Final Order No. DOH-24-1260-ESO-MQA
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Department of Health
By: Christina Jacob
Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

In Re: Emergency Suspension of the License of
Thomas J. Shaknovsky, D.O.
License No: OS 16658
Case Numbers: 2024-38038 and 2024-38135

ORDER OF EMERGENCY SUSPENSION OF LICENSE

Joseph A. Ladapo, MD, PhD, State Surgeon General, ORDERS the emergency suspension of the osteopathic physician license of Thomas J. Shaknovsky, D.O., (Dr. Shaknovsky) in the State of Florida. Dr. Shaknovsky is licensed as an osteopathic physician in the State of Florida, having been issued license number OS 16658. Dr. Shaknovsky's address of record is 4516 Olde Plantation Place, Destin, Florida 32541. The following Findings of Fact and Conclusions of Law support the emergency Suspension of Dr. Shaknovsky's license to practice osteopathic 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 osteopathic medicine pursuant to chapters 20, 456, and 459, Florida Statutes (2024). Section 456.073(8), Florida Statutes (2024), authorizes the State Surgeon General to summarily suspend Dr. Shaknovsky's osteopathic physician license, in accordance with section 120.60(6), Florida Statutes (2024).

2. At all times material to this order, Dr. Shaknovsky was licensed as an osteopathic physician, having been issued license number OS 16658.

3. Dr. Shaknovsky is board certified in General Surgery.

4. At all times material to this Order, Dr. Shaknovsky held surgical privileges at Ascension Sacred Heart Emerald Coast (Ascension) in Miramar Beach, Florida.

Facts involving Patient G.D.

5. On or about Friday, May 12, 2023, Patient G.D., a 58-year-old man, presented to Ascension for a scheduled adrenalectomy[1] due to a mass on his left adrenal gland.

6. Adrenal glands are small triangular glands located on the top of each kidney.

7. During the surgery, Dr. Shaknovsky removed a portion of Patient G.D.'s pancreas instead of the adrenal gland. The pancreas is a large gland located behind the stomach and is surrounded by the gallbladder, liver, and spleen.

8. Dr. Shaknovsky did not remove Patient G.D.'s adrenal gland.

[1] An adrenalectomy is a surgical procedure to remove one or both adrenal glands.

9. Dr. Shaknovsky documented in the operative report that he removed Patient G.D.'s left adrenal gland.

10. Ascension did not have on-site pathologists on Friday, so Dr. Shaknovsky sent the tissue he removed to pathology for review.

11. On May 15, 2024, a pathologist reviewed the purported "adrenal" gland and determined that it was pancreatic tissue.

12. On or about May 16, 2023, Patient G.D. presented to Ascension with leakage and pain around his abdominal drain and vomiting.

13. In response to the allegations, Dr. Shaknovsky claimed that the adrenal gland had "migrated" to a different part of the body.

14. Patient G.D. suffered from long-term, permanent harm as a result of Dr. Shaknovsky's error.

Facts Involving Patient W.B.

15. On or about August 18, 2024, Patient W.B., a 70-year-old man, presented to Ascension with complaints of abdominal pain.

16. Patient W.B. completed imaging, which revealed a suspected enlarged spleen and blood in the peritoneum with no active hemorrhage.

17. Dr. Shaknovsky reviewed Patient W.B.'s records and advised him to undergo surgical intervention. Patient W.B. declined surgical intervention, but agreed to be admitted for medication management.

18. The following day, Dr. Shaknovsky again recommended surgical intervention. Again, Patient W.B. declined surgical intervention and repeatedly expressed his wishes to return home to Alabama.

19. On the third day, Dr. Shaknovsky continued to pressure Patient W.B. to proceed with surgical intervention and cited Patient W.B.'s declining hemoglobin, which had decreased only marginally over the past three days. At this time, Patient W.B. relented and agreed to surgical intervention.

20. Dr. Shaknovsky scheduled Patient W.B.'s laparoscopic splenectomy to occur on May 21, 2024, at around 4:00 p.m.

21. Operating room (OR) staff members noted that Dr. Shaknovsky scheduled the splenectomy and were concerned with it being done so late in the day since they only had a skeletal crew. OR staff knew splenectomies were complicated procedures that could quickly deteriorate and were not regularly performed at Ascension. OR staff had concerns that Dr. Shaknovsky did not have the skill level to safely perform this procedure.

22. On May 21, 2024, Dr. Shaknovsky arrived at the hospital approximately an hour late and Patient W.B. was not brought to the operating room until approximately 5:20 p.m. Patient W.B. was placed under general anesthesia.

23. Dr. Shaknovsky began the procedure laparoscopically but elected to convert to an open procedure due to poor visibility caused by Patient W.B.'s distended colon and blood in the abdomen. Dr. Shaknovsky did not document Patient W.B.'s distended colon in his decision to convert to an open procedure.

24. In Dr. Shaknovsky's Operative Report, he detailed that once he converted to an open procedure, he identified the spleen, removed the gastrospleic and gastrocolic ligaments[2]; mobilized the spleen to expose retroperitoneal attachments; removed the splenoral and splenorphrenic ligaments[3]; dissected the spleen from the surrounding structures; and dissected the splenic artery and vein from surrounding tissue.

25. Dr. Shaknovsky documented that he observed that the spleen was large and quite friable and that after dissecting the attachments, the spleen was "quite mobile."

[2] The gastrosplenic ligament (GSL) is a thin ligament that connects the stomach to the spleen. The gastrocolic ligament (GCL) is a fatty plane that connects the stomach to the transverse colon.
[3] The splenoral and splenorphrenic ligaments are attachments that connect the spleen to other structures in the abdomen.

26. During this portion of the dissection, Dr. Shaknovsky claimed that he clamped a splenic artery aneurysm[4] close to the spleen to avoid possible rupture.

27. At this point in the procedure, Dr. Shaknovsky documented that he identified the splenic artery and appreciated the splenic artery aneurysm close to the splenic hilum. Dr. Shaknovsky documented that he prepared to transect the artery, but just prior to achieving control of it with a stapling device, the aneurysm spontaneously ruptured, resulting in severe hemorrhage.

28. Patient W.B.'s vitals began to decline as he hemorrhaged and OR staff called the code.[5]

29. Dr. Shaknovsky documented that during the code, he packed the abdomen with sponges, was able to control the ruptured aneurysm with a surgical clamp, transected the splenic vein and artery, and removed the spleen from Patient W.B.

30. However, in a later interview, Dr. Shaknovsky claimed that he had never been able to control the aneurysm, but instead decided to complete the

[4] Splenic artery aneurysm is defined as a condition where there is a focal dilation in the diameter of the splenic artery that is 50% greater than the normal vessel diameter.
[5] While there is no formal definition for a "Code," doctors often use the term as slang to refer to a patient in cardiopulmonary arrest, requiring a team of providers (sometimes called a "code team") to rush to the specific location and begin immediate resuscitative efforts.

splenectomy in a last-ditch effort to control the bleeding after Patient W.B. had already been in cardiac arrest[6] for fifteen minutes.

31. Dr. Shaknovsky claimed that he fired the stapling device blindly into the abdomen and removed an organ that he believed to be a spleen.

32. Dr. Shaknovsky claims that due to his shock and the chaos of the situation, he was unable to properly identify the organ he removed and assumed it must be the spleen.

33. Dr. Shaknovsky also claimed that the spleen was grossly enlarged and deformed and that the liver was in an unusual location, contributing to his misidentification.

34. Dr. Shaknovky's Operative Report contained deceptive and untrue statements that failed to accurately describe what occurred in the procedure.

35. The witnesses in the OR consistently and clearly recounted a summary of events that is markedly more troublesome than Dr. Shaknovsky's written account of what occurred.

36. According to witnesses in the OR, when Patient W.B.'s abdomen was opened, a megacolon[7] burst out of the abdominal cavity, disrupting visibility. Dr.

[6] Cardiac arrest is when the heart stops beating, preventing blood flow to the brain and other organs.
[7] Megacolon is an abnormal dilation of the colon that is not caused by mechanical obstruction.

Shaknovsky did not document that Patient W.B. had a large and distended colon that disrupted visibility during the open procedure.

37. While OR staff cleared the field by moving the large colon and suctioning blood, Dr. Shaknovsky identified a vessel that he intended to cut and noted that he could feel it pulsing under his finger. He told the staff member assisting him, "that's scary."

38. Dr. Shaknovsky grabbed the vessel, positioned a surgical stapling device around it, and fired the stapler.

39. Immediately after performing the dissection, Patient W.B. began to severely hemorrhage and went into cardiac arrest. OR staff members observed a significant amount of blood pouring out, immediately disrupting visibility in the field.

40. The operative staff tried to suction the blood and began an emergency blood transfusion protocol. The CRNA called a code and OR staff began performing CPR.

41. While the staff worked the code, Dr. Shaknovsky stayed in Patient W.B.'s abdomen and continued dissecting even though the abdomen was full of blood and there was no visibility. He did not ask staff for a clamp or cauterizer.

42. Dr. Shaknovsky fired the stapling device blindly into Patient W.B.'s abdomen.

43. Eventually, Dr. Shaknovsky removed a 2,106 gram liver measuring 23.0 x 18.8 x 11.0 cm from Patient W.B. and identified it as a spleen.

44. A normal spleen is up to 12 cm long and weighs approximately 70-200 grams. An enlarged spleen can be up to 20 cm and weigh up to 400-500 grams.

45. Spleens and livers are anatomically distinct, have different consistencies, and are different colors. Additionally, the spleen is located on the left side of the abdomen while the liver is on the right side.

46. The staff looked at the readily-identifiable liver on the table and were shocked when Dr. Shaknovsky told them that it was a spleen. One staff member felt sick to their stomach.

47. Despite the operative staff's best efforts, Patient W.B. was unable to be resuscitated and was pronounced deceased.

48. Dr. Shaknovsky told the staff that Patient W.B. died from a ruptured splenic artery aneurysm.

49. Dr. Shaknovsky requested that the organ he removed from Patient W.B. be labeled as a "spleen" and sent it to pathology. The person responsible

for labeling the specimen knew it was not a spleen but did as they were instructed.

50. After time of death was called, Dr. Shaknovsky left the operating room. He returned to the operating room three times after that. Each time Dr. Shaknovsky returned to the operating room, he stated that Patient W.B.'s splenic artery aneurysm ruptured and that was what caused the bleeding.

51. The staff in the room felt that Dr. Shaknovsky was attempting to convince them that this is what occurred, even though they witnessed something different.

52. The third time Dr. Shaknovsky returned to the room, he asked if someone measured the "spleen." The specimen had not been measured. Dr. Shaknovsky requested to go to pathology to view the specimen.

53. Dr. Shaknovsky viewed the specimen and claims that at that time, he still assumed it was a spleen.

54. A pathologist reviewed the specimen and confirmed that it was an intact liver.

55. Patient W.B. underwent an autopsy. During the autopsy, the medical examiner observed that Patient W.B.'s spleen and its attachments were untouched and in the normal position, his liver was missing, and his inferior vena

cava had been severed. Additionally, the medical examiner noted that there was no evidence of a ruptured splenic artery aneurysm.

56. The vena cava is the largest vein in the body and brings deoxygenated blood from the body back to the heart for new oxygen. The inferior vena cava connects the liver to the heart.

57. Based on these findings, Dr. Shaknovsky dissected Patient W.B.'s inferior vena cava, resulting in the bleeding event that precipitated his death.

58. Section 459.001, Florida Statutes, provides:

> [t]he Legislature recognizes that the practice of osteopathic medicine is potentially dangerous to the public if conducted by unsafe and incompetent practitioners. The Legislature finds further that it is difficult for the public to make an informed choice when selecting an osteopathic physician and that the consequences of a wrong decision could seriously harm the public health and safety. The primary legislative purpose in enacting this chapter is to ensure that every osteopathic physician practicing in this state meets minimum requirements for safe and effective practice. It is the legislative intent that osteopathic physicians who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in this state.

59. In the course of their practice, osteopathic physicians are responsible for performing medical procedures in a manner that is correct and safe. General surgery is a complicated specialty that requires an intimate understanding of a

patient's anatomy, including an ability to problem-solve when faced with unexpected findings, events, or emergencies. When a patient is under general anesthesia, it is the surgeon's ultimate responsibility to maintain control of the operating room and navigate the team through any unforeseen circumstances. Any lapse in judgment can result in severe patient injury, even death. Osteopathic physicians must be able to think clearly and rationally during an emergency. In the event of an adverse incident, it is important for osteopathic physicians to accurately document and record everything that occurred.

60. Dr. Shaknovsky erroneously removed a portion of Patient G.D.'s pancreas during an adrenalectomy and Patient W.B.'s entire liver during a splenectomy. Patient G.D. was permanently harmed and Patient W.B. died. Dr. Shaknovsky has denied wrongdoing and claimed that the patient's organs "migrated" to an unusual place in the body or presented with abnormal anatomy. Dr. Shaknovsky's failure to admit his error illustrates either his lack of clinical appreciation for what occurred during the procedures and/or his lack of integrity.

61. Dr. Shaknovsky's repeated egregious surgical errors resulting in significant patient harm coupled with his failure to take responsibility for these errors indicates that his reckless conduct is likely to continue. Therefore, Dr.

Shaknovsky's continued practice as an osteopathic physician presents an immediate, serious danger to the health, welfare, and safety of the public.

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

63. First, the Department considered a restriction prohibiting Dr. Shaknovsky from performing adrenalectomies and splenectomies based on his previous errors. However, this restriction would be insufficient to protect the public. Dr. Shaknovsky has repeatedly misidentified key anatomical structures. He has confused the kidneys with a pancreas and the spleen with the liver. Dr. Shaknovsky misidentified the inferior vena cava – one of the most significant vessels in the human body. General surgery is complex and once a patient is open, a surgeon needs to be capable of addressing issues with any of the organs or vessels, including unforeseen issues. Based on the facts of this Order, Dr. Shaknovsky has demonstrated that he is unable to do this with reasonable skill and safety to patients.

64. Additionally, Dr. Shaknovsky's misidentification of the liver was not a momentary misidentification. Despite converting to an open procedure to

increase visibility, he dissected the liver, cutting the individual attachments to the abdomen. Each attachment that was severed was another opportunity for Dr. Shaknovsky to recognize that he was handling the completely wrong organ due to the anatomical differences between spleens and livers. Liver dissection is complicated and time intensive. Despite having ample opportunity to realize his mistake and keep looking for the spleen, Dr. Shaknovsky failed to do so. Therefore, any restriction tailored to protect the public must also include a complete restriction from performing general surgery.

65. However, even this restriction would not address Dr. Shaknovsky's egregious conduct of fabricating medical records. Dr. Shaknovsky's removal of Patient W.B.'s liver is a grievous medical error. Despite it being abundantly clear that the organ removed from Patient W.B. was a liver, Dr. Shaknovsky implausibly insisted that it was a spleen and directed staff to label it as such. Even if Dr. Shaknovsky genuinely believed he was removing the spleen during the confusion of the code, once the organ was out of the body, it should have been apparent to a general surgeon that it was a liver. The other staff in the OR knew it was not a spleen. Dr. Shaknovsky even went to pathology after the surgery to look at the organ again after the chaos of the surgery was over. At this point, he should have created an operative report that detailed his mistake. However, he took this

deception a step further by describing the removal of the spleen in the Operative Report with great detail – identifying that he dissected specific structures and ligaments that were never touched. Dr. Shaknovsky purposefully identified the source of the significant bleed as a ruptured splenic artery aneurism and attempted to convince the OR staff that this is what caused the hemorrhage. However, the medical examiner found no evidence of a ruptured aneurysm. There is no other explanation for this than Dr. Shaknovsky attempting to avoid blame for severing a significant vessel. This level of dishonesty and fraud is incompatible with the level of integrity that is necessary to be able to practice safely as an osteopathic physician.

66. It is a privilege to be licensed to practice as an osteopathic physician. In order to maintain the public trust, osteopathic physicians must have integrity and be truthful in their documentation. Dr. Shaknovsky's blatant disregard for the truth, falsification of an operative report, and attempt to convince OR staff to acquiesce to his version of events is a breech of the public trust. Dr. Shaknovsky's dishonesty cannot be contained to only operative reports; it colors every aspect of the practice of osteopathic medicine. The public must be able to trust that Dr. Shaknovsky's description of patient care, whether that is in an emergency room, clinic, or primary care practice, is true. That trust is irrevocably broken. Therefore,

there is no restriction that can adequately protect the public from an osteopathic physician who is willing to lie and pressure others to lie on their behalf.

67. Based on the foregoing, there are no less restrictive means, other than the terms of this Order, that will adequately protect the public from Dr. Shaknovsky's continued practice as an osteopathic physician.

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 section 20.43, Florida Statutes (2024), and chapters 456 and 459 as set forth above.

2. Section 456.072(1)(bb), Florida Statutes (2023-2024), authorizes discipline, including suspension, 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.

3. Dr. Shaknovsky violated section 456.072(1)(bb) by:

a. Removing a portion of Patient G.D.'s pancreas during an adrenalectomy; and/or

b. Dissecting and removing Patient W.B.'s liver during a splenectomy.

4. Section 459.015(1)(o), Florida Statutes (2023-2024), 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 osteopathic physician or the osteopathic physician extender and supervising osteopathic 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.

5. Rule 64B15-15.004, Florida Administrative Code, provides that for the purpose of implementing the provisions of section 459.015(1)(o), osteopathic physicians shall maintain written legible records on each patient in English, with sufficient detail to clearly demonstrate why the course of treatment was undertaken. 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.

6. Dr. Shaknovsky violated section 459.015(1)(o) and Rule 64B15-15.004 by:

a. Failing to document the removal of a portion of Patient G.D.'s pancreas;

b. Failing to document Patient W.B.'s large and distended colon; and/or

c. Failing to accurately document the course and results of Patient W.B.'s surgery.

7. Section 459.015(1)(m), Florida Statutes (2023-2024), authorizes discipline, including suspension, for making deceptive, untrue, or fraudulent representations in or related to the practice of osteopathic medicine or employing a trick or scheme in the practice of osteopathic medicine.

8. Dr. Shaknovsky violated section 459.015(1)(m), by:

a. Creating medical records that made deceptive, untrue, or fraudulent representations of what occurred during Patient W.B.'s surgery;

b. Falsely representing that he dissected Patient W.B.'s spleen;

c. Falsely representing that Patient W.B.'s splenic artery aneurysm ruptured during the procedure;

d. Falsely representing that the significant hemorrhage occurred before he fired the stapling device;

e. Falsely representing that he was able to control Patient W.B.'s ruptured aneurysm with a surgical clamp;

f. Falsely representing that he was able to transect the splenic vein and artery despite admitting to performing the dissection blind;

g. Falsely representing to OR staff that the specimen he removed from Patient W.B. was a spleen; and/or

h. Falsely representing to OR staff that Patient W.B.'s hemorrhage was caused by a ruptured splenic artery aneurysm.

9. Section 120.60(6) authorizes the State Surgeon General to summarily suspend an osteopathic physician's license upon a finding that the osteopathic physician presents an immediate, serious danger to the public health, safety, or welfare.

10. Dr. Shaknovsky's continued practice of osteopathic medicine 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.

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

1. The license of Thomas J. Shaknovsky, D.O., to practice as an osteopathic physician, license number OS 16658, is immediately suspended.

2. A proceeding seeking formal discipline of the license of Dr. Shaknovsky will be promptly instituted and acted upon in compliance with sections 120.569 and 120.60(6), Florida Statutes (2024).

DONE and ORDERED this 24th day of September, 2024.

Joseph A. Ladapo, MD, PhD
State Surgeon General

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NOTICE OF RIGHT TO JUDICIAL REVIEW

Pursuant to sections 120.60(6) and 120.68, Florida Statutes (2024), 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.