STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 02-1228PL
J. ANTONIO ALDRETE, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Administrative Law Judge Don W. Davis conducted the administrative hearing in this matter on June 13-14, 2002, in Shalimar, Florida, on behalf of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Shirley J. Whitsitt, Esquire
James W. Earl, Esquire
Senior Attorneys
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For Respondent: Jon M. Pellett, Esquire
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent committed violations of Section 458.331(1), (t), (q), and (m), Florida

Statutes, justifying the imposition of disciplinary measures against Respondent's medical license, and if so, what penalties should be imposed.

PRELIMINARY STATEMENT

An Administrative Complaint was filed by Petitioner in Department of Health (DOH) Case No. 1999-58907, on February 25, 2002, against Respondent's license to practice medicine. The Administrative Complaint charged Respondent with three violations of the medical practice act, specifically those proscriptions set forth in Section 458.331(1)(t), (q), and (m), Florida Statutes. All three charges or counts in the Administrative complaint were premised on his care and treatment of patient J.S. on July 28, 1999. Respondent timely disputed the allegations of the Administrative Complaint and the case was referred to the Division of Administrative Hearings for formal hearing.

At the final hearing, Petitioner presented the testimony of Joyti Patel, M.D., as an expert witness via teleconference and offered five (5) exhibits in evidence, including a transcript of the deposition of B.S., the husband of J.S., which was admitted with reservation pending a later ruling on Respondent’s objections to the deposition. Respondent’s Motion to exclude portions of B.S.’s deposition testimony is now denied and the deposition transcript has been considered in preparing this Recommended Order.

At the final hearing, Respondent testified in his own behalf, and offered the testimony of Thomas Brown, M.D., Sonya Johnson, Frederika Monpetit, and Valentina Aldrete; and the expert testimony of William Witt, M.D. and Herbert Ferrari, M.D. Respondent also presented a total of 13 exhibits.

At the request of the parties, time was extended for the filing of proposed recommended orders (PROs). The two-volume Transcript was filed July 9, 2002. Petitioner and Respondent filed their respective PROs and those submittals have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Petitioner is the state agency responsible for regulating the practice of medicine in Florida pursuant to Section 20.43 and Chapters 456 and 458, Florida Statutes.

2. Respondent is a licensed medical physician in Florida holding license number ME 15595. Respondent received his Florida license in 1970 and at the time of the formal hearing, he had practiced medicine for 42 years. He is Board-certified in Anesthesiology with a Certificate of Added Qualification in Pain Management. He was Board-certified in anesthesiology in 1967 and received his certificate of added qualification in Pain Management when it was first offered in 1993.

3. Respondent first evaluated J.S. on December 11, 1998. At that time, J.S. sought treatment from Respondent for complaints of severe back and leg pain. She had quite a lengthy history of back problems, having suffered falls in 1986 and 1994, and having undergone four previous back surgeries.

4. J.S. had seen various physicians for her complaints, and was on various medications, including Prozac, Klonopin, Prilosec, Premarin, levothyroxine, and hyoscyamine. She reported a history of thyroidectomy due to thyroid cancer, hysterectomy, sinus surgery, and excision of fibromatous tumor from her right shoulder. She also reported a history of seizures.

5. On her initial visit to Respondent's office, J.S. completed a Pain Management Questionnaire. On the questionnaire, she indicated she was often forgetful and suffered from memory deficits and problems with her ability to concentrate.

6. Between December 1998 and July 28, 1999, J.S. was treated about seven times by Respondent for her back pain. The treatment consisted of insertion of an epidural catheter and infusion pump in her back, which would release various medications, for the purpose of relieving her back pain. J.S. often returned to the office for dressing changes, pump refills, and reinsertion of the epidural catheter. These procedures were

all completed successfully, without complication. J.S. was very happy with the results, and reported that the medication administered via the pump was her only relief from pain.

7. On July 28, 1999, Patient J.S. saw the Respondent for this same procedure. The evidence is undisputed that this type of treatment by Respondent was medically appropriate to address J.S.'s pain condition.

8. Respondent placed a catheter through a needle, removed the needle, and tunneled the catheter – i.e., placed it underneath the skin in the back of J.S. at the L2-L3 level of her back. Respondent then injected medication, including Marcaine and Fentanyl into the catheter between 11:33 a.m. and 11:45 a.m. Shortly after the Respondent administered the last injection of Marcaine to J.S., she said her right leg was getting numb.

9. Because J.S. stated she had leg numbness, Respondent turned off the pump to prevent the further release of medications into J.S. He then left the room to talk to a new patient. Respondent returned to the room approximately five minutes later upon being informed by his office staff that there was a problem with J.S. When Respondent entered the room, he found that J.S. was pale, unresponsive, and barely breathing; her heart rate was 39.

10. The intrathecal space is the spinal canal where spinal fluid is located. The epidural space is close to the intrathecal space, and it is easy to go from one space to the other when trying to inject within the epidural space.

11. Having Marcaine enter the intrathecal space and having the patient experience a “high spinal” are known complications of the procedure performed on J.S.

12. A “high spinal” can cause significant numbness. As the medication rises up the spinal fluid, it can cause visual dilation, cardiovascular vascular collapse, and respiratory problems. For this reason, the occurrence of a “high spinal” is risky.

13. A physician knows a “high spinal” may be occurring if a patient complains of numbness in the lower extremities. As the medication rises upwards toward the upper extremities, the patient can complain of difficulty breathing, and experience a drop in blood pressure and heart rate. Such patients become obtunded, or unresponsive, requiring resuscitation.

14. It is uncontroverted that J.S. sustained a “high spinal” on July 28, 1999, which is a serious medical complication and life-threatening situation. One of the dangers to J.S. during the time she experienced the “high spinal” was the deprivation of oxygen to her organs, including her brain.

15. Respondent had left the room and did not return until he was notified by office staff of a problem with J.S. As a result, Respondent did not know how long Patient J.S. had been without adequate perfusion of her organs, although he estimated that it could have been anywhere from 30 seconds to two minutes.

16. As depicted in Petitioner's proposed recommended order and undisputed by Respondent, treatment and legend drugs administered to J.S. from about noon on July 28, 1999, until about 6 p.m., when Respondent called for an ambulance, are as follows:

TIME (approximately)	EVENTS
11:55 am	The Respondent began resuscitative efforts on Patient J.S. by administering oxygen via Ambu bag at 6 liters/minute.
11:58 am	The Respondent then ordered the nurse to administer 50mg of Ephedrine (a drug used in the treatment of allergies and asthma) and .15 mg of Epinephrine (a potent stimulant of the sympathetic nervous system) to Patient J.S. in the left deltoid region.

12:00 pm	The Respondent started an IV of 500 cc of Lactated Ringers (a solution containing sodium chloride, potassium chloride, calcium chloride, and sodium lactate in distilled water used to replenish the body's fluids and electrolytes) in Patient J.S.'s left elbow at 75cc/hr and inserted a tracheal tube since Patient J.S's oxygen saturation level was in the 80% range.
12:01 pm	The Respondent administered 50 mcg of Epinephrine to Patient J.S. intravenously.
12:35 pm	The Respondent administered 5 cc of 2% Lidocaine (a drug used as a local anesthetic and to alleviate irregularities in the force or rhythm of the heart) to Patient J.S. intertracheally.
12:36 pm	The Respondent administered 2 cc of 2% Lidocaine to Patient J.S. intravenously.
12:37 pm	The Respondent pulled out the epidural catheter from Patient J.S.'s back.

12:38 pm	The Respondent administered 50 mcg of Epinephrine to Patient J.S. intravenously.
12:39 pm	The Respondent administered 100 mg of Dilantin (a drug used to control seizures) to Patient J.S. intravenously and noted that Patient J.S.’s temperature was 95.6 degrees Fahrenheit.
12:40 pm	The Respondent administered 50 mg of Bretylium (a drug used to treat rapid heart rate and irregularities in the rhythm of the heart) to Patient J.S. intravenously and noted that Patient J.S.’s pulse was 150 and her blood pressure was 178/111.
12:45 pm	The Respondent administered 50 ml of 8.4% Sodium Bicarbonate solution (baking soda) to Patient J.S. intravenously and noted that Patient J.S.’s blood pressure was 163/89, her oxygen saturation was 99%, and her pulse was 142.

1:00 pm	The Respondent tried to start another IV of 500 ml of Lactate Ringers in Patient J.S.’s left foot, but was unsuccessful. The Respondent noted that Patient J.S.’s blood pressure was 96/58 and pulse was 128.
1:08 pm	The Respondent administered 200 mcg of Neosynephrine (a decongestant which constricts blood vessels) to Patient J.S. intravenously.
1:15 pm	The Respondent started another IV in Patient J.S.’s right jugular vein.
1:45 pm	The Respondent noted that Patient J.S.’s blood pressure was 113/71, pulse was 114, and oxygen saturation was 99%.
1:49 pm	The Respondent administered 0.1 mg of Narcan to Patient J.S. intravenously.
1:53 pm	The Respondent administered 0.1 mg of Narcan (a drug used to reverse the effects of opiods) to Patient J.S. intravenously.

1:54 pm	The Respondent decreased the amount of oxygen being administered to Patient J.S. by way of the Ambu bag from 6 liters/minute to 4 liters/minute.
2:00 pm	The Respondent discontinued the IV in the right jugular vein because it was found to be infiltrated.
2:01 pm	The Respondent administered 200 mcg of Neosynephrine to Patient J.S. intravenously in the left arm and started another IV in the left foot.
2:13 pm	The Respondent suctioned Patient J.S.’s trachea and added a second airway.
2:30 pm	The Respondent noted that Patient J.S. was breathing on her own, though she was wheezing and having labored respirations; her temperature was 96.1 degrees Fahrenheit, her blood pressure was 100/68, her pulse was 124, and her oxygen saturation was 92%.
2:34 pm	The Respondent administered 300 mcg of Neosynephrine to Patient J.S.

2:45 pm	The Respondent administered 12 mg of Dexamethasone (a drug used to treat inflammatory disorders) to Patient J.S. intravenously.
2:52 pm	The Respondent decreased the amount of oxygen being administered to Patient J.S. by way of the Ambu bag from 4 liters/minute to 1 liter/minute and noted that Patient J.S.'s blood pressure was 109/71, pulse was 126, and oxygen saturation was 94%.
3:00 pm	The Respondent pulled the tracheal tube out to 22 cm and re-taped it.
3:35 pm	The Respondent administered 3 cc of 2% Xylocaine (a drug used to alleviate rhythmic irregularities in the heart) to Patient J.S. via the tracheal tube.
3:59 pm	The Respondent administered 500 mg of Solu-cortef (a drug used to suppress normal immune response and inflammation) to Patient J.S. intravenously.

4:00 pm	The Respondent placed a nerve stimulator on Patient J.S.’s right temporal nerve to check nerve response and noted that the patient moved her head toward the right when the nerve stimulator was activated.
4:20 pm	The Respondent noted that Patient J.S. was moving all four extremities and opening her eyes on command.
4:50 pm	The Respondent administered 2 puffs of Azmacort (a drug used to combat asthma attacks) to Patient J.S. through the tracheal tube.
5:09 pm	The Respondent started an IV of 500 ml of Lactated Ringers in Patient J.S.’s left foot.
5:10 pm	The Respondent administered 1 mg of Brevibloc (a drug used to lower blood pressure) to Patient J.S. intravenously.
5:14 pm	The Respondent administered 1 mg of Brevibloc to Patient J.S. intravenously.

5:24 pm	The Respondent administered 250 mcg of Lanoxin (a drug used to increase cardiac output and lower the heart rate) to Patient J.S. intravenously.
5:35 pm	The Respondent administered 250 mcg of Lanoxin to Patient J.S. intravenously.
5:36 pm	The Respondent administered dura tears ointment to Patient J.S.'s eyes.
5:58 pm	The Respondent called 911 for emergency transport of J.S. to the hospital.

17. Following Respondent's 911 call for a ambulance crew to transport J.S. to Fort Walton Beach Medical Center at approximately 5:58 p.m., Emergency Medical Services (EMS) personnel arrived at approximately 6:15 p.m.

18. When the EMS personnel arrived at the Respondent's office, J.S. was unstable, with a high heart rate of 153, pale, and unresponsive.

19. At approximately 6:40 p.m., J.S. arrived at Fort Walton Beach Medical Center and was admitted to the Emergency Room.

20. Respondent was not allowed to see J.S. at the hospital.

21. As established by testimony of Dr. Patel, Petitioner's Expert, the Standard of Care required of the Respondent after he

administered Marcaine to J.S. and heard her state that her right leg had become numb, was to closely monitor the patient by looking for the signs of a developing "high spinal." Respondent failed to meet the Standard of Care in treating J.S. when he left her in the treatment room with only a licensed practical nurse (LPN) with no specific training in resuscitation or dealing with potential complications arising from the procedure.

22. Additionally, as established by the testimony of Dr. Patel, Respondent failed to meet the Standard of Care when he failed to call in a timely manner for emergency personnel to transport J.S. to the hospital where she would have been better monitored and treated for complications. Instead, he pursued resucitative measures on J.S. for about six hours. A time period which extended about four and one-half hours beyond the maximum time period that Dr. Patel, Petitioner's expert, opined was acceptable.

23. An additional aggravating factor in this matter is Respondent's prior disciplinary history with the State of Ohio received in evidence pursuant to Rule 64B8-8.002, Florida Administrative Code.

CONCLUSIONS OF LAW

24. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter.

The parties received adequate notice of the administrative hearing. Section 120.57(1), Florida Statutes.

25. The burden of proof is on Petitioner. Petitioner must show by clear and convincing evidence that Respondent committed the violations alleged in Administrative Complaint and the reasonableness of any proposed penalty. Department of Banking and Finance, Division of Securities and Investor Protection vs. Osborne Stern and Company, 670 So. 2d 932, 935 (Fla. 1996); State ex rel. Vining v. Florida Real Estate Commission, 281 So. 2d 487 (Fla. 1973); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1st DCA 1987).

26. Petitioner satisfied its burden of proof with regard to Count one of the Administrative Complaint. The proof is clear and convincing that Respondent violated the Standard of Care with regard to the time that he permitted to elapse before EMS personnel were called and transported J.S. to the hospital. Additionally, Respondent violated this standard through his absence from the treatment room after symptoms of a high spinal were beginning to be manifested. Clear and convincing evidence has both qualitative and quantitative requirements. The factual testimony of Petitioner's expert, and the records submitted in the case satisfy both the qualitative and quantitative requirements for clear and convincing evidence.

27. The evidence is not clear and convincing with regard to Count two of the Administrative Complaint, alleging violation of the proscription against failure to keep adequate records justifying the course of treatment. Respondent kept appropriate records. Further, the parties do not dispute the propriety of the procedure performed by Respondent on J.S. The course of treatment reflected in records of J.S., should not be confused with the real issue at hand, i.e., whether Respondent violated the Standard of Care by waiting an excessive length of time before sending J.S. to the hospital.

28. Count three of the Administrative Complaint accuses Respondent of the violation of administering legend drugs in inappropriate or excessive quantities. Credible evidence that Respondent committed this violation does not rise to level of the required standard of clear and convincing. Accordingly, Respondent is not guilty of commission of this alleged offense.

29. Pursuant to Section 458.331(2), Florida Statutes, the Board of Medicine is empowered to revoke, suspend, or otherwise discipline the license to practice medicine of any physician found to have committed a violation of the offenses alleged in this cause.

30. Rule 64B8-8.001-2, Florida Administrative Code (1999) places the appropriate penalty for violating the standard of care proscribed by Section 458.331(1)(t), Florida Statutes,

within a guideline range of two years probation to revocation, or denial of licensure; and an administrative fine from $250 to $5,000.

RECOMMENDATION

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

RECOMMENDED:

That in accordance with Petitioner's disciplinary guidelines, that a final order be entered finding Respondent guilty of violating Section 458.331(1)(t), Florida Statutes; suspending Respondent's license for one year to be re-instated only upon completion of 20 hours of continuing medical education above the minimum required for maintenance of licensure with the area of study for such additional hours to be determined by the Board of Medicine; and imposition of a fine of $5,000.

DONE AND ENTERED this 8th day of August, 2002, in Tallahassee, Leon County, Florida.

DON W. DAVIS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 8th day of August, 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.