STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. RONALD A. FORD, M.D., Respondent.	)	Case No. 01-3164PL

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on November 6 and 7, 2001, at Lakeland, Florida, before Susan B. Kirkland, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Robert C. Byerts, Esquire
Agency for Health Care Administration
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For Respondent: William B. Taylor, IV, Esquire
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STATEMENT OF THE ISSUES

Whether Respondent violated Section 458.331(1)(t), Florida Statutes, and, if so, what discipline should be imposed.

PRELIMINARY STATEMENT

On August 25, 2000, Petitioner, Department of Health, Board of Medicine (Department), filed an Administrative Complaint against Respondent, Ronald A. Ford, M.D. (Dr. Ford), alleging that he violated Section 458.331(1)(t), Florida Statutes. Dr. Ford requested a formal hearing, and the case was forwarded to the Division of Administrative Hearings on August 13, 2001, for assignment to an Administrative Law Judge.

The parties filed a Prehearing Stipulation in which they agreed to certain facts contained in paragraphs 1-6 of Section E of the Prehearing Stipulation. Those facts have been incorporated into this Recommended Order.

At the final hearing, the Department called the following witnesses: Ronald Lee Barbour, M.D.; Lorena Duncan, R.N.; Lisa Hanshaw deSaenz, R.N.; Lynn Teagles, R.N.; and Laurence Neufeld, M.D. Petitioner's Exhibits 1-4 were admitted in evidence. Dr. Ford testified on his own behalf and called John J. Carthy, M.D., and Larry Williams, M.D. as his witnesses. Respondent's Exhibits 1-3 were admitted in evidence. Joint Exhibit 1, the medical records for Patient R.A.L., were admitted in evidence.

At the final hearing, the parties agreed to file their proposed recommended orders within 30 days of the filing of

the Transcript, which was filed on November 28, 2001. The parties timely filed their Proposed Recommended Orders, which have been considered in the rendering of this Recommended Order.

FINDINGS OF FACT

1. At all times material to this proceeding, Dr. Ford was a licensed physician in the State of Florida. His license, numbered ME 0051042, was issued on July 8, 1987.

2. Patient R.A.L, presented to the Emergency Department of Winter Haven Hospital (Hospital) at approximately 1:35 p.m. on October 9, 1997. R.A.L.'s initial chief complaint was right flank pain since 9:00 a.m. that day. He reported a history of vomiting and diarrhea and stated that it felt like a kidney stone, of which R.A.L. had a history. Right flank pain is common with a patient having a kidney stone or kidney problem.

3. R.A.L. was initially examined by Dr. David Siegel about 30 minutes after R.A.L. came to the emergency room. On physical examination palpation, there was no flank pain, but R.A.L. did have moderate pain diffusely throughout all areas of his abdomen. His abdomen was not acutely distended, and there were normal bowel sounds.

4. On Dr. Siegel's order R.A.L. was given Toradol intravenously at 2:22 p.m. to relieve the pain. Toradol is a

non-steroidal anti-inflammatory drug. R.A.L. was also given fluids intravenously.

5. R.A.L.'s symptoms did not provide Dr. Siegel with a definitive diagnosis. Dr. Siegel ordered the following tests to be performed: a complete blood count, an amylase, a urinalysis, a PTPDT, and X-rays of the abdomen.

6. The complete blood count was done to make sure that the patient was not anemic and to see if there was an elevated white blood count, which would be indicative of some type of infection or acute abdominal process. The complete blood count showed a significantly elevated white blood cell count of 24.3. The test also revealed that there was a left shift of a differential, which means that there was a high differential percentage-wise of segmented and banded white blood cells. The combination of the significantly elevated white blood cell count and the left shift indicated that there was an acute infectious process or an acute illness.

7. The amalyse test measures a serum enzyme that is secreted from the pancreas. If the serum enzyme is elevated, it could be indicative of pancreatitis. The amalyse test was normal.

8. The urinalysis would show whether there was an infection and would show some abnormalities if there were a kidney stone. R.A.L.'s urine checked out normal.

9. At 3:00 p.m. R.A.L. voided. His urine was strained, but there were no kidney stones present.

10. R.A.L. did not have an adequate response to the Toradol. He was given Demerol intravenously at 3:10 p.m.

11. Based on the test results, Dr. Siegel was unable to make a definitive diagnosis. Because of R.A.L.'s clinical condition and his continued pain, Dr. Siegel ordered an abdominal Computed Tomography (CT) scan to see if he could further define what was going on in R.A.L.'s abdomen. Because of the absence of flank pain, the elevated white blood cell count, and the normal urinalysis report, Dr. Siegel did not rule out the possibility of kidney stones, but did feel that some abdominal process of significance was higher on the list of possible diagnoses than kidney stones.

12. Dr. Siegel went off duty at 5:30 p.m. and turned the care of R.A.L. over to Dr. Ronald Barbour. Dr. Siegel gave Dr. Barbour an oral report of his findings and indicated that he was primarily concerned about a serious intra-abdominal process. Before finishing his shift, Dr. Siegel dictated a written report, which was immediately transcribed and placed in R.A.L.'s chart. Dr. Siegel expected Dr. Barbour to get the results of the CT scan and determine whether the results would allow a diagnosis.

13. When Dr. Barbour came on duty, he went to see R.A.L., who told Dr. Barbour that he was still having some pain. R.A.L. asked for something to relieve the pain, and Dr. Barbour ordered Demerol for him.

14. Dr. Barbour received a call from the radiologist, who said that the CT scan was consistent with a small bowel obstruction. Dr. Barbour told R.A.L. that it appeared he had a bowel obstruction and that he would be admitted to the Hospital.

15. It is the Hospital's policy to contact a patient's primary care physician when a patient is being admitted to the Hospital from the Emergency Department. Dr. Ford was R.A.L.'s primary care physician. Dr. Ford was called by an Emergency Department nurse. Dr. Barbour spoke with Dr. Ford and advised him that the CT scan showed a small bowel obstruction. Dr. Ford stated that he would admit R.A.L. No mention was made of a surgical consult during the conversation. Dr. Barbour did not call a surgeon for a consult because normally if the patient has a primary care physician, the primary care physician would choose the surgeon should a surgical consult be necessary.

16. R.A.L. was admitted to the Hospital at approximately 8:45 p.m. At that point, the responsibility for the care and treatment of the patient shifted from Dr. Barbour to Dr. Ford.

Dr. Ford gave admission orders to Lorina Duncan, a nurse in the Emergency Department. The orders included administering Demerol and Phenergan as needed and giving the patient a saline solution intravenously. Dr. Ford also ordered tests to be done the following morning. The nurse's notes do not indicate that Dr. Ford told her to order a surgical consult for the next morning.

17. R.A.L. was given Demerol and Phenergan in the Emergency Department at 9:55 p.m. At 10:10 p.m. R.A.L. was signed out of the Emergency Department to the medical/surgical floor of the Street Building, which is known as Street One.

18. When R.A.L. was admitted to the Hospital, his abdomen was not distended. By the time he was admitted to Street One, his abdomen was distended and firm, and he was complaining of abdominal pain and nausea. When he was placed in his bed, he positioned himself in a fetal position, which is indicative of being in pain. He had no bowel sounds. While the nurse was getting a medical history, R.A.L. was lethargic and would drift off in the middle of the admission questions. His breathing was shallow and rapid.

19. It took the nurse over an hour to complete the admission assessment on R.A.L. after he had come to Street One. At 11:50 p.m., R.A.L. was complaining that his pain had increased throughout his stomach. He indicated that his

nausea was better. R.A.L. requested a patient-control anesthetic (PCA), which allows the patient to administer a metered dose of pain medication to himself by pushing a button.

20. Around midnight the nurse had the hospital operator page Dr. Ford. He returned the nurse's call. She told Dr. Ford that R.A.L.'s abdomen was distended and that he was lethargic. R.A.L. had had no pain medication administered since being admitted to Street One, and his next dose of pain medication was to be given at 1:00 a.m. The nurse told Dr. Ford that R.A.L. was complaining of pain and wanted to have a PCA. Dr. Ford gave an order for a Demerol PCA, which would allow a five-milligram dose every five minutes with a maximum of 150 milligrams in four hours.

21. The nurse told Dr. Ford that R.A.L. had been complaining of nausea. Dr. Ford asked whether R.A.L. had vomited, and she advised the doctor that R.A.L. had not. They discussed the possible use of a naso-gastric (NG) tube, which extends from the nose down to the stomach. It is used to aspirate the contents of the stomach, which decreases nausea and distention. Dr. Ford did not order a NG tube.

22. At 12:30 a.m., October 10, 1997, the Demerol PCA was started. At 4:30 a.m., R.A.L. was complaining of shortness of

breath. His abdomen was more distended and firm. Dr. Ford was paged, and he gave orders for lab work to be done.

23. At 4:45 a.m. R.A.L. went into distress and died. Dr. Ford arrived at the Hospital about 5:05 a.m.

24. A small bowel obstruction is a condition characterized by the inability of gastrointestinal fluid and material to pass through the small bowel due to some sort of blockage. Symptoms include pain, nausea, vomiting and a change in or cessation of bowel sounds. Small bowel obstructions generally cause the bowels to become inflamed and swollen, which can lead to a cut off of the blood supply to the bowel and result in the rupture of the bowel. If the bowel ruptures, it is a very acute, life-threatening situation which must be treated rapidly.

25. Small bowel obstructions are generally classified as a partial or simple obstruction, and a complete or strangulated obstruction. A strangulated small bowel obstruction means the vascular system has been compromised and the blood supply to a part of the bowel has been cut off. If the blood supply has been cut off, the bowel tissue will become gangrenous, then necrotic, and finally die. Surgery can alleviate the strangulation.

26. Strangulated small bowel obstructions represent 20 to 40 percent of all small bowel obstructions. Post-operative

adhesions, bands of scar tissue which form inside the abdomen, are the predominate cause of strangulated bowel obstructions. Severe and constant pain, as opposed to cramping, intermittent pain, can characterize a strangulated small bowel.

27. A strangulated small bowel is a very serious condition. Diagnosis requires obtaining a careful history, recognition of previous operations, a "hands on" physical examination and diagnostic testing. With a small bowel obstruction, a patient's condition can change rapidly, sometimes in a matter of hours. Because any change in the condition of the patient can indicate a significant problem, serial abdominal examinations are important. Early detection and evaluation of complications from small bowel obstructions are also important.

28. In the case of R.A.L., the level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances would have been for Dr. Ford to come to the Hospital and physically examine R.A.L. when the patient was admitted to the Hospital under his care and after Dr. Ford was called by the nurse around midnight, apprising him of R.A.L.'s condition.

29. Dr. Ford did not come to the Hospital to examine from the time R.A.L. was admitted to the Hospital under his care to the time R.A.L. died.

30. A strangulated bowel is a surgical emergency. If a physician fails to diagnose and treat a strangulated small bowel, the patient will likely die. The physician will normally consult a surgeon when the patient presents with a small bowel obstruction. In performing a surgical consult, the surgeon will make the determination of whether and when to perform surgery. The sooner the surgeon is involved, the less the chances of compromising the patient's bowel or general physical condition. Calling a surgeon early in the course of treating a patient with a small bowel obstruction is the prudent thing to do.

31. In the case of R.A.L., the level of care, skill, and treatment, which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, would have been for Dr. Ford to call for a surgical consult when R.A.L. was admitted to the Hospital under his care. Dr. Ford did not call for a surgical consult from the time R.A.L. was admitted to the Hospital under his care to the time R.A.L. died.

CONCLUSIONS OF LAW

32. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. Sections 120.569 and 120.57, Florida Statutes.

33. The Department has alleged that Dr. Ford has violated Section 458.331(1)(t), Florida Statutes, which provides that the following acts are grounds for disciplinary action by the Department:

> 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.

34. The Department must establish the allegations in the Administrative Complaint by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

35. The Department alleged that Dr. Ford violated Section 458.331(1)(t), Florida Statutes, in that he "did not examine Patient R.A.L. or order a consultation with a general surgeon at any time during the approximately eight (8) hours between the time Respondent admitted Patient R.A.L. to his service and the time of Patient R.A.L.’s death, despite being apprised of Patient R.A.L.’s condition."

36. The Department has established by clear and convincing evidence that Dr. Ford failed to practice medicine with the level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances when he failed to come to the Hospital to examine R.A.L. and when he failed to order a surgical consult for R.A.L. Dr. Ford has violated Section 458.331(1)(t), Florida Statutes.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a Final Order be entered finding that Ronald A. Ford, M.D. violated Section 458.331(1)(t), Florida Statutes, placing him on two years' probation, imposing an administrative fine of $5,000, and requiring him to take five hours of continuing medical education in the area of risk management and 16 hours of continuing medical education in the area of diagnosing and treating abdominal and gastrointestinal disorders.

DONE AND ENTERED this 5th day of February, 2002, in Tallahassee, Leon County, Florida.

SUSAN B. KIRKLAND
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 5th day of February, 2002.

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.