastic Surgery, none of Dr. Brown's staff wore facial coverings while in close proximity to Patient B.F.'s open wound and repeatedly used gauze that had touched an unsterile surface. The staff's failure to adhere to sterility practices indicates that Dr. Brown failed to appropriately supervise, monitor, or control his staff. Moreover, Mr. Kirby failed to wear a mask while suturing B.F. during a procedure with Dr. Brown, showing that Dr. Brown authorized this conduct.

124. Medical doctors must also have the good judgment to ensure that the individuals that they delegate to provide services to their patients are licensed and trained. Dr. Brown delegated multiple medical tasks to H.R., including laser treatment and injections on patients, without her maintaining any licensure or apparent supervision. Dr. Brown's blatant authorization of unlicensed activity indicates that Dr. Brown has poor judgment and cannot be trusted to ensure that his patients receive appropriate care when in an office setting.

125. Additionally, and most egregiously, Dr. Brown's treatment of H.R. was careless and haphazard. Dr. Brown did not know what medications H.R. ingested prior to the procedures; used a tumescent solution prepared by an

untrained, unlicensed, and unsupervised person; and then injected an unknown amount of undiluted lidocaine/Xylocaine into H.R. The level of disregard Dr. Brown paid to patient safety, even when the patient was his wife, indicates that Dr. Brown is unwilling or incapable of providing the appropriate level of care to his future patients. Dr. Brown's most problematic violation during H.R.'s procedure was his failure to react swiftly in response to a serious medical emergency. Despite less experienced staff members requesting to call 911, Dr. Brown delayed the transport of H.R. by telling his staff "no" or to wait. This was compounded by his staff's apparent lack of knowledge and training. Despite H.R. experiencing a medical emergency, Dr. Brown's staff were unable to locate and utilize any life saving devices like an AED or crash cart.

126. 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.

127. An independent medical expert has determined that Dr. Brown's treatment of H.R. was a violation of the standard of care. The scope and variety of issues with Dr. Brown's practice in the office setting constitute a danger to future patients. Dr. Brown's poor management of his practice has prohibited him

from being able to ensure the safety and wellbeing of patients undergoing in-office procedures. Therefore, Dr. Brown's continued unrestricted practice as a medical doctor presents an immediate, serious danger to the health, welfare, and safety of the public.

128. The Department considered restricting Dr. Brown's license to require him to practice under the immediate supervision of a physician licensed under chapter 458 or 459, Florida Statutes, to ensure that procedures occurring at Dr. Brown's office were conducted safely and by appropriate personnel. However, due to Dr. Brown's status as the owner of Restore Plastic Surgery, there is no feasible supervision restriction that would prevent Dr. Brown from continuing to perform surgical procedures at Restore Plastic Surgery, as he has the ability to open and operate the office without the knowledge of any mandated supervisor. This was exemplified by how Dr. Brown closed his office to the public during H.R.'s procedure and did not have any other licensed healthcare providers present. Additionally, any supervisor would be employed or contracted by Dr. Brown and would risk retaliatory action against their employment if they were to report Dr. Brown's behavior. This uneven power dynamic between the owner/operator of the facility and his staff would not adequately protect the public.

129. Additionally, Restore Plastic Surgery is not a registered facility with the Department and the Department would have no way to monitor Dr. Brown's compliance with such a restriction. In order to ensure that Dr. Brown is supervised, he would have to be restricted to performing procedures only in a facility regulated by the Department or the Agency for Healthcare Administration.

130. In addition to the violations related to Dr. Brown's office, Dr. Brown also showed an extreme deficiency in responding to a medical emergency. To prevent another situation where Dr. Brown fails to immediately initiate emergency transfer to a higher level of care, Dr. Brown must be restricted to only performing procedures in a hospital licensed under chapter 395, Florida Statutes, under the immediate supervision of a licensed physician. Through this restriction, the Department ensures that Dr. Brown's patients will be in a licensed, sterile facility equipped to manage medical emergencies when undergoing medical procedures. An immediate supervisor will be able to ensure that Dr. Brown does not perform any unauthorized procedures while the patients are under anesthesia and to ensure that patients receive appropriate emergency care if needed. Additionally, this oversight will ensure that only licensed and trained individuals are able to provide medical services to Dr. Brown's patients.

131. Therefore, there are no less restrictive means, other than the terms of this Order, that will adequately protect the public.

132. Based on the forgoing, Dr. Brown'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)1., Florida Statutes (2021-2023), authorizes discipline, including restriction, for committing medical malpractice as defined in section 456.50, Florida Statutes (2021-2023).
3. 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.
4. Dr. Brown violated section 458.331(1)(t) by falling below the minimum standard of care by:

- a. Permitting H.R. to administer her own pre-operative medications;
- b. Using a tumescent solution prepared by an unlicensed and unsupervised individual and without being able to verify the concentration of the solution;
- c. Failing to initiate an emergency transfer for H.R. after she suffered a seizure;
- d. Failing to initiate an emergency transfer for H.R. after her vitals began to decline.

5. Section 458.331(1)(m), Florida Statutes (2021-2023), authorizes discipline, including restriction, 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.

6. 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.

7. Dr. Brown violated section 458.331(1)(m), 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 keep 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 keep documentation of Patient J.H.'s December 5, 2022, appointment;
 - d. Failing to create or keep documentation of Patient J.H.'s December 7, 2022, appointment;

- e. Failing to create or keep 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 December 20, 2022, appointment;
- g. Failing to accurately document the medications H.R. consumed prior to her procedure on November 21, 2023;
- h. Failing to accurately document the type and dosage/concentration of anesthetic used during H.R.'s procedure.

8. Section 458.331(1)(f), Florida Statutes (2021), authorizes discipline, including restriction, 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.

9. Dr. Brown violated section 458.331(1)(f) by aiding, assisting, procuring, or advising H.R. to perform actions that constitutes the practice of medicine including:

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

- b. Injecting Kenalog and 5-FU into B.F.'s abdominal scar on March 9, 2023;
- c. Preparing tumescent solution for her own procedure on November 21, 2023;
- d. Suturing her own surgical wound during her own procedure on November 21, 2023.

10. Section 458.331(1)(bb), Florida Statutes (2021-2023), authorizes discipline, including restriction, 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.

11. Dr. Brown violated section 456.072(1)(bb) by:
- a. Performing gluteal fat transfer on Patient B.F. without her consent;
and
 - b. Performing gluteal fat transfer on Patient J.H. without her consent.

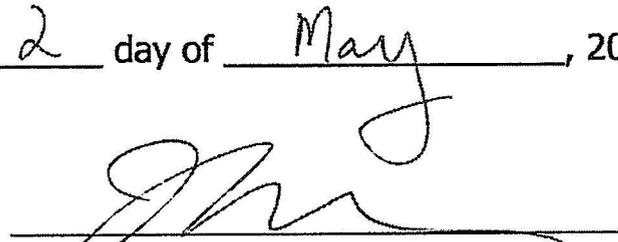
WHEREFORE, in accordance with section 120.60(6), it is **ORDERED**
THAT:

In Re: Emergency Restriction of the License of
Benjamin Jacob Brown, M.D.
License No.: ME 122557
Case Numbers 2023-51255

1. The medical license for Benjamin Jacob Brown, M.D., ME 122557, is immediately restricted. Respondent may only perform procedures or surgeries in a hospital licensed by chapter 395, Florida Statutes (2023), and while under the immediate supervision of a physician licensed under chapter 458 or 459, Florida Statutes (2023).

2. A proceeding seeking formal discipline of the medical license of Benjamin Jacob Brown, M.D., will be promptly instituted and acted upon in compliance with sections 120.569 and 120.60(6), Florida Statutes (2023).

DONE and ORDERED this 2 day of May, 2024.



Joseph A. Ladapo, MD, PhD
State Surgeon General

PREPARED BY:

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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.