STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF CLINICAL LABORATORY PERSONNEL,	)	
Petitioner,	)	
vs.	)	Case No. 99-2325C
JAMES A. BEYER,	)	
Respondent.	)	

RECOMMENDED ORDER

A hearing was held in this case in Fort Myers, Florida, on July 29, 1999, before Arnold H. Pollock, an Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Howard M. Bernstein, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317-4229

For Respondent: James A. Beyer, pro se
2501 8th Street West
Lehigh Acres, Florida 33971

STATEMENT OF THE ISSUE

The issue for consideration in this case is whether Respondent's license as a medical technologist in Florida should be disciplined because of the matters alleged in the Administrative Complaint filed herein.

PRELIMINARY MATTERS

By Administrative Complaint dated June 1, 1998, the Agency for Health Care Administration charged Respondent, James A. Beyer, with failing to follow the procedures for specimen handling and processing, test analyses, and reporting and maintaining records of patient test results in the clinical laboratory in which he worked, in violation of Rule 64B-13.003(2)(b), Florida Administrative Code, and Section 483.825(7), Florida Statutes. Respondent requested formal hearing on the allegations, and this hearing ensued.

At the hearing, the Agency presented the testimony of Martha Sunyog, administrative director of the laboratory at Naples Community Hospital, and Donna Teague, records custodian for Naples Community Hospital. The Agency also introduced Petitioner's Exhibits 1 and 2. Respondent testified in his own behalf. He introduced no exhibits.

A Transcript of the proceedings was furnished. Counsel for Petitioner submitted matters in writing after hearing which were carefully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times pertinent to the issues herein, the Board of Clinical Laboratory Personnel was the state agency in Florida responsible for the regulation of the medical technology profession in this state, and for the licensing of medical

technologists in Florida. Respondent, James A. Beyer, was licensed as a medical technologist under license number JC0033961, originally issued on November 27, 1995, and current until June 30, 2000.

2. On February 23, 1996, B.A., a 21-year-old female, was admitted to Naples Community Hospital complaining of increasing abdominal pain. Laboratory tests run on the patient indicated she was undergoing an ectopic pregnancy. A diagnostic laporoscopy was performed, as were subsequent laporotomy and left salpingectomy with lysis of adhesions. It was also determined she had severe pelvic inflammatory disease with bilateral tubo-ovarian complexes. As a result, she was placed on drug and antibiotic therapy which improved her condition. The pathology report based on the surgery performed on the patient revealed no evidence of intrauterine pregnancy in the fallopian tube specimen. She was discharged from the hospital on February 29, 1996. Final diagnosis, as indicated on the discharge summary, was "left ectopic pregnancy" with secondary diagnoses of chronic pelvic inflammatory disease and extensive pelvic adhesions.

3. Notwithstanding the final diagnosis, as noted on the discharge summary, the Agency contends a second pregnancy test done on the patient revealed she was not pregnant. The laboratory tests giving rise to the allegedly erroneous initial diagnosis were processed in the hospital's lab by one of two technologists. Respondent was one of the two. It appears the

test results for patient B.A. were confused in the lab with those of another patient.

4. No evidence was presented to show who actually handled and processed B.A.'s specimen, nor was any evidence introduced by Petitioner to show what the laboratory's appropriate procedures were. However, Respondent's initials were entered into the computer as having done the allegedly erroneous test.

5. Respondent labeled the incident regrettable, as indeed it was. He admits that human error caused the mix-up in specimens, but notes that the incident took place in the primary care chemistry section of the laboratory which was staffed by several different individuals. He claims it is impossible to determine who was responsible for the error. Respondent has no memory of doing the procedure and does not believe he did it. His belief is based on several factors.

6. The first of these is that for the error to have occurred, there would have to have been at least two specimens present: that of B.A. and that of another patient. The demographic information relating to B.A. would have to have been placed on the analyzer with the specimen from the other patient. When Respondent does this test, it is his procedure to hold the specimen in his hand while he reads the label and enters the patient identification information into the analyzer computer. Then he labels the serum cup to be used with the same patient identification information as is on the specimen container he is

holding. Before running the test, he verifies the identification number on the test sample cup against the identification number in the computer, and it is inconceivable to him that he would have picked up another patient's sample and placed a portion of it on the instrument instead of the sample on which he was working.

7. Another reason he believes he did not commit the error is that the incident was thoroughly and promptly investigated by laboratory and hospital personnel, and the human error cause was treated without placing blame on anyone. No disciplinary action was taken against him by the hospital, and he is still employed by Naples Community Hospital in the laboratory in the same position as before the incident occurred. His annual ratings before and after the incident have been "meets" or "exceeds" standards.

8. Respondent is of the opinion that the Department of Health's investigation into the incident was superficial at best and lacks concrete evidence to support the claims of misconduct made.

9. Petitioner presented no information to indicate what are the appropriate procedures to be followed in the laboratory for the procedure in issue.

CONCLUSIONS OF LAW

10. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter in this case. Section 120.57(1), Florida Statutes.

11. Petitioner seeks to discipline Respondent's license as a medical technologist, alleging that he failed to follow proper and established laboratory procedures in the incident involving patient B.A., which resulted in test results from another patient's sample being identified as that of B.A. Petitioner alleges this is a violation of Section 483.825(7), Florida Statutes.

12. Section 483.825(7), Florida Statutes, permits disciplinary action against a licensee who has: "violat[ed] or aid[ed] or abett[ed] in the violation of any provision of this part, or the rules adopted hereunder." If, as alleged, Respondent violated Rule 64B3-13.003(2)(b), Florida Administrative Code, such code violation would constitute a violation of the statute as well.

13. Rule 64B-13.003(2)(b), Florida Administrative Code, requires a technologist to follow the clinical laboratory's procedures for specimen handling and processing, test analyses, and reporting and maintaining records of patient test results. If Petitioner proved that Respondent violated that professional standard, that would constitute a violation upon which to base discipline of his license.

14. Petitioner carries the burden of proof in this matter, however, and that burden requires it to prove Respondent's guilt of the matters alleged by clear and convincing evidence. Osborne vs. Ster & Co., 670 So. 2d.932, (Fla. 1996); Ferris v. Turlington, 570 So. 2d 212, (Fla. 1987). Here, Petitioner has shown that a mistake was made in the laboratory, and that Respondent worked in the laboratory. It has not, however, presented any evidence to demonstrate what is the proper procedural standard for this test.

15. Respondent admits that his initials were placed in the computer for this test. However, the evidence of record does not clearly or convincingly establish Respondent's guilt of the matters alleged.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is recommended that the Board of Clinical Laboratory Personnel enter a final order dismissing the Administrative Complaint against Respondent.

DONE AND ENTERED this 8th day of September, 1999, in Tallahassee, Leon County, Florida.

ARNOLD H. POLLOCK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of September, 1999.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.