STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 01-4923PL

WALTER RAY DEAL, M.D.,

Respondent.

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly-designated Administrative Law Judge, Jeff B. Clark, held a formal administrative hearing in this case on March 22, 2002, in Tampa, Florida.

APPEARANCES

For Petitioner: Ephraim D. Livingston, Esquire
Agency for Health Care Administration
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Tallahassee, Florida 32317-4229

For Respondent: William Taylor, Esquire
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STATEMENT OF THE ISSUES

Whether or not Respondent, Walter Ray Deal, M.D., violated Subsection 458.331(1)(t), Florida Statutes, and, if so, what discipline should be imposed?

PRELIMINARY STATEMENT

On November 19, 2001, Petitioner, Department of Health, Board of Medicine, filed an Administrative Complaint alleging that Respondent, Walter Ray Deal, M.D., failed to practice medicine with that level of care, skill, and treatment, which is recognized by a reasonable prudent similar physician as being acceptable under similar conditions and circumstances in his treatment of Patient E.R. from April 6 through 7, 2002, in violation of Subsection 458.331(1)(t), Florida Statutes.

On December 3, 2001, Respondent filed an Election of Rights disputing the allegations of fact contained in the Administrative Complaint and requesting a formal hearing. On December 27, 2001, the case was transmitted by the Agency for Health Care Administration to the Division of Administrative Hearings.

On December 31, 2001, an Initial Order was sent to the parties. On January 16, 2002, the case was set for final hearing on March 21 and 22, 2002, in Tampa, Florida. On February 21, 2002, Respondent requested that the hearing be rescheduled to March 22, 2002. On March 20, 2002, the parties filed a Joint Prehearing Stipulation which contained admitted facts which are incorporated into this Recommended Order.

At the March 22, 2002, final hearing, Petitioner presented the testimony of Jerry Jacobson, M.D., an expert witness; Barbara Bass, R.N.; and Rajesh Dave, M.D., by deposition. Petitioner presented six exhibits which were admitted into evidence and numbered Petitioner's Exhibits 1-5 and 8.

Respondent presented himself and the testimony of Henry Smoak, III, M.D.; Edward M. Copeland, IV, Esquire; and Don Giffin, L.P.N., by deposition. Respondent offered one exhibit which was admitted into evidence and marked Respondent's Exhibit 1.

At the close of the testimony, the parties requested 30 days after the transcript of proceedings was filed with the Division of Administrative Hearings to file proposed recommended orders. The Transcript of proceedings was filed on April 11, 2002.

On April 4, 2002, Petitioner filed a Motion to Reopen File, which was granted. On April 24, 2002, Respondent filed a Motion for Extension of Time to File Proposed Recommended Orders, which was granted. The parties had until June 10, 2002, to file proposed recommended orders. On June 3, 2002, Petitioner filed a Motion for Extension of Time to File Proposed Recommended Orders, which was granted. The parties had until June 17, 2002, to file proposed recommended orders. Both parties timely filed

Proposed Recommended Orders which were thoughtfully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

Based on the evidence and the testimony of witnesses presented and the entire record in this proceeding, the following findings of fact are made:

1. Petitioner, Department of Health, Board of Medicine, is the state agency charged with regulating the practice of medicine pursuant to Section 20.42, Florida Statutes, Chapter 456, Florida Statutes, and Chapter 458, Florida Statutes.

2. Respondent, Walter Ray Deal, M.D., is and has been, at all times material to the Administrative Complaint filed in this matter, a licensed physician in the State of Florida, having been issued license number ME 0056589.

3. At or around 6:25 p.m. on April 6, 2000, Patient E.R. presented at the Emergency Room of Morton Plant Mease Health Care/North Bay Hospital, with pain and swelling in the right lower extremity.

4. The Emergency Triage/Assessment Form, which is completed by nurses in the Emergency Room, reports that Patient E.R., who was first seen at 6:30 p.m., was 73 years old and had a chief complaint of "pain to RLE [right lower extremity] for a very long time, swollen . . ." This form also contains

information on Patient E.R.'s current medical status including medications and a medical history.

5. Respondent first examined Patient E.R. at approximately 7:15 p.m.; she reported her chief complaint to be chronic pain in the right knee which had worsened since Dr. Zaidi, a rheumatologist, had drained the knee.

6. During his examination, Respondent checked (placed a checkmark) on the Emergency Physician Record indicating that in his examination he found the patient's heart had regular rate and rhythm and normal heart sounds.

7. At 7:30 p.m., Respondent noted in Patient E.R.'s treatment plan: "Labs, Pain Meds, IV Antibx." This record reflects that Respondent ordered that the patient be administered 50 mg of Demerol and 50 mg Phenergan and 500 mg of Leviquin intramuscularly and the ESR (erythrocytic sedimentation rate), which is a nonspecific test for inflammatory responses. The pain medication appears to have been administered almost immediately (7:35 p.m.); the antibiotic at approximately 8:12 p.m.

8. There is controversy about what "Labs" were ordered by Respondent. His testimony indicates that he ordered the CBC, the comprehensive metabolic, and the urine laboratory chemistries.

9. The hospital records indicate that the following additional diagnostic tests were ordered: Cardiac Enzymes and Troponin chemistries, an E.K.G. and portable chest x-ray. It appears from the hospital records that a different writing instrument (the ink colors are different) and, perhaps, a different hand ordered the diagnostic tests mentioned in this paragraph.

10. The results of the chemistries ordered by Respondent are reported on the Emergency Physician Record; the Emergency Physician Record does not contained results of an E.K.G. or x-ray. In addition, laboratory reports for non-cardiac-related chemistries are on Lab Acn# 54968; laboratory reports for cardiac related chemistries are on Lab Acn# 54984. While the sample collection time for the blood tests is 7:20 p.m., the cardiac-related tests were conducted later in the evening than the non-cardiac related tests.

11. The controversy regarding what tests were ordered by Respondent is further clouded by the testimony of Rajesh Dave, M.D., who in the late evening of July 6, 2000, admitted Patient E.R. to the hospital, and Respondent's narrative letter dated February 1, 2001, directed to the Agency for Health Care Administration, in which he acknowledges ordering all of the diagnostic tests mentioned hereinabove.

12. Prior to hearing, Respondent retracted the admission contained in his letter to the Agency for Health Care Administration to ordering the Cardiac Enzymes and Troponin chemistries, the E.K.G. and chest x-ray. The retraction was based on confusion between Respondent and his attorney which was confirmed by the testimony of Edward Copeland, Esquire, the attorney who prepared the narrative letter signed by Respondent. I find that the testimonies of Respondent and Mr. Copeland are credible and find that someone other than Respondent ordered the diagnostic tests which are in question.

13. Dr. Dave denied ordering the cardiac-related tests; he denies even being in the hospital that evening. His testimony is in conflict with Respondent's and Emergency Room Nurse Don Giffin's nursing notes, which state: "Dr. Dave here to examine patient and wrote orders." Dr. Dave became responsible for Patient E.R.'s care and treatment when she was ordered admitted to the hospital at 9:45 p.m.

14. Respondent testified that he had two conversations with Dr. Dave on July 6, 2002; the first, a telephone conversation, immediately prior to first seeing Patient E.R. and the second, a face-to-face conversation, at approximately 9:30 p.m. at the front desk of the Emergency Room. After the second conversation, Respondent wrote orders to admit Patient E.R. for a "23 hour admission" to the hospital as Dr. Dave's

patient and ordered consultations with other physicians. He wrote other admission orders, ordered medications and "ivf d5 1/2 NS 40 meq kcl/l @ 125cc hr" (intravenous fluids one-half normal saline with 40ml equivalents of potassium chloride per liter at 125 cc per hour).

15. North Bay Hospital protocol does not allow an Emergency Room physician to admit a patient to the hospital. Respondent was acting as a scrivener for Dr. Dave when he entered the orders admitting Patient E.R. to the hospital.

16. At 8:17 p.m. the laboratory reported to the Emergency Room that Patient E.R. had a low serum potassium level.

17. Petitioner's expert witness opined that Respondent fell below the standard of care when, after becoming aware of the low serum potassium level (which the expert deemed "critically low"), he did not immediately order an E.K.G. to determine the appropriate speed of potassium supplementation. He further opined that Respondent either did not read the E.K.G. or did not properly evaluate it. He further opined that the rate of potassium supplementation as ordered by Respondent was completely inadequate.

18. The results of the Cardiac Enzymes and Troponin tests were normal. The E.K.G. test was given and the results simultaneously published at 10:04 p.m. The E.K.G. showed a run

of non-sustained ventricular tachycardia which is a potentially fatal arrhythmia.

19. After being ordered admitted as a 23-hour admission as Dr. Dave's patient at 9:45 p.m., Patient E.R. arrived at the 23-hour floor at 10:30 p.m. The hospital records reflect that at 10:20 p.m., the floor nurse was advised by the Emergency Room nurse of the low serum potassium, of the physician's orders for potassium supplementation, and that the potassium supplementation ordered was not available in the Emergency Room. The 23-hour floor nurse's notes reflect that she "advised that we have none at this time."

20. Following Patient E.R.'s admission, at approximately 10:45 p.m., Dr. Dave was called and advised of the admitting orders including the rate of potassium supplementation. While he changed some of the orders, he did not change the rate of potassium supplementation. He did change Patient E.R.'s admission from a 23-hour admission to a full admission which necessitated transferring Patient E.R. to the Third Floor of the hospital.

21. At 11:10 p.m. the 23-hour floor nurse received a bed assignment on the Third Floor and gave a report to the Third Floor nurse; the 23-hour floor nurse's notes include the following: "report . . . including low K [potassium] and need for D5 1/2 NS c 40 meq KCL [the ordered potassium

supplementation] she said they had on 3rd floor and will be able to start fluids."

22. The 11:55 p.m. Third Floor nurse's notes reflect that the "IVF started." Patient E.R. expired shortly after 3:00 a.m.

23. Respondent's expert witness opined that Respondent did not fall below the standard of care in his treatment of Patient E.R.; that is, that Respondent practiced 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. He opined that Respondent rendered appropriate treatment to Patient E.R., who presented with knee pain and had no cardiac or respiratory complaints. He further opined that, while the serum potassium level was low and needed to be addressed, no symptoms or complaints were demonstrated pertaining to low potassium level and nothing was evident that raised cardiac issues; the low potassium was not critically important in this clinical situation and was a common presentation for an older person. He opined that based on the clinical evaluation and findings by the Emergency Room staff and physician, even with the low potassium, no E.K.G. was warranted. I find the opinion rendered by Respondent's expert witness to be more credible than the opinion offered by Petitioner's expert witness and accept the opinion of Respondent's expert. Respondent's expert's opinion was reinforced, in part, by the

continuing treatment afforded Patient E.R. by Dr. Dave after she was admitted to the hospital.

CONCLUSIONS OF LAW

24. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this cause pursuant to Subsection 120.57(1), Florida Statutes.

25. The Board of Medicine is empowered to revoke, suspend or otherwise discipline the license of a physician for violation of Subsection 458.331(1)(t), Florida Statutes.

26. License revocations and discipline procedures are penal in nature. Petitioner must demonstrate the truthfulness of the allegations in the Administrative Complaint dated November 19, 2001, by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

27. The "clear and convincing" standard requires:

> [T]hat the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

28. Because the discipline imposed for the violation of Subsection 458.331(1)(t), Florida Statutes, is penal in nature, the statute alleged to have been violated, must be strictly construed in favor of the licensed physician. Breesmen v. Department of Professional Regulation, Board of Medicine, 567 So. 2d 469 (Fla. 1st DCA 1990); Farzad v. Department of Professional Regulation, 443 So. 2d 373 (Fla. 1st DCA 1983); Bowling v. Department of Insurance, 394 So. 2d 165 (Fla. 1st DCA 1981).

29. Where the licensee is charged with a violation of professional conduct and the specific acts or conduct required of the professional are explicitly set forth in the statute or valid rule promulgated pursuant thereto, the burden on the agency is to show a deviation from the statutorily-required acts; but where the agency charges negligent violation of general standards of professional conduct, i.e., the negligent failure to exercise the degree of care reasonably expected of a professional, the agency must present expert testimony that proves the required professional conduct, as well as the deviation therefrom. Purvis v. Department of Professional Regulation, 461 So. 2d 134 (Fla. 1st DCA 1984).

30. Petitioner has charged Respondent with violating the following relevant provisions of Subsection 458.331(1)(t), Florida Statutes:

> [T]he 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.

31. Petitioner failed to prove that, under the circumstances, Respondent deviated from the appropriate standard of care. While there is the proven occurrence of the tragic death of a patient, that incident alone does not indicate Respondent fell below the standard of care.

32. In arriving at his opinion, Petitioner's expert witness testified that Respondent failed to do several things that the expert witness felt should have been done: (1) he failed to order an E.K.G. in response to the "critically low" serum potassium level; (2) if he did order an E.K.G., he failed to look at it or he failed to properly evaluate it; and (3) the potassium supplementation he ordered was inadequate.

33. In each instance, persuasive evidence was presented that Respondent did not deviate from the standard of care. Evidence was offered that Patient E.R.'s symptoms, as presented in the Emergency Room prior to her admission to the hospital, warranted the course of treatment ordered by Respondent. It was not established that he ordered, or should have ordered, an E.K.G. or ever saw the E.K.G. results on the evening of her admission; he certainly did not note the results in the Emergency Physician Record. While there is a consensus that

Patient E.R.'s potassium level was low, there is marked disagreement as to its "criticalness," and to the appropriate level of potassium supplementation ordered by Respondent given the symptoms demonstrated by the patient.

34. Such equivocal evidence on the critical allegations of "failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician . . ." does not satisfy the clear and convincing standard of proof imposed by Florida law.

RECOMMENDATION

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

RECOMMENDED that Petitioner enter a final order finding that Respondent is not guilty of violating Subsection 458.331(1)(t), Florida Statutes, as alleged in the Administrative Complaint.

DONE AND ENTERED this 2nd day of July, 2002, in Tallahassee, Leon County, Florida.

JEFF B. CLARK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 2nd day of July, 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.