STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 03-1614PL
JOSE ROSADO, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Administrative Law Judge Don W. Davis of the Division of Administrative Hearings (DOAH) held a formal hearing in the above-styled case on August 13, 2003, in Tavares, Florida.

APPEARANCES

For Petitioner: Kim M. Kluck, Esquire
Department of Health
Prosecutorial Services Unit
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Tallahassee, Florida 32399-3265

For Respondent: William M. Furlow, Esquire
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STATEMENT OF THE ISSUE

The issue in this case is whether Jose Rosado, M.D., (Respondent), violated Section 458.331(1)(t), and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaint filed on November 13, 2002, the Department of Health (Petitioner) alleged 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. Specifically, it is alleged that Respondent failed to contact an infectious disease specialist for a consultation during treatment of a patient and/or failed to treat that patient for a resistant strain of staphylococcus with the minimum treatment of ten to fourteen days of intravenous antibiotics. Petitioner has alleged Respondent's action constitutes a violation of Section 458.331(1)(t).

Respondent disputed the allegations of the Administrative Complaint and requested formal administrative proceedings. The matter was transferred to DOAH on May 2, 2003.

At the final hearing, Respondent testified on his own behalf and presented the deposition testimony of Felipe Ortiz, M.D. In addition, Respondent offered three medical journal articles into evidence as Respondent’s Exhibits A, B, and C. Petitioner objected on the grounds of hearsay and relevance to all three exhibits and ruling was reserved at that time. The journal articles have not been established as authoritative treatises and were not established as such through Respondent's

expert witness. It is determined that the journal articles are not admissible. Petitioner presented the deposition testimony of Carlos Sotolongo, M.D. The parties also presented three joint exhibits.

A Transcript of the final hearing was filed on August 27, 2003. The parties requested and were granted leave to file Proposed Recommended Orders more than ten days after the filing of the transcript.

Both Respondent and Petitioner filed Proposed Recommended Orders, which have been reviewed in conjunction with the preparation of this Recommended Order and addressed to the extent possible.

All citations are to Florida Statutes (2002) unless otherwise indicated.

FINDINGS OF FACT

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Florida law.

2. At all times material to these proceedings, Respondent has been a licensed physician in the State of Florida, having been issued license number ME 0068035.

3. Respondent is board-certified in internal medicine and cardiovascular diseases.

4. On March 10, 1997, Patient W.B.C., a 72-year-old man, arrived at the Leesburg Regional Medical Center (LRMC) emergency

room. He complained of a sudden onset of weakness in his left hand and arm with numbness and tingling.

5. Respondent was Patient W.B.C.'s primary care physician. Respondent admitted Patient W.B.C. with a diagnosis of cerebrovascular accident, mitral regurgitation, sick sinus syndrome and a history of myocardial infarction. Respondent ordered that Patient W.B.C. undergo a head CT scan, carotid Doppler, 2-D echocardiogram, an electroencephalogram, and a neurological consultation.

6. Based on the test results and the consultation, Respondent diagnosed Patient W.B.C. with right cerebrovascular accident, mitral regurgitation, sick sinus syndrome, and history of myocardial infarction. Respondent then discharged the patient with Ticlid, a medication to prevent further cerebrovascular accidents and aspirin.

7. On March 16, 1997, Patient W.B.C. was admitted to LRMC complaining of weakness, dizziness and a fever. His vital signs revealed a temperature of 103.0 F, a pulse of 118, and a blood pressure of 139/75. The emergency room physician ordered a chest x-ray, EKG, and urine and blood cultures.

8. The chest x-ray revealed no acute cardiopulmonary abnormality. Urine tests revealed features consistent with the possibility of urosepsis. Blood work showed a white blood count of 9.15, elevated but within the normal range.

9. Also on March 16, Respondent ordered that antibiotics be given prophylactically until the blood cultures came back from the laboratory.

10. The cultures came back positive for staphylococcus aureus (staph). Staph is a notoriously "bad bug" and Staphylococci aureus bacteremia has a high mortality rate. Staph aureus can originate from several possible sources including infections through the urinary tract system, IV sites, aspiration into the lungs, and pneumonia (although not very common).

11. Staphylococci in the bloodstream is known as bacteremia. Bacteremia can lead to endocarditis which is an infection of the inner lining of the heart and the heart valves. Endocarditis is a life-threatening condition that can quickly damage the heart valves and lead to heart failure or even death.

12. Patients with certain cardiac conditions such as mitral valve regurgitation have a higher risk of developing endocarditis. Patient W.B.C. had such a history.

13. On March 17, 1997, Patient W.B.C. was started on intravenous antibiotics by Respondent. Patient W.B.C. continued to receive the intravenous antibiotics for four days from March 17, 1997, through March 20, 1997.

14. Respondent then switched Patient W.B.C. to oral antibiotics and kept the patient in the hospital one more day

prior to discharging him with instruction to continue on the oral antibiotics for another ten days.

15. Patient W.B.C. was discharged on March 21, 1997. He was not referred to an infectious disease specialist nor had Respondent obtained a consultation with any specialist to determine the length of time that the patient's infection should be treated. Respondent felt that he was adequately qualified to treat this patient, and the treatment appeared to work. Respondent thought the bacteria growing in the patient's blood "likely" originated from a lung infection.

16. An infectious disease specialist should have been consulted to give guidance as to how long to treat the infection. The standard of care for treating a staph aureus infection where there is a known source of infection requires 14 days of intravenous antibiotics. Where the source is not known, then four to six weeks of antibiotics is recommended. In this case, the infection, a resistant staph infection found in the patient's blood, could have originated from several sources. While such staph could have sprung from a source in the lung, this is by no means likely and the infection could have originated from another source.

17. The standard of care required that Respondent contact an infectious disease specialist for an evaluation and/or that

he treat Patient W.B.C.'s staphylococcus with a minimum of 10 to 14 days of intravenous antibiotics.

18. On or about April 11, 1997, Patient W.B.C., presented to the emergency room at LRMC complaining of congestion, shortness of breath, fever of 100.3° F, and a cough. The emergency room physician performed a physical exam which revealed vital signs of a temperature of 101.3° F, a pulse of 104, and a blood pressure of 90/54. A chest x-ray, blood work and a urine culture were ordered.

19. Patient W.B.C. was then admitted on April 11, 1997, with a diagnosis of pneumonia, an old cerebrovascular accident and coronary artery disease. The ER physician started Patient W.B.C. on a plan of treatment which included intravenous antibiotics, Vancomycin, IV fluids, and blood cultures. A physical examination on the patient revealed a temperature of 101.3° F, a pulse of 104 and blood pressure of 91/53. The attending physician diagnosed him with probable sepsis with pneumonia.

20. On April 12, 1997, the blood cultures came back positive for Staphylococcus aureus bacteremia.

21. On April 15, 1997, Patient W.B.C. was afebrile (without fever) and his white blood cell count was 10.23, which is within the normal range of 4.0 to 11.0. The patient

continued in this condition through April 18, 1997, despite suffering from sepsis.

22. On April 18, 1997, Respondent approved Patient W.B.C. for transfer to another institution for consideration for urgent mitral valve replacement. On April 19, 1997, Patient W.B.C. arrested and was pronounced dead at 5:53 a.m.

23. Petitioner's expert, Carlos Sotolongo, M.D., is board-certified in internal medicine, cardiovascular disease and nuclear cardiology. As established by Dr. Sotolongo's testimony, Respondent practiced below the standard of care by failing to treat Patient W.B.C. with a sufficient number of days of intravenous antibiotics and by failing to consult an infectious disease specialist. According to Dr. Sotolongo, there is a difference in the way that an uncomplicated pneumonia is treated as opposed to a pneumonia complicated by bacteremia. The latter must be treated more aggressively.

24. Based on the foregoing, Respondent violated Section 458.331(1)(t), by failing 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.

CONCLUSIONS OF LAW

25. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding, pursuant to Sections 120.569 and 120.57(1).

26. Pursuant to Section 458.331(2), Petitioner, Board of Medicine is empowered to revoke, suspend or otherwise discipline the license of a physician for the following violation of Section 458.331(1):

> (t) Failing 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.

27. License disciplinary proceedings are penal in nature. State ex rel. Vining v. Florida Real Estate Commission, 281 So. 2d 487 (Fla. 1973). In this disciplinary proceeding, Petitioner must prove the alleged violations of Section 458.331(1)(t), Florida Statutes, by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1st DCA 1987).

28. Petitioner in this case has demonstrated, by clear and convincing evidence, that the 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.

29. The disciplinary guidelines of the Board of Medicine, found at Rule 59R-8.001, Florida Administrative Code, provide a

range of penalties for violations of the provisions of Section 458.331(1)(t), as follow:

> (t) Failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent physician as being acceptable under similar conditions and circumstances--From two(2) years probation to revocation or denial, and an administrative fine from $250.00 to $5,000.00.

RECOMMENDATION

Based on the foregoing, it is recommended that a Final Order be entered finding that Respondent violated Section 458.331(1)(t), and imposing a penalty which includes a formal reprimand, payment of an Administrative Fine in the amount of $5,000.00 within 180 days, and eight hours of Continuing Medical Education (CME) to be completed within the next 12 months dealing with the diagnosis and treatment of infections and/or risk management.

DONE AND ENTERED this 1st day of October, 2003, 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
Division of Administrative Hearings
this 1st day of October, 2003.

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.