STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 99-3870
CATHERINE MARIE LYNCH, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

On April 18-19, 2000, a formal administrative hearing was held in this case in Tampa, Florida, before J. Lawrence Johnston, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Richard Ellis, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317-4229

For Respondent: Bruce D. Lamb, Esquire
Ruden, McCloskey, Smith,
Shuster & Russell, P.A.
401 East Jackson Street, Suite 2700
Tampa, Florida 33602-2378

STATEMENT OF THE ISSUE

The issue in this case is whether Respondent, Catherine Marie Lynch, M.D., should be disciplined on charges alleged in the Amended Administrative Complaint filed by Petitioner, the Department of Health (DOH), in DOH Case No. 98-14411. Essentially, the charges are that Respondent practiced obstetrical medicine below acceptable standards on November 9,

1997, by not decreasing or discontinuing a patient's Pitocin and by delaying performance of a Cesarean section notwithstanding fetal heart rate (FHR) decelerations requiring contrary action.

PRELIMINARY STATEMENT

On August 24, 1999, DOH filed an Administrative Complaint against Respondent in DOH Case No. 98-14411. Respondent disputed the charges and requested a formal administrative proceeding. The case was referred to the Division of Administrative Hearings (DOAH) and set for final hearing in Tampa, Florida, on February 2-4, 2000. On the parties' agreed motion, final hearing was continued to April 18-20, 2000. On February 16, 2000, Petitioner was given leave to file an Amended Administrative Complaint, which was filed on March 7, 2000.

On March 27, 2000, Petitioner filed a Motion for Taking Official Recognition of the Amended Final Order in Department of Health v. Mohammad Fathi Abdel-Hameed, M.D., DOAH Case Nos. 97-0337 and 97-0338. On April 17, 2000, Respondent filed a Motion to Take Official Recognition of Florida Administrative Code Rules 64B8-6.002 through 64B8-6.0005 in effect on November 9, 1997--the date of the medical care in question in this case.

At final hearing, both motions for official recognition were granted, subject only to relevance of the Abdel-Hameed Amended Final Order, which was marginal at best. (Petitioner's Proposed Recommended Order conceded that the Abdel-Hameed Amended Final Order only was being used to prove that "Pitocin must be used

carefully.") Petitioner called the patient's husband, Frank Britt, Sheila Devanesan, M.D., and Harold Schulman, M.D. Petitioner had Petitioner's Exhibits 1 through 9 admitted in evidence. Petitioner's Exhibit 3 was a transcript of the deposition testimony of Scott E. Musinski, M.D. Respondent testified in her own behalf and called Robert W. Yelverton, M.D. Respondent had Respondent's Exhibits 1 through 5 admitted in evidence.

After presentation of the evidence, Petitioner ordered a transcript, and the parties requested 20 days from the filing of the transcript in which to file proposed recommended orders. The Transcript was filed on May 4, 2000, and the timely proposed recommended orders filed by both parties have been considered.

FINDINGS OF FACT

1. Respondent, Catherine Marie Lynch, is and was at all times material to the allegations in the Amended Administrative Complaint, a licensed physician in the State of Florida, having been issued License No. ME 0061336.

2. Respondent received a Bachelor of Science degree in science and biology from Georgetown University in Washington, D.C., in 1986. She received her Doctor of Medicine degree from the University of South Florida (USF) College of Medicine in Tampa, Florida, in 1990. She completed a standard residency program in obstetrics and gynecology through the USF College of Medicine in 1994. Dr. Lynch currently holds hospital

appointments at Tampa General Hospital (Tampa General), H. Lee Moffitt Cancer Center, Bay Pines Veterans Administration Hospital, and Town 'N' Country Hospital, all in Tampa, Florida.

3. After her formal education, Dr. Lynch joined the faculty of the USF College of Medicine in July of 1994 as an instructor. She was promoted to Assistant Professor of Medicine in July of 1995 and was appointed Director of the Division of General Obstetrics and Gynecology of the USF College of Medicine in 1997. Since 1994, Dr. Lynch has been involved in the education of medical students and resident physicians, teaching both general obstetrics and gynecology, as well as urogynecology, incontinence, and pelvic reconstruction. She is responsible for oversight of the attending physicians within the Division of General Obstetrics and Gynecology, for operating room assignments and labor and delivery assignments, and coverage for these physicians. She also is responsible for the development of the schedule for resident physicians. These attending physicians and resident physicians provide care and treatment to patients at Tampa General Hospital, other hospitals, and obstetrics clinics.

4. Respondent is Board-certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology, having first become Board-certified in November 1996. She is a Fellow of the American College of Obstetrics and Gynecology.

Staffing at Tampa General

5. During November of 1997, there were approximately 24 residents in the obstetrics and gynecology (OB/GYN) residency program at the USF College of Medicine. There were six residents per year of matriculation.

6. During a regular work week in November of 1997, 21 of the 24 residents would cover a variety of services on the labor and delivery floor and throughout Tampa General. The other three would be at other locations, such as Genesis, a clinic, or the Moffitt Cancer Center. But November 9, 1997, the date in question in this case, was a Sunday. On weekends (and nights), "full services" were consolidated under the "on-call team." This team consisted of a first-year resident, a second-year resident, a third-year resident, a fourth-year resident, and one attending physician. The "on-call" team would cover all of the services provided at Tampa General, including not only labor and delivery but also antepartum, admissions to regular hospital floor, the postpartum ward, the gynecology ward, the gynecology-oncology ward, the emergency room, and emergency surgeries (such as ectopic pregnancy surgeries.)

7. The "on-call" team's first-year resident is primarily responsible for the triage (initial evaluation) of patients who presented to labor and delivery for evaluation as to whether such patients needed to be admitted to the hospital or could return to their residence. In addition, the first-year resident is

primarily responsible for the "laboring" patients on labor and delivery under the supervision of the third-year resident.

8. The "on-call" team's second-year resident responds to calls or questions on any of the wards for obstetrical or gynecological problems or complaints other than labor and delivery. The second-year resident also consults with other physicians in the area of obstetrics and gynecology and sees patients in the emergency room. The second-year resident also is responsible for operative interventions, whether gynecological or obstetrical in nature, under the supervision of the fourth-year resident.

9. The "on-call" team's third-year resident is responsible for supervision of the first-year resident in labor and delivery. Its fourth-year resident is responsible for oversight of the other residents. The fourth-year resident also is responsible for any sort of operative intervention, whether it be gynecological or obstetrical in nature.

10. The "on-call" team's attending physician oversees all of the residents.

11. Residents practice as unlicensed doctors-in-training under Section 458.345, Florida Statutes. Florida Administrative Code Rule 64B8-6.005 provides:

> Resident Physician and Assistant Resident Physician; Duties of. An assistant resident or resident physician participates in an organized graduate education program in which he has daily contact with patients and assumes increasing responsibility for their

> care under the supervision of the attending staff of the hospital. The assumption of responsibility is a most important aspect of residency training. As each assistant resident or resident physician demonstrates increasing knowledge and ability, an increasing amount of reliance should be placed in his judgment in the diagnosis and in treatment of patients. He may also participate in the teaching of interns and medical students to an increasing extent. In surgery and surgical specialties, the assistant resident and resident physician should be given ample opportunity to perform major surgical procedures under direct supervision of qualified members of the professional staff of the hospital, particularly in the later stages of his training, in order that he may acquire surgical skill and judgment.

This rule was in effect in November 1997, and remained in effect at the time of the final hearing.

12. In 1997, the USF OB/GYN residency program utilized both didactic lectures and clinical training to educate medical students and residents. Such training included the assessment of patients in labor, including the interpretation of fetal heart rate (FHR) monitoring strips.

Chronology of Events at Tampa General

13. On Sunday, November 9, 1997, Respondent was the "on-call" team's attending physician at Tampa General. The team's first-year resident was Sheila Devanesan, M.D. The second-year resident was Cathy Johnson, M.D. The third-year resident was Scott E. Musinski, M.D. The fourth-year (chief) resident was Kimberly Huffman, M.D.

14. On November 9, 1997, the patient, S.N., then age 40, was two days past her estimated due date of delivery. The gestational age of the fetus was 40 weeks. S.N. had received her prenatal care at the Genesis outpatient clinic of Tampa General and was classified as a low-risk patient. She had delivered vaginally after normal pregnancies in 1978 and 1983. She had no infections or any other medical condition during her pregnancy in 1997 that would have impaired the health of the fetus.

15. S.N. experienced a spontaneous rupture of the membranes of the amniotic sac at approximately 8:00 a.m. on November 9, 1997. She and her husband, Frank Britt, came to Tampa General and arrived at approximately 9:35 a.m. Nursing staff initiated electronic fetal heart monitoring for S.N. by way of the maternal abdomen, along with electronic monitoring of the patient's uterine contractions.

16. At Tampa General, the electronic fetal heart monitor and uterine contraction sensors are attached to several display monitors. One is in the patient's labor and delivery room; others are located in the doctors' lounge, at the nursing station, and in the "well" on the labor and delivery floor. The display monitors only depict current events. The history of the FHR and the patient's contractions while on labor and delivery are recorded on a paper strip located only in the patient's room.

17. The first "on-call" team member to examine and assess S.N. on November 9, 1997, was Sheila Devanesan, M.D., who saw the

patient at approximately 9:45 a.m. Dr. Devanesan performed a cervical examination, which indicated that S.N.'s cervix was dilated to five centimeters. Dr. Devanesan also noted the presence of light meconium (fetal fecal matter) in the amniotic fluid. The volume of meconium was not felt to present a problem for the fetus.

18. In the course of her initial examination and assessment, Dr. Devanesan also noted the presence of variable fetal heart decelerations but characterized the fetal heart rate (FHR) as "reassuring" at that time.

19. Fetal heart decelerations denote a decline in fetal heart beats-per-minute (bpm) to a rate below the FHR "baseline." The baseline is an average of the beat-to-beat variations in the FHR when the FHR is neither accelerating nor decelerating. The baseline can vary from fetus to fetus and also can vary during the course of any one patient's labor. Generally, the baseline heart rate of a fetus will be between 120 and 160 bpm.

20. Fetal heart decelerations are not uncommon during labor and delivery, and are not necessarily indicative of fetal distress. However, certain categories of fetal heart decelerations are of more concern to the clinician than others.

21. In this case, "variable" fetal heart decelerations were found virtually from the time electronic fetal heart monitoring was initiated at 9:35 a.m. Variable decelerations can indicate a compressed umbilical cord, which in turn can require intervention

by the obstetrician, or even a change in the plan of delivery (from a vaginal delivery to delivery by Cesarean section). Repeated variable decelerations can deplete fetal oxygen reserves and lead to complications, including metabolic acidosis.

22. At approximately 10:00 a.m. on November 9, 1997, Dr. Musinski performed a sonogram in an attempt to determine the cause of the variable decelerations. Based on the sonogram, he diagnosed oligohydramnios, or deficient amniotic fluid. Compression of the umbilical cord is a complication of oligohydramnios.

23. With help from Dr. Musinski, Dr. Devanesan placed a fetal scalp electrode to more precisely monitor fetal heart rate at approximately 10:12 a.m. Dr. Devanesan also ordered amnioinfusion (infusion of fluid into the amniotic sac) in the amount of 500 cubic centimeters (cc's), at approximately 10:19 a.m. Amnioinfusion is an appropriate intervention to treat possible cord compression from oligohydramnios.

24. Respondent came to S.N.'s bedside at 10:34 a.m. and reviewed the FHR tracing strip recorded by electronic fetal heart monitoring. Generally, it was Respondent's practice to review the strip retroactively 30-45 minutes whenever she was at bedside in labor and delivery. Appropriately, Respondent did nothing to change the care being provided to the patient by the residents at that point.

25. At 11:00 a.m., it was decided to give the patient an epidural for pain. An epidural is the infusion of pain medication through a catheter into a location in the patient's spine; it relieves pain without affecting the patient's level of consciousness. To place an epidural catheter, the patient must be repositioned to a sitting position. This repositioning can cause FHR decelerations.

26. The patient's labor record confirms that she was in a sitting position for placement of the epidural at 11:00 a.m. The patient's record indicates that a test dose was administered through the epidural at 11:10 a.m.

27. Dr. Devanesan performed another cervical examination at 11:36 a.m., and found S.N.'s cervix still dilated to five centimeters. The patient's record indicates that a bolus of Fentanyl was given to the patient by epidural at 11:37 a.m.

28. The administration of Fentanyl through an epidural catheter can cause FHR decelerations.

29. After conferring with Dr. Musinski, Dr. Devanesan gave an order for a second amnioinfusion at 11:40 a.m. due to continued variable decelerations. The second order was for 250 cc's; according to the patient's hospital record, it was the last amnioinfusion ordered for or administered to the patient.

30. Due to S.N.'s lack of progress in labor, Dr. Devanesan gave an order for Pitocin at 11:52 a.m., after conferring with Dr. Musinski, to augment labor by stimulating uterine

contractions. Dr. Devanesan's order was for 1 milli-International Unit (mIU), to be increased by 1 mIU every 30 minutes up to 20 mIU's of Pitocin or until adequate contractions began. There is no evidence that Respondent participated in the decision to start Pitocin.

31. Pitocin is a brand name; the generic name for the drug is oxytocin. Pitocin is not used to manage fetal heart decelerations. To the contrary, Pitocin is generally contraindicated where FHR is considered non-reassuring. But one mIU is a miniscule amount, and the progression of 1 mIU every 30 minutes was very conservative.

32. Dr. Devanesan noted on S.N.'s chart that FHR was "overall reassuring" at 11:40 a.m. Respondent reasonably believed that Dr. Devanesan had the education and training to identify nonreassuring, as well as reassuring, FHR patterns. But Dr. Devanesan testified at final hearing that she did not have the competence as a first-year resident to judge when FHR patterns were nonreassuring overall.

33. At approximately 12:03 p.m., after successive, milder fetal heart decelerations that morning, the fetus experienced an abrupt deceleration, from its baseline of approximately 120 bpm to just under 50 bpm. The heart rate did not return to baseline for approximately four minutes.

34. At approximately 12:07 p.m., the notation "U/S" appears on the heart monitor strip. That notation may refer to a second

ultrasound examination; however, neither Dr. Devanesan nor Dr. Musinski could recall performing a second ultrasound.

35. At approximately 12:10 p.m., Dr. Devanesan was at S.N.'s bedside. The heart monitor strip bears a nurse's notation at 12:10 p.m., reading "Off by Dr. Devanesan to stop flash light." The monitor in the labor room flashed automatically to call attention to significant FHR decelerations. The screen had activated in response to the 12:03 p.m. deceleration. Dr. Devanesan instructed nursing staff to turn off a flashing screen at that time, since the medical professionals were aware of the patient's recurrent decelerations.

36. Following the 12:03 p.m. deceleration, the FHR decelerated to approximately 50 bpm again at 12:10 p.m., 12:14 p.m., and 12:20 p.m., in tandem with uterine contractions. The 12:10 p.m. deceleration is notable in itself due to its onset, which is less abrupt than the 12:03 p.m., deceleration. The gradual nature of the deceleration is suspicious for possible hypoxia, or lack of oxygen, in the fetus.

37. Fetal heart rate decelerated to 60 bpm at approximately 12:27 p.m., remained at 60 bpm for approximately thirty seconds, and did not return to baseline for approximately three minutes.

38. Fetal heart rate decelerated to 50 bpm at approximately 12:36 p.m., again during a uterine contraction. Also at that time, Pitocin was increased from one mIU to two mIU's.

39. Dr. Devanesan returned to S.N.'s bedside at approximately 12:45 p.m. due to her concern with continued fetal heart decelerations. At the same time, the FHR became irregular, with multiple decelerations over the course of the next eight minutes. Nurses' notes for 12:45 p.m. indicate fetal heart decelerations to "60's-90's for approx. 3-4 [minutes with] slow return to 100's".

40. Dr. Musinski came to S.N.'s bedside at approximately 12:55 p.m., likewise due to concern with fetal heart decelerations. He performed a vaginal (cervical) examination at that time, and found S.N. to be dilated to seven-to-eight centimeters.

41. At 12:58 p.m., Respondent joined Dr. Musinski at S.N.'s bedside, along with Catherine Johnson, M.D., a second-year resident in obstetrics and gynecology. Dr. Musinski did not recall why Respondent came to the labor room. Respondent testified that she observed the fetal heart tracing on one of the remote monitors and made an independent determination to come to S.N.'s bedside.

42. Respondent testified further that she spent approximately ten minutes at S.N.'s bedside; she also testified that she was there until 1:15 or 1:20 p.m. She testified that she instructed Dr. Musinski to perform a cervical examination. Respondent also performed a cervical examination. The cervical

examination indicated that S.N.'s cervix remained dilated to seven-to-eight centimeters.

43. Respondent also testified that, while Respondent was at bedside on this occasion, she instructed Dr. Musinski to perform a fetal scalp stimulation. A fetal scalp stimulation (also known as Clark's test) is a simple assessment measure used to learn whether the fetus is acidotic. Essentially, the doctor stimulates the fetal scalp and looks for a FHR acceleration in response. If so, the doctor has some reassurance that the fetus is not acidotic at that time.

44. There is no notation in Dr. Musinski's progress note of 1:03 p.m. to indicate that the fetal scalp stimulation was performed, or what results were obtained if it was performed. There is a notation in Dr. Musinski's 1:03 p.m. note indicating significant variable fetal heart decelerations, with "prolonged recovery" and good beat-to-beat variability. However, Respondent testified that there was a reassuring response to the fetal scalp stimulation performed by Dr. Musinski.

45. During her time at bedside on this occasion, Respondent became aware of the administration of Pitocin. The heart monitor strip in fact indicates that the dosage of Pitocin was increased to three mIU's at 1:01 p.m. Respondent did not think it was necessary to decrease or discontinue Pitocin at that time.

46. While at bedside on this occasion, Respondent reviewed the fetal heart monitor strip. Respondent conceded that there

were nonreassuring FHR tracings prior to her arrival at 12:58 p.m. At approximately 1:07 p.m., fetal heart rate decelerated from 150 to 90 bpm, recovered momentarily to 120, and then decelerated to 60, returning to baseline approximately two minutes later. But while Respondent was still at bedside, she saw some improvement and drew the conclusion that FHR still was reassuring overall, notwithstanding the variable decelerations. She left with the instruction that she be notified if FHR patterns deteriorated so that the team could decide what to do next.

47. At approximately 1:25 p.m., the FHR accelerated momentarily to 150 bpm and then declined abruptly to 60, in tandem with a uterine contraction. Robert Yelverton, M.D., Respondent's own expert witness, conceded that fetal heart rate did not return to baseline until almost 1:30 p.m.

48. At approximately 1:38 p.m., fetal heart rate decelerated to approximately 65 bpm, in tandem with a uterine contraction, and did not return to baseline for approximately two minutes.

49. At approximately 1:48 p.m., Dr. Musinski performed another cervical examination; he found S.N.'s cervix dilated to seven centimeters and 70% effaced. The fetus was in minus 1 station (not yet to mid-pelvis). The results of that examination are noted on both the fetal heart monitor strip itself and in Tampa General's nurses' notes. The strip itself indicates that

the fetus experienced a heart deceleration to 60 bpm at 1:48 p.m., in tandem with a uterine contraction.

50. At approximately 1:55 p.m., fetal heart rate accelerated momentarily to 150 bpm, then abruptly decelerated to 60, and did not return to baseline until over two minutes later, and then decelerated twice more over the next four minutes.

51. At approximately 2:00 p.m., the dosage of Pitocin was increased to five mIU's. Also at 2:00 p.m., Dr. Musinski came to the patient's bedside and reviewed the fetal heart tracing.

52. Beginning at approximately 2:01 p.m., the fetal heart tracing took on a markedly different appearance. The tracing at that point becomes notably flat in nature, whether at, above, or below baseline. There was no more beat-to-beat variability.

53. A marked lack or absence of beat-to-beat variability can indicate metabolic acidosis, which is of great concern to the clinician, and can dictate an intervention or change in the plan of delivery, and on an emergency basis depending upon circumstances.

54. In instances of metabolic acidosis, the fetus begins to break down fats as well as sugars in order to create energy supply, due to lack of normal intake of oxygen. In the process, lactic and other acids accumulate, resulting in acidosis.

55. Dr. Musinski again reviewed the tracing on the heart monitor strip and examined S.N. at 2:18 p.m. Again, he found S.N.'s cervix dilated to seven centimeters.

56. There was a conflict in the evidence as to what happened next. Dr. Musinski recalled discussing a Cesarean with Respondent at approximately 2:18 p.m. Other evidence tends to support Dr. Musinski's version of events. A written consent form for a Cesarean was signed by Dr. Musinski and the patient's husband and bore the handwritten time of 2:18 p.m. Respondent denied that Respondent discussed a Cesarean with her at 2:18 p.m. She also testified that she never was notified of the loss of baseline variability but saw the tracing on one of the other three monitors at approximately 2:35 p.m., just after finishing a Cesarean on another patient with Drs. Huffman and Devanesan. Respondent testified that, at that point, she sent Dr. Huffman to the patient's labor room and instructed the nursing staff to set up for a fetal scalp pH test sample. Respondent believed that the consent form must have been signed later when circumstances became even more urgent. See Findings 66-67, infra. Otherwise, Respondent would have expected the patient to sign, not just her husband. But Respondent had no cogent explanation as to why the time 2:18 p.m. would have been written on the form.

57. The patient's husband also recalled talking to Respondent about a Cesarean at some point during the afternoon, presumably at or after the time the consent form was signed, and being told that the delivery would be vaginal. But the evidence is not clear as to exactly when the husband spoke to Respondent.

58. Considering all of the evidence on this point, although it may be suspected that Dr. Musinski spoke to Respondent about a Cesarean around 2:18 p.m., the evidence on this point was not clear and convincing, and the Respondent's version of the circumstances leading to her coming to bedside must be accepted.

59. Multiple fetal heart decelerations followed from 2:18 p.m. to 2:37 p.m., bearing an uncertain relationship to uterine contractions during that span of time. In accordance with Dr. Devanesan's order, Pitocin was increased to six mIU's at 2:30 p.m.

60. Dr. Huffman arrived at S.N.'s bedside at 2:37 p.m. She viewed the tracing on the heart monitor strip and performed a cervical examination. Dr. Huffman's examination indicated that S.N.'s cervix was still dilated to seven centimeters.

61. Respondent herself entered S.N.'s room at 2:40 p.m. She intended to proceed with a fetal scalp pH at that point and ordered nursing staff to place S.N. in the lithotomy position for the procedure.

62. The term pH refers to potential of hydrogen, and the value assigned upon clinical laboratory examination determines the extent to which blood is normal, or has excessive alkaline content, or excessive acid. The values given are logarithmic in nature: e.g., a blood pH of 6 is ten times more acidic than a blood pH of 7; and a blood pH of 5 is one hundred times more

acidic than a blood pH of 7. Normal blood pH in the fetus is 7.25 to 7.35.

63. A fetal scalp pH test is a means of assessing the health of the fetus in labor. A mixture of arterial and venous blood is taken from the fetal scalp. While somewhat useful, the test only tells the clinician the fetal pH at the point in time when the sample is drawn. The test lacks predictive value concerning the onset of metabolic acidosis.

64. After reviewing the tracing strip, and seeing that baseline had increased to 150 bpm, but with no beat-to-beat variability, Respondent abandoned the fetal scalp pH test, deciding instead to try to complete a vaginal delivery. (This may have been what the patient's husband was recalling when he testified that Respondent told him it would not be a Cesarean but a vaginal delivery.) Respondent performed a cervical examination of S.N. and found S.N.'s cervix to be dilated to nine centimeters. However, she also found that the fetus was in an occiput transverse position, with the fetal head unfavorably situated for a spontaneous vaginal delivery.

65. At hearing, Respondent described her actions at that point as follows:

> A. . . . And I hoped that if I could bring it down just a little further, get rid of that last bit of cervix, I could get forceps in and pull the baby out in under five minutes.
> Q. You demonstrated that the fetal head was turned sideways; is that correct?
> A. Yes.

> Q. And that's not the ideal position for use of forceps; is that correct?
> A. Correct.
> Q. So what did you decide to do at that point?
> A. Well, since the baby had come down just with repositioning the mother, obviously her, you know, increasing intra-abdominal pressure, just with the abdominal pressure, with the change, in position of the tubal lithotomy for the scalp pH, when I did the exam I hoped that since she already had two large babies, that if she could give me one good push she could bring the baby down to plus two and it would be a[n] easy-outlet delivery.

66. Respondent asked S.N. to push at approximately 2:45 p.m., in an attempt to deliver the baby vaginally. The baby was not delivered at that point, however. Instead, the baby remained in utero, and prolonged fetal bradycardia (slowing of heart rate) ensued. Fetal heart rate decelerated to 60 bpm, and remained at 60 bpm for approximately three minutes. The heart monitor strip then shows a momentary return to baseline in tandem with a shift of S.N. to left lateral position, following which fetal heart rate decelerated back to 60 bpm, and then decelerated further to 40 bpm, over the next several minutes.

67. Pitocin continued to be administered throughout Respondent's unsuccessful attempt to effect a vaginal delivery. It was not discontinued until 2:51 p.m., and then apparently only due to impending transport of S.N. to the operating room for an emergency Cesarean section. Respondent ordered an emergency Cesarean section at approximately that time, and the Cesarean

section was performed at approximately 3:00 p.m. by Dr. Johnson, with Respondent assisting.

68. The baby was delivered by Cesarean section at 3:01 p.m. In the course of the baby's delivery, Respondent found the umbilical cord over the baby's shoulder and down its back. The shoulder over which the cord coursed had been pressing against the maternal pubic bone, causing cord compression.

69. One minute after birth, the baby's Apgar score was zero, equivalent to an absence of any signs of life. The baby was resuscitated following delivery, but there was a conflict in the evidence as to whether and how quickly the baby was initially intubated.

70. Respondent's first iteration of the facts of this case, given in her attorney's correspondence dated August 26, 1998, indicates simply as follows: "Roberto Rivera, M.D., successfully intubated Baby Boy N. and provided ventilation. Jennifer Casetelli, M.D., monitored the heart rate, and the pediatric nurse provided cardiac compressions. At 5 minutes, the Apgar score was 3; 2 for heart rate, and 1 for skin color. At this point, Baby N. was receiving positive pressure ventilation via the endotracheal tube and was transported to the Neonatal Intensive Care Unit (NICU)." Respondent reviewed the August 26, 1998, correspondence before it was dispatched by her attorney, and she authorized its dispatch.

71. At hearing, Respondent told a different story. According to her initial hearing testimony, she personally witnessed a first-year pediatric resident unsuccessfully attempt to intubate the baby, and it took over two minutes for the baby to be intubated. Respondent later answered another question about the intubation as follows:

> Q. Do you know how many attempts it took before the child was intubated?
> A. I know there was only one interval in which bagging occurred between attempts. What I observed, and in fact asked the anesthesia individual to go over and help, at which time--by the time the anesthesia resident got there the second-year had the tube in, the clock was reading about 2:10. I think it said 2:15. And it had been over a minute or more that they had been trying to get the tube down. (Vol. II transcript p. 228.)

72. There are no notations in either the mother's chart or the baby's chart to indicate any difficulty of intubation. To the contrary, the notation in the baby's chart reads: "Apgar at 5 minutes was 3 with patient intubated." With the baby delivered at 3:01 p.m., an Apgar score of 3 at five minutes "with patient intubated" would mean that the baby was intubated at 3:06 p.m., if not sooner. Respiratory care notes in the baby's chart in fact indicate that the baby was intubated as of 3:03 p.m.

73. Upon the baby's delivery at 3:01 p.m., the umbilical cord was clamped and cut, and a blood specimen taken from the cord for clinical laboratory analysis. The pertinent laboratory result was a cord blood pH of 7.15, which would signify acidosis.

74. The baby was admitted to the neonatal intensive care unit (NICU) at 3:08 p.m. At 3:15 p.m., the baby suffered cardiorespiratory arrest. A "code" (emergency response) was called at that time in the NICU. The "Code 19 Flow Sheet" indicates that the code ended at 3:30 p.m., with the baby resuscitated at that time. NICU progress notes indicate that the baby's heart rate was steady at 148 bpm at 3:30 p.m. However, a blood sample drawn at 3:24 p.m. for arterial blood gas analysis resulted in a pH of 6.81, which is grossly acidotic.

75. The baby was hospitalized at Tampa General for 25 days. He was treated with phenobarbital for seizures. He was diagnosed with metabolic acidosis on November 9 and 10, 1997. Reports of outpatient visits after discharge indicate developmental delays and a diagnosis of severe static encephalopathy, i.e., permanent brain damage.

Medical Expert Evaluation

76. The medical experts who testified in this case had differences of opinion as to the nomenclature as well as the significance of the variable decelerations evidenced by the FHR monitor tracings in this case. They also differed to when it was necessary to reduce or stop Pitocin and when it was necessary to initiate a Cesarean section. Respondent and her witness, Robert W. Yelverton, M.D., would be willing to wait longer than Petitioner's expert, Harold Schulman, M.D. Preliminary excerpts

from authoritative literature will help put the subsequent discussion of these differences of opinion in context.

77. The American College of Obstetricians and Gynecologists (ACOG) Technical Bulletin 207, published in July 1995, and still in effect on November 9, 1997, begins by stating:

> Intrapartum fetal heart rate (FHR) monitoring can help the physician identify and interpret changes in FHR patterns that may be associated with such fetal conditions as hypoxia, umbilical cord compression, tachycardia, and acidosis. The ability to interpret FHR patterns and understand their correlation with the fetus' condition allows the physician to institute management techniques, including maternal oxygenation, amnioinfusion, and tocolytic therapy.
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> Transient and repetitive episodes of hypomema and hypoxia, even at the level of the central nervous system (CNS), are extremely common during normal labor and are generally well tolerated by the fetus. Further, a progressive intrapartum decline in baseline fetal oxygenation and pH is virtually universal; levels of acidemia that would be ominous in an infant or adult are commonly seen in normal newborns. Only when hypoxia and resultant metabolic acidemia reach extreme levels is the fetus at risk for long-term neurologic impairment. For purposes of this bulletin, the following definitions will be used:
>
> | | |
> |---|---|
> | Hypoxemia: | Decreased oxygen content in blood |
> | Hypoxia: | Decreased level of oxygen in tissue |
> | Acidemia: | Increased concentration of hydrogen ions in the blood |

Acidosis:	Increased concentration of hydrogen ions in tissue
Asphyxia:	Hypoxia with metabolic acidosis

The bulletin later makes the following pertinent statements about interpretation of FHR patterns:

> Variable decelerations are the most common decelerations seen in labor and indicate umbilical cord compression; they are generally associated with a favorable outcome. Only when they become persistent, progressively deeper, and longer lasting are they considered nonreassuring. Although progression is more important than absolute parameters, persisting variable decelerations to less than 70 bpm lasting greater than 60 seconds are generally concerning. In addition to prolonged and deep variable decelerations, those with persistently slow return to baseline are also considered nonreassuring, as these reflect hypoxia persistent beyond the relaxation phase of the contraction. The response of the baseline FHR to the variable decelerations and the presence or absence of accelerations are important in formulating a management plan for the patient with significant variable decelerations. When nonreassuring variable decelerations are associated with the development of tachycardia and loss of variability, one begins to see substantial correlation with fetal acidosis.
>
> Late decelerations may be secondary to transient fetal hypoxia in response to the decreased placental perfusion associated with uterine contractions. Occasional or intermittent late decelerations are not uncommon during labor. When late decelerations become persistent (ie, present with most contractions), they are considered nonreassuring, regardless of the depth of the deceleration. Later decelerations caused by reflex--those mediated by the CNS [central nervous system]--generally become deeper as

> the degree of hypoxia becomes more severe. However, as metabolic acidosis develops from tissue hypoxia, late decelerations are believed to be the result of direct myocardial depression, and at this point, the depth of the late deceleration will not indicate the degree of hypoxia.
>
> A prolonged deceleration, often incorrectly referred to as bradycardia, is an isolated, abrupt decrease in the FHR to levels below the baseline that lasts at least 60-90 seconds. These changes are always of concern and may be caused by virtually any mechanism that can lead to fetal hypoxia. The severity of the event causing the deceleration is usually reflected in the depth and duration of the deceleration, as well as the degree to which variability is lost during the deceleration. When such a deceleration returns to the baseline, especially with more profound episodes, a transient fetal tachycardia and loss of variability may occur while the fetus is recovering from hypoxia. The degree to which such decelerations are nonreassuring depends on their depth and duration, loss of variability, response of the fetus during the recovery period, and, most importantly, the frequency and progression of recurrence. (Footnotes omitted.)

The bulletin goes on to discuss evaluation and management of nonreassuring patterns:

> With a persistently nonreassuring FHR pattern in labor, the clinician should approach the evaluation and management in a four-step plan as follows:
>
> 1. When possible, determine the etiology of the pattern.
> 2. Attempt to correct the pattern by specifically correcting the primary problem or by instituting general measure aimed at improving fetal oxygenation and placental perfusion.

3. If attempts to correct the pattern are not successful, fetal scalp blood pH assessment may be considered.
4. Determine whether operative intervention is warranted and, if so, how urgently it is needed.

> The search for the cause of the nonreassuring FHR pattern should be directed by the clinician's interpretation of the pattern. . . . For severe variable or prolonged decelerations, a pelvic examination should be performed immediately to rule out umbilical cord prolapse or rapid descent of the fetal head. If no causes of such decelerations are found, one can usually conclude that umbilical cord compression is responsible.
>
> General measures that may improve fetal oxygenation and placental perfusion include administering maternal oxygen by a tight-fitting mask, ensuring that the woman is in the lateral recumbent position, discontinuing oxytocin, and, if maternal intravascular volume status is in question, beginning intravenous hydration.

After discussing administration of oxygen to the mother, which was done in this case, the bulletin goes on to make the following pertinent observations about maternal position, epidural block, oxytocin, and amnioinfusion:

> Maternal Position
>
> Maternal position during labor can affect uterine blood flow and placental perfusion. In the supine position, there is an exaggeration of the lumbar lordotic curvature of the maternal spine facilitating compression of the vena cava and aortoiliac vessels by the gravid uterus. This results in decreased return of blood to the maternal heart leading directly to a fall in cardiac output, blood pressure, and uterine blood flow. In the supine position, aortic

compression by the uterus may result in an increase in the incidence of late decelerations and a decrease in fetal scalp pH. The lateral recumbent position (either side) is best for maximizing cardiac output and uterine blood flow and is often associated with improvement in the FHR pattern. Other maternal positions may accomplish similar uterine displacement.

Epidural Block

Some degree of maternal hypotension is a relatively common complication of epidural block, occurring in 5-25% of procedures. . . . During the period of hypotension, uteroplacental perfusion may be compromised. This may be manifested by fetal tachycardia, prolonged decelerations, decreased beat-to-beat variability, late decelerations, or some combination of these.

The frequency of prolonged decelerations after administration of epidural analgesia has been reported to be 7.9-12.5%. Uterine hypertonia with resultant prolonged decelerations has been observed in patients receiving epidural block during labor even in the absence of systemic hypotension. Management of epidural-associated decelerations should focus on treatment of the specific cause--either the increased uterine tone or maternal hypotension.

Oxytocin

Careful use of oxytocin is necessary to minimize uterine hyperstimulation and potential maternal and fetal morbidity. If nonreassuring FHR changes occur in patients receiving oxytocin, the infusion should be decreased or discontinued. Restarting the infusion at a lower rate or increasing it in smaller increments may be better tolerated.

Amnioinfusion

Variable decelerations are frequently encountered in both the first and second stages of labor. Those occurring prior to

> fetal descent at 8-9 cm of dilatation are most frequently seen in patients with oligohydramnios.
>
> In patients with decreased amniotic fluid volume in either preterm or term pregnancies, replacement of amniotic fluid with normal saline infused through a transcervical intrauterine pressure catheter has been reported to decrease both the frequency and severity of variable decelerations. Replacement of amniotic fluid may be elected therapeutically in patients with progressive variable decelerations. Although randomized, controlled trials are lacking, it is reasonable to replace amniotic fluid prophylactically at the onset of labor in patients with known oligohydramnios. Studies also have demonstrated that amnioinfusion results in reductions in rates of cesarean delivery for "fetal distress," primarily due to variable decelerations, and fewer low Apgar scores at birth. Acute saline amnioinfusion has been reported to be an effective therapy that relieves most repetitive variable or prolonged intrapartum decelerations and is without apparent maternal or fetal risk. Investigators have also reported a decrease in newborn respiratory complications from meconium in patients who receive amnioinfusion. This results presumably from the dilutional effect of amnioinfusion and possibly from prevention of in utero fetal gasping that may occur during episodes of hypoxia caused by umbilical cord compression. (Footnotes omitted.)

Finally, the bulletin discusses management of persistent nonreassuring FHR patterns as follows:

> If the FHR pattern remains uncorrected, the decision to intervene depends on the clinician's assessment of the likelihood of severe hypoxia and the possibility of metabolic acidosis, as well as the estimated time to spontaneous delivery. For the fetus with persistent nonreassuring decelerations, normal FHR variability and the absence of

> tachycardia generally indicate the lack of acidosis. However, variability is difficult to quantify except in the extremes.
>
> Persistent late decelerations or severe variable decelerations associated with the absence of variability are always nonreassuring and generally require prompt intervention unless they spontaneously resolve or can be corrected rapidly with immediate conservative measures (i.e., oxygen, hydration, or maternal repositioning). The absence of variability or markedly decreased variability demonstrated on an external monitor is generally reliable. The presence of FHR variability is not confirmatory, however, and, in the presence of nonreassuring decelerations, a fetal electrode should be placed when possible.
>
> The presence of spontaneous accelerations of greater than 15 bpm lasting at least 15 seconds virtually always ensures the absence of fetal acidosis. Fetal scalp stimulation or vibroacoustic stimulation can be used to induce accelerations; these also indicate the absence of acidosis. Conversely, there is about a 50% chance of acidosis in the fetus who fails to respond to stimulation in the presence of an otherwise nonreassuring pattern. In these fetuses, assessment of scalp blood pH, if available, may be used to clarify the acid-base status. This technique, while occasionally helpful, is used uncommonly in current obstetric practice. If the FHR pattern remains worrisome, either induced accelerations or repeat assessment of scalp blood pH is required every 20-30 minutes for continued reassurance. In cases in which the FHR patterns are persistently nonreassuring and acidosis is present or cannot be ruled out, the fetus should be promptly delivered by the most expeditious route, whether abdominal or vaginal. (Footnotes omitted.)

78. Another publication accepted by the experts as authoritative was an article by Drs. Low and Victory called

"Predictive Value of Electronic Fetal Monitoring for Intrapartum Fetal Asphyxia with Metabolic Acidosis" published in Obstetrics and Gynecology, February 1999 (the Low article). The Low article reported the results of a matched case-control study of 71 births with and 71 births without asphyxia. The Low article's discussion of the results of the study stated in part:

> The unnecessary intervention reported in previous randomized clinical trials is understandable in view of the results of this study. Interpretation of FHR records is complicated by false-positive FHR patterns. Because predictive FHR patterns are not specific and fetal asphyxial exposure is an infrequent event, the positive predictive values of these findings were low, ranging from 18% for the most specific pattern to 2.6% when all predictive patterns were included. Because of the large number of false-positive patterns, the potential for unnecessary clinical intervention is great.
>
> This study demonstrates that the prediction of fetal asphyxial exposure by FHR patterns is possible, but difficult. There is a narrow window of 1 hour before diagnosis when FHR patterns will predict a pronounced metabolic acidosis. If the goal is to predict fetal asphyxial exposure before decompensation, one cannot wait for evidence of absent baseline variability. At this stage, the asphyxial exposure is moderate or severe, with substantial newborn morbidity. Asphyxial exposure must be considered if two or more cycles of minimal baseline variability and late or prolonged decelerations are observed in the record. Even these criteria will not identify all cases of asphyxial exposure. In the asphyxia group, ten infants had a single cycle of minimal baseline variability or late or prolonged decelerations, and four had no

> predictive FHR variables. The asphyxial exposure was mild in these latter cases.
>
> * * *
>
> During labor and delivery, fetal asphyxial exposure occurs in 2% and moderate and severe exposure in less than 0.3% of pregnancies. The goal of intrapartum fetal surveillance is to reduce the incidence of asphyxial exposure and to prevent moderate and severe asphyxial exposure. Electronic fetal monitoring with the identification of predictive FHR patterns can be a useful screening test in intrapartum surveillance for fetal asphyxia. The identification of predictive FHR patterns requires continuous scoring of FHR records because of the narrow 1-hour window of these patterns with developing metabolic acidosis. Predictive FHR patterns require supplementary tests such as fetal blood gas and acid-base assessment to confirm the diagnosis of fetal asphyxia and to identify the false-positive results to avoid unnecessary intervention.

The Low article defined "prolonged" decelerations as decelerations lasting from 120 to 300 seconds. "Cycles" consisted of ten-minute increments of time during the last four hours of labor.

79. Dr. Shulman defined a deceleration as a 15-bpm decline in FHR lasting at least 15 seconds. According to Dr. Shulman's definitions, a deceleration from 120 to 90 bpm would be called "mild-to-moderate" if it lasted 45 seconds. A deceleration below 70 bpm would be termed "severe" even if it lasted only 30 seconds, according to Dr. Shulman, as it could result in oxygen deprivation. Dr. Shulman defined a "prolonged" deceleration as one lasting more than 60-90 seconds, measured from onset to return to baseline.

80. Initially, Dr. Yelverton defined a "prolonged" deceleration as a decline of 30 or more bpm lasting 120 or more seconds. Later, he accepted the ACOG Technical Bulletin 207 definition of 60-90 seconds used by Dr. Shulman. However, Dr. Yelverton measures the duration of a deceleration from beginning to end of the nadir plateau. If that measurement does not exceed 60 seconds, Dr. Yelverton would not call the deceleration "prolonged" even if it took considerably longer for the FHR to return to baseline. He would characterize such a deceleration as a "classic variable deceleration with a slow return to baseline."

81. Respondent defined a "prolonged" variable deceleration as one that drops to 70 bpm or less and does not exceed 70 bpm for 90 seconds or more.

82. Dr. Shulman reserved his most serious criticism of Respondent until her visit to bedside at 12:58 p.m. Regardless of differences of opinion as to nomenclature and the seriousness of the early variable decelerations, Dr. Yelverton conceded that, by that point in time, the FHR patterns were becoming nonreassuring. Dr. Schulman believed that it was necessary to stop Pitocin and begin preparations for a Cesarean at that time since repositioning, maternal oxygenation, and amnioinfusion had not stopped the variable decelerations. In his view, there already had been enough variable decelerations of sufficient amplitude and duration. Respondent and Dr. Yelverton disagreed.

They thought caution was required but that labor toward a vaginal delivery still could proceed at that point.

83. Respondent and Dr. Yelverton were critical of Dr. Shulman for not correlating the FHR monitoring strip with information other than the uterine contractions being recorded on the strip that could help explain some of the variable decelerations. For example, progress notes and other information in the record indicate various reasons why the patient was being repositioned from time-to-time, either causing or relieving cord compression. Similarly, the administration of epidural medication can affect FHR patterns. But regardless of the reason for variable decelerations, they can have an adverse effect on the fetus, especially if they are severe or prolonged or persistent. With good reason, Dr. Shulman was impressed with the amplitude, duration, and persistence of the variable decelerations regardless of their cause.

84. Dr. Shulman's view of the case reflected an unwillingness to accept much risk of compromise of the fetus as a result of metabolic acidosis. Since metabolic acidosis is difficult to predict, short of loss of baseline variability, Dr. Shulman would be inclined to "bail out" and do a Cesarean after two or three of what he termed "prolonged" or "severe" variable decelerations. Although it could not be determined with certainty, he would be fearful that the FHR patterns signified

hypoxia and that, by 12:58 p.m., the cumulative effects could result in metabolic acidosis without much additional warning.

85. Respondent and Dr. Yelverton disagreed. They thought it was appropriate for Respondent to observe the patient until approximately 1:15 p.m., as she did. There was some improvement in the tracing by the time Respondent left the patient's bedside, and both Respondent and Dr. Yelverton thought it was acceptable to proceed further toward vaginal delivery at that point, with an admonition to the residents to watch the tracings closely and notify Respondent if they deteriorated. (It is noted that Dr. Yelverton, at least, also would not have criticized a doctor who opted for a Cesarean at 12:58 p.m.)

86. Notwithstanding the testimony of Dr. Shulman, it is found that a Cesarean was not mandatory at 1:15 p.m. There was some improvement in the strip during Respondent's bedside visit, and the evidence was not sufficient to prove that no reasonably prudent physician would have allowed labor to continue. However, as Respondent acknowledged in her instructions to the residents, the team should have been very concerned about the tracings, should have monitored the tracings and the condition of the fetus closely, and should have been prepared to intervene promptly if not reassured as labor progressed.

87. Dr. Shulman also believed that it was mandatory to cease Pitocin at 12:58 p.m. Respondent and Dr. Yelverton, on the other hand, emphasized the low dosage of Pitocin being

administered at the time (3 mIU's). They also noted that the patient's contractions were not very strong, and there was no evidence of uterine hypertonis. They did not see a clear, direct connection between the Pitocin and the FHR. Under these circumstances, it is found that, notwithstanding Dr. Shulman's testimony, it was not mandatory to stop Pitocin by 1:15 p.m. even though Pitocin is relatively contraindicated if the FHR is nonreassuring. However, they should have been prepared to stop Pitocin if not reassured as labor progressed.

88. Although the FHR tracings again became nonreassuring after Respondent left the patient's bedside, Respondent was not notified until sometime after baseline variability was lost at approximately 2 p.m. The reason for the delay is not clear from the evidence but probably was at least in part due to Respondent's being occupied with the care of another patient who required a Cesarean in this general time period. (Reference to the other patient was general; there was no evidence as to specifics at to the time or nature of the other Cesarean.)

89. Respondent and her expert conceded that Pitocin should have been discontinued when the FHR lost baseline variability. Dr. Yelverton also conceded that a Cesarean should have been initiated no more than ten minutes later. However, Respondent's culpability for not discontinuing Pitocin and initiating a Cesarean at that time is complicated by questions as to when

Respondent became aware of the loss of baseline variability. See Findings 56-58, supra.

90. Respondent also testified that, when she arrived at bedside at 2:40 p.m., she assumed Pitocin already had been discontinued by the nursing staff in accordance with a hospital protocol for nurses. Respondent testified that she thought there was a protocol requiring the nurses to discontinue Pitocin when a doctor ordered a fetal scalp blood pH. In fact, the protocol cited by Respondent did not address sampling for a fetal scalp blood pH. It does, however, provide for discontinuance of oxytocin immediately "if significant nonreassuring FHR patterns occur, i.e., late or prolonged decelerations, bradycardia." Based on the FHR tracings, it would have been reasonable for Respondent to assume that the nursing staff had discontinued Pitocin by the time Respondent arrived at bedside at 2:40 p.m.

91. Besides the hospital protocol for oxytocin, the dosage of Pitocin still was only 5 mIU's, and the patient's contractions still were not especially strong. At the same time, Respondent was occupied taking other actions on behalf of the patient. See Finding 88, supra. Under these circumstances, it is understandable and excusable that Respondent might not notice the Pitocin and discontinue it. It is not found that her failure to discontinue Pitocin immediately at 2:40 p.m. or during efforts to deliver vaginally constituted a "failure to practice medicine with that level of care, skill, and treatment which is recognized

by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances."

92. Even assuming Respondent's version of the circumstances leading to her coming to the patient's bedside at 2:40 p.m., the evidence was clear and convincing that, at that time, she became aware of the tracing strip showing no baseline variability since approximately 2 p.m. Consistent with his belief that Respondent already should have proceeded to a Cesarean, Dr. Shulman believed that it was necessary to do so immediately at 2:40 p.m. Dr. Yelverton also testified that a Cesarean should have been initiated no later than 2:15 p.m. However, he excused Respondent's decisions and actions after her arrival at bedside.

93. As reflected in Dr. Yelverton's testimony, it is difficult to second-guess a doctor's clinical judgment in such circumstances. Respondent examined the patient; judged the patient to be fully effaced and dilated to nine centimeters; and judged the fetus to be at "zero station," i.e., in mid-pelvis. Given the patient's two previous vaginal deliveries, it was Respondent's judgment that a relatively quick, assisted vaginal delivery was possible. If she was right, her decision would have been best for the baby (as well as the patient). However, the baby's head position was not favorable for the hoped-for outcome. Respondent's choice was risky, and failure would compound the distress of the fetus and delay the Cesarean. In hindsight, it is clear that Respondent made the wrong decision in trying for an

assisted vaginal delivery instead of proceeding immediately to a Cesarean delivery. But under all of the circumstances, it is not found that Respondent's decision constituted a "failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances."

94. It also cannot be found that Respondent's decisions alone resulted in the negative outcome in this case. It appears from the evidence that events occurring after the Cesarean delivery caused further damage to the baby. See Findings 69-74, supra. It appears from the evidence that, absent the unfortunate subsequent events, permanent brain damage may not have resulted.

CONCLUSIONS OF LAW

95. Section 458.331(1)(t), Florida Statutes, authorizes the Board of Medicine to discipline a physician on proof of:

> Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

96. Section 458.331(3), Florida Statutes, provides:

> In any administrative action against a physician which does not involve revocation or suspension of license, the division shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.

Petitioner concedes that its burden in this case was to prove the allegations by clear and convincing evidence. See also Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987). (Even though Petitioner's Proposed Recommended Order only sought imposition of a fine and probation, the Amended Administrative Complaint sought revocation or suspension.)

97. In this case, the poor outcome resulted in part from Respondent's misjudgments and willingness to accept more risk of metabolic acidosis than Dr. Shulman. Nonetheless, Petitioner did not prove by clear and convincing evidence that Respondent failed to "practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances."

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Board of Medicine enter a final order finding Respondent not guilty.

DONE AND ENTERED this 3rd day of July, 2000, in Tallahassee, Leon County, Florida.

J. LAWRENCE JOHNSTON
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of July, 2000.

COPIES FURNISHED:

Richard Ellis, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317-4229

Bruce D. Lamb, Esquire
Ruden, McCloskey, Smith,
Shuster & Russell, P.A.
401 East Jackson Street, Suite 2700
Tampa, Florida 33602-2378

Angela T. Hall, Agency Clerk
Department of Health
Bin A02
2020 Capital Circle, Southeast
Tallahassee, Florida 32399-1703

William W. Large, General Counsel
Department of Health
2020 Capital Circle, Southeast
Tallahassee, Florida 32399-1701

Tanya Williams, Executive Director
Board of Medicine
1940 North Monroe Street
Tallahassee, Florida 32399-0750

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.