STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 05-4576PL
MANUEL ALVARADO, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case before Larry J. Sartin, an Administrative Law Judge of the Division of Administrative Hearings, on April 6 and 7, 2006, in Tavares, Florida.

APPEARANCES

For Petitioner: Lynne A. Quimby-Pennock
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For Respondent: Carl Motes, Esquire
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STATEMENT OF THE ISSUE

The issue in this case is whether Respondent, Manuel Alvarado, M.D., committed violations of Chapter 458, Florida

Statutes, as alleged in an Administrative Complaint issued by Petitioner, the Department of Health, on July 19, 2005, in DOH Case Number 2004-00926, and amended by Order entered March 31, 2006; and, if so, what disciplinary action should be taken against his license to practice medicine in Florida.

PRELIMINARY STATEMENT

On or about July 19, 2005, the Department of Health filed an Administrative Complaint against Respondent Manuel Alvarado, M.D., an individual licensed to practice medicine in Florida, before the Board of Medicine, in which it alleged that Dr. Alvarado had committed violations of Section 458.331(1)(t), Florida Statutes (2003).[1] Respondent disputed the allegations of fact contained in the Administrative Complaint and requested a formal administrative hearing pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes (2005).[2]

On December 16, 2005, the matter was filed with the Division of Administrative Hearings with a request that an administrative law judge be assigned to conduct proceedings pursuant to Section 120.57(1), Florida Statutes (2005). The matter was designated DOAH Case Number 05-4576PL and was assigned to Administrative Law Judge Charles C. Adams. The case was transferred to the undersigned on or about April 4, 2006.

The final hearing was scheduled to be held on March 14 and 15, 2006, by Notice of Hearing entered January 10, 2006. The

hearing was subsequently continued in response to a Joint Motion for Continuance filed February 17, 2006. The final hearing was rescheduled for April 6 and 7, 2006.

On March 30, 2006, Petitioner's Motion to Amend Administrative Complaint was filed. In the Motion Petitioner sought leave to amend paragraphs 5 and 8 of the Administrative Complaint to reflect that the date of the events alleged therein started was "August 18, 2003" rather than "August 19, 2003." The Motion was granted by Order entered March 31, 2006.

On March 31, 2006, a Joint Pre-hearing Stipulation was filed by the parties. The Joint Pre-hearing Stipulation contains "Facts Admitted and Requiring No Proof." Most of those admissions have been incorporated into the Findings of Fact of this Recommended Order and have been identified as "Admitted Facts."

At the final hearing Petitioner presented the testimony of Patient O.C., Anna W. Wimberly, R.N.,[3] and Penny Danna,[4] M.D., who was accepted as an expert in this matter.[5] Petitioner offered and had admitted Petitioner's Exhibits 1 through 3.[6]

Respondent testified on his own behalf and presented the testimony of Shivakumar S. Hanubal, M.D. Dr. Hanubal was accepted as an expert in obstetrics and gynecology. Respondent also offered and had admitted Respondent's Exhibits 1 and 2.

Respondent's Exhibit 1 is the one-volume Transcript of the deposition testimony of Alfred H. Moffett, Jr., M.D.

Joint Exhibits 1 and 2 were also offered by the parties and were admitted.

The two-volume Transcript of the final hearing was filed on May 5, 2006. By Notice of Filing Transcript entered May 8, 2006, the parties were informed that the Transcript had been filed and that their proposed recommended orders were to be filed on or by May 15, 2006. Both parties filed proposed recommended orders on May 15, 2006. The proposed orders of both parties have been fully considered in rendering this Recommended Order.

On June 1, 2006, Respondent filed Exceptions to Petitioner's Proposed Recommended Order. On June 5, 2006, Petitioner filed Petitioner's Motion to Strike Respondent's "exceptions to Petitioner's Proposed Recommended Order." Petitioner has pointed out that the time to file "exceptions" is after a recommended order is entered and the place to file is with the agency. Petitioner has represented that Respondent has no objection to the Motion and it is, therefore, granted. No consideration has been given to the exceptions.

FINDINGS OF FACT

A. The Parties.

1. Petitioner, the Department of Health (hereinafter referred to as the "Department"), is the agency of the State of Florida charged with the responsibility for the investigation and prosecution of complaints involving physicians licensed to practice medicine in Florida. § 20.43 and Chs. 456 and 458, Fla. Stat. (2005). (Admitted Facts).

2. Respondent, Manuel Alvarado, M.D., is, and was at the times material to this matter, a physician licensed to practice medicine in Florida, having been issued license number ME 59124. (Admitted Facts). Dr. Alvarado has been licensed in Florida since 1991. Dr. Alvarado's mailing address of record is 1414 East Main Street, Leesburg, Florida 34748. (Admitted Facts). Dr. Alvarado has practiced medicine in Leesburg, Florida since June 1991.

3. Dr. Alvarado is board-certified in Obstetrics and gynecology. (Admitted Facts).

4. No evidence that Dr. Alvarado has previously been the subject of a license disciplinary proceeding was offered.

B. Patient O.C.

5. At issue in this case is Dr. Alvarado's treatment of Patient O.C., on August 18 and 19, 2003.

6. Patient O.C. at the times relevant in this case was 25 years of age.

7. Patient O.C., at all times relevant, was pregnant. This was Patient O.C.'s first pregnancy. After becoming pregnant, Patient O.C. utilized Advanced Obstetrics and Gynecology (hereinafter referred to as "Advanced") for pre-natal care. Advanced, located in Leesburg, Florida, was at the times relevant to this matter a group practice conducted by Shivakumar S. Hanubal, M.D., and Dr. Alvarado.

8. Patient O.C. was attended primarily by Dr. Shivakumar, but she was also seen on one or two occasions for pre-natal care by Dr. Alvarado.

C. Patient O.C. was a High-Risk Patient.

9. Patient O.C. was considered to be a "high-risk" patient due to three factors.

10. First, Patient O.C. was obese. When she first reported for pre-natal care she weighed approximately 285 pounds. Her weight increased to between 300 and 330 pounds by August 18, 2003.

11. Obesity is considered a "high-risk" factor because obese patients generally have a higher risk for gestational diabetes, preeclampsia,[7] and a large fetus. Additionally, obesity results in additional problems during labor including an increased incidence of cesarean section delivery.

12. Secondly, Patient O.C. was diagnosed with gestational diabetes, which occurs in some women during pregnancy.

13. Gestational diabetes can cause the baby to be large or "macrosomic," which in turn can cause complications during delivery. It can also cause an excess amount of amniotic fluid, referred to as polyhydramnios. There is also a higher rate of fetal mortality when gestational diabetes is present. Gestational diabetes can, however, be controlled and, in the case of Patient O.C., it was.

14. Finally, Patient O.C. smoked cigarettes. She smoked both before and during her pregnancy.

15. Smoking reduces oxygenation to the uterus, placenta, and the fetus. This increases the risks of intrauterine birth growth restriction and increases the risk of placental abruption (where the placental sheers off the wall of the uterus) as well.

16. Dr. Alvarado was aware that Patient O.C., due to her weight, the gestational diabetes, and her smoking, was a "high risk" patient. The evidence failed to prove that Dr. Alvarado failed to consider this fact in his treatment of Patient O.C.

D. The Events of August 18, 2003.

17. On August 18, 2003, Patient O.C. noticed that she had begun to discharge mucus with pinkish streaks/dark brown spots. (Admitted Facts). Becoming concerned, she telephoned Advanced, and after speaking with someone at Advanced's answering service,

received a telephone call from Dr. Alvarado, who was the "on call" obstetrician at Leesburg Regional Medical Center (hereinafter referred to as "Leesburg Regional") that day. (Admitted Facts). Dr. Alvarado was also the on-call physician for Advanced. Dr. Alvarado had arrived at Leesburg Regional at approximately 6:00 a.m., August 18, 2003, where he remained until sometime after 2:15 a.m., August 19, 2003. (Admitted Facts).

18. Dr. Alvarado spoke with Patient O.C., who advised him of the mucus discharge. When he asked whether she had felt any fetal movement, she indicated that the baby was moving but "not as usual."[8] (Admitted Facts). Dr. Alvarado advised her to go to the labor room of Leesburg Regional for a non-stress test.[9] (Admitted Facts). Dr. Alvarado contacted the labor room to report that Patient O.C. was to be evaluated and asked that a non-stress test be performed on her and that he be informed of the results. (Admitted Facts).

19. As directed, Patient O.C. presented to the Leesburg Regional maternity unit at approximately 8:05 p.m. (Admitted Facts), after initially reporting to the emergency room.

20. Dr. Alvarado was contacted about Patient O.C. at about 8:30 p.m., at which time he gave a verbal order to place an external fetal heart monitor on Patient O.C. (Admitted Facts).

21. A fetal heart monitor measures the heart beat of a fetus. The measurements are recorded continuously on a fetal heart rate monitor strip. Initially, upon placement of a monitor, a "baseline" rate is determined. The base line rate is the mean heart rate per minute of the fetus measured over approximately a ten-minute interval. A "normal" baseline heart rate will range from 120 beats to 160 beats per minute.

22. Once the baseline heart rate is established, the heart rate of the fetus is monitored for expected variations in the heartbeat rate. It is normal for the heartbeat rate to accelerate and decelerate from the baseline rate over an extended period of time.

23. In addition to monitoring the fetal heartbeat rate, the contractions of the mother are also monitored.

24. When a contraction occurs, it is expected that the fetal heart rate will decelerate abruptly. This deceleration is normal and is considered reassuring if the deceleration abruptly ends in less than 30 seconds after it begins.

25. A primary purpose for monitoring contractions and the fetal heart rate is to give the physician assurances that the fetus is not experiencing hypoxia (lack of oxygen to the brain).

26. While variable decelerations and accelerations in heartbeat are expected and considered reassuring, a "late" deceleration is not. A "late" deceleration is a decline in the

heart rate from the baseline which takes place just after the peak of a contraction and lasts for 60 seconds or more. A late deceleration can be an indication of fetal hypoxia if it is followed persistently by other late decelerations and a lack of good variability between such events.

27. Fetal heart rate monitors may be placed externally or internally. An external monitor is placed on the mother's stomach and utilizes Doppler waves which are projected at the fetus and are then interpreted by computer to determine the fetal heart rate.

28. An internal monitor requires that the mother's membrane be ruptured, releasing the amniotic fluid, and that the cervix is dilated at least one or two centimeters. An electrode is then placed directly on the scalp of the fetus. Contractions may also be monitored internally using an intrauterine pressure catheter that records the actual pressure of contractions.

29. Dr. Alvarado's instructions to place an external monitor on Patient O.C. were followed by Ann Willis Wimberly, R.N. Due to Patient O.C.'s size, however, it was difficult to obtain a good reading of the fetal heart rate or Patient O.C.'s contractions. Patient O.C. was also somewhat noncompliant with her care, causing further difficulty obtaining accurate readings.

30. Nurse Wimberly also took and recorded a "history" of Patient O.C., including her weight and the facts that she had gestational diabetes, smoked a pack of cigarettes a day, reported "brownish stuff" coming out of her, and had experienced pelvic pressure that day.

31. Nurse Wimberly performed a vaginal examination of Patient O.C. and reported that she was "closed, thick [sic] minus three, palatable" which means that Patient O.C.'s cervix was not open, she was not thinning out, and the baby was still high up and ballottable, which in turn means there was fluid around the baby.

32. At 8:30 p.m. Dr. Alvarado evaluated Patient O.C. and reviewed the fetal heart monitor strip. (Admitted Facts). The baby's fetal heart rate base line was determined to be between 160 and 170 beats[10] per minute. (Admitted Facts). This heart rate was above the normal base line expected for a fetal heart base line rate. At this point, the fetal heart monitor had recorded some accelerations, but no decelerations.

33. Patient O.C. had only been monitored for approximately 10 to 15 minutes at the time Dr. Alvarado reviewed the fetal heart rate monitoring strips. This was, as Dr. Alvarado acknowledged at hearing, an inadequate period of time to get adequate data.

34. At 8:40 p.m., Dr. Alvarado left Patient O.C. to attend to a patient in labor. (Admitted Facts). At this time Patient O.C. was essentially stable and the baby's heart rate was essentially within the base line established upon Dr. Alvarado's initial review of the fetal heart monitor strip. (Admitted Facts).

35. Nurse Wimberly continued to monitor Patient O.C.'s fetal heart rate and found that she was experiencing variable accelerations and decelerations, which were reassuring.

36. At approximately 8:50 p.m., Patient O.C. experienced four decelerations. Between 8:50 p.m. and 10:00 p.m., nothing was recorded following a few decelerations. Dr. Danna was unable to identify the decelerations as "late," in part due to the lack of good contraction information. This period was followed by readings which Dr. Danna described credibly as "very sketchy over the next one [strip panels] and the next one and next one, very sketchy." Transcript, Volume I, Page 148, Lines 8-9. From then until early the next morning, there continued to be what may have been late decelerations, but due to the inadequacy of the data as to Patient O.C.'s contractions, Dr. Danna was unable to state convincingly that late decelerations were in fact taking place.

37. A nitrazine test was performed on Patient O.C. at approximately 10:30 to 10:35 p.m. when Patient O.C. complained

of brownish fluid leaking out. A nitrazine test measures the pH level in the vagina. The test was positive. This is an indication that delivery should occur within 24 hours.[11]

38. At 11:16 p.m., a nurse called Dr. Alvarado and informed him that the baby was moving well. (Admitted Facts). Patient O.C. had denied any further contractions and asked to go home. (Admitted Facts). The nurse informed Dr. Alvarado of these facts. Dr. Alvarado was attending another patient and asked Patient O.C. to wait for his evaluation before going home. (Admitted Facts).

E. The Events of August 19, 2003.

39. At 12:31, a.m., August 19, 2003, Dr. Alvarado attended Patient O.C. (Admitted Facts). When he entered the room in which Patient O.C. was located, Patient O.C. was sitting on the end of the bed ready to go home. (Admitted Facts). The external fetal heart monitor had been removed and she denied having any contractions. (Admitted Facts). Patient O.C.'s "significant other," however, reported more leaking of fluid. (Admitted Facts). Dr. Alvarado was informed that a second nitrazine test was positive. (Admitted Facts).

40. Dr. Alvarado examined Patient O.C., performing a nitrazine test and reviewed her fetal heart monitor strip. (Admitted Facts). The nitrazine test was again positive.

41. Dr. Alvarado decided to admit Patient O.C. to Leesburg Regional. (Admitted Fact).[12]

42. While the results of the external fetal heart monitor were not conclusive, Nurse Wimberly became concerned enough with the results to suggest to Dr. Alvarado that she was seeing decelerations which she characterized as sometimes "variable" and sometimes "late." This conversation took place at approximately 12:50 a.m. Dr. Alvarado disagreed with Nurse Wimberly's characterization of the decelerations as "late." Nurse Wimberly did not insist nor record in her notes that there were late decelerations because of the difficulty she was experiencing getting a good reading from Patient O.C., both of the fetal heartbeat rate and Patient O.C.'s contractions.

43. At 1:02 a.m., Dr. Alvarado was called to attend to another patient. (Admitted Facts).

44. At 1:12 a.m., Patient O.C. was placed back on an external fetal heart monitor. (Admitted Facts).

45. At 1:50 a.m., Dr. Alvarado returned and examined Patient O.C. (Admitted Facts). Nurse Wimberly discussed with Dr. Alvarado the difficulty she was experiencing attempting to monitor the baby's fetal heartbeat rate with an external monitor. Dr. Alvarado agreed that an internal monitor was necessary.

46. Dr. Alvarado artificially ruptured Patient O.C.'s, membrane to place the fetal scalp electrode and intrauterine monitor.[13] (Admitted Facts). Although Patient O.C. was not in labor when he ruptured her membrane, Dr. Alvarado's plan was to induce labor at 6:00 a.m. if Patient O.C. did not go into active labor by then. (Admitted Facts).

47. When Dr. Alvarado ruptured Patient O.C.'s membrane, meconium-stained amniotic fluid was noted. (Admitted Facts). Meconium is a bowel movement which occurs in the amniotic sac. The presence of meconium in the amniotic fluid is an indicator that there may be some stress on the part of the fetus. According to Dr. Danna, the presence of meconium:

> does not necessarily mean you have to rush the patient to the operating room and do a deliver. It depends on how the fetal monitoring strip looks, but it could indicate some stress and your awareness has to be heightened that this is a high risk labor and you need to pay attention to the fetal monitoring strip for evidence of hypoxia. There is also risks of meconium aspiration where the baby aspirates the meconium into the lungs and that could be very serious.

Transcript, Volume I, Page 139, Lines 22-25, and Page 140, Lines 1-4.

48. Although there was meconium present, the evidence in this case failed to prove the extent to which its presence was an indication that Patient O.C.'s fetus was in distress at the

time Patient O.C.'s membrane was ruptured. The evidence also failed to prove when the bowel movement which the meconium evidenced took place.

49. Dr. Alvarado had, prior to rupturing Patient O.C.'s membrane, performed a vaginal examination and found her to be two and a-half centimeters dilated and to have progressed from thick to 80 percent thinned out.

50. Dr. Alvarado placed an electrode on the baby's scalp to monitor the baby's heart rate and an intrauterine pressure catheter in Patient O.C. to monitor Patient O.C.'s contractions. (Admitted Facts). The intrauterine pressure catheter placement was completed at approximately 2:00 a.m. From that time on, the fetal heart rate monitoring strips were more precise.

51. At 2:15 a.m. Patient O.C. was experiencing contractions every one to three minutes for 60 seconds and the fetal heart rate was 150 to 160. (Admitted Facts).

52. Dr. Alvarado, once the internal fetal heart monitor and the intrauterine pressure catheter were placed, only reviewed the resulting fetal heart monitor strip for approximately 15 minutes. He did so, despite his testimony at hearing that the strip should be monitored for at least an hour. Dr. Alvarado was asked the following questions and gave the following responses in this regard:

> Q. Okay. Why did you ask them to continue monitoring her?
>
> A. Well, you cannot make a judgment with ten-minute tracings. Every patient that goes to the hospital -- even with no concern, nor risk factor, or anything like -- will be monitored for at least one hour. She just arrived. She had only about ten minutes by the time that the nurse got to her and put the monitor on. It was only about ten or fifteen minutes. We needed to know a little bit longer what was going on.

Transcript, Volume II, Page 229, Lines 14-23. While this testimony dealt with the initial external monitoring of Patient O.C., the facts in this case proved that, because the initial monitoring of Patient O.C. was problematic and to a large extent unreassuring, and given the fact that she was a high-risk patient, Dr. Alvarado was in error when he assumed that he already had sufficient data to leave Patient O.C. after only approximately 15 minutes of data from the internal monitoring.

53. Dr. Alvarado returned to the Leesburg Regional emergency room at 2:15 a.m. to attend to patients and subsequently left for his home, which is located less than five minutes from the hospital. (Admitted Facts).

54. After Dr. Alvarado left Patient O.C., Nurse Wimberly continued to monitor the fetal heart rate strip. The fetal heart rate continued to be generally the same evidenced by the external monitoring strips.

55. At 2:22 a.m., the baby's fetal heart rate dropped into the 90's for 60 seconds, before returning to the base line. (Admitted Facts). Dr. Alvarado was not notified of this drop. (Admitted Facts).

56. At 2:30 a.m. Patient O.C. complained of pain and Dr. Alvarado was notified. (Admitted Facts).

57. At 2:43 a.m., the fetal heart rate exhibited a clear late deceleration, dropping for approximately 40 seconds. (Admitted Facts). Dr. Alvarado was notified. (Admitted Facts). Nurse Wimberly recognized the decelerations and initiated routine interventions but failed to notify Dr. Alvarado. (Admitted Facts).

58. Between 3:58 a.m. and 4:15 a.m., the chart shows several more fetal heart monitor late decelerations and nurse "fails to notify" Dr. Alvarado of any. (Admitted Facts).

59. The following, while of little relevance, are included in this Recommended Order because they are "Admitted Facts":

a. At 4:20 a.m. Nurse Wimberly left Dr. Alvarado a message on his home phone answering machine that Dr. Hanubal was coming to the Leesburg Memorial to deliver Patient O.C.'s baby.[14]

b. Dr. Alvarado was not notified of Patient O.C.'s request that Dr. Hanubal deliver the baby.

c. The nurse informed Dr. Hanubal about the decelerations and he ordered an emergency cesarean section, which was performed at approximately 4:50 a.m.

d. The chart reflects the baby was pronounced dead at 6:40 a.m. Dr. Alvarado does not know what resuscitation efforts were undertaken. Dr. Alvarado arrived in a labor room at 7:00 a.m. for a cesarean, and was surprised with the news and fact that he was never notified.

e. A cesarean is the surgical delivery of an infant through an incision in the mother's abdomen and uterus.

F. The Administrative Complaint.

60. On July 19, 2005, the Department filed an Administrative Complaint in which it alleged that Dr. Alvarado, in his treatment of Patient O.C., had violated Section 458.331(1)(t), Florida Statutes, which requires that a physician 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 . . . ." (hereinafter referred to as the "Standard of Care").

61. In paragraph 26 of the Administrative Complaint, it has been alleged that Dr. Alvarado violated the Standard of Care by one or more of the following:

> (a) Failing to accurately diagnose Patient O.C.'s condition;

(b) Failing to remain in the hospital after initiating labor by rupturing Patient O.C.'s membranes;
(c) Failing to accurately diagnose fetal heart distress;
(d) Failing to accurately diagnose [the] risk to [the] fetus when meconium fluid was noted upon rupture of membranes.

62. While Dr. Alvarado has raised an issue as to whether the Administrative Complaint is constitutionally vague, an issue which this forum has no jurisdiction to address,[15] he did not request a more definite statement from the Department during this proceeding.

G. Dr. Alvarado's Violation of the Standard of Care.

63. Dr. Alvarado's treatment and care of Patient O.C. as described in this Recommended Order and based upon the credited opinion of Dr. Danna, violated the Standard of Care as alleged in paragraphs 26(a) and (b) of the Administrative Complaint.

64. The evidence failed to prove that Dr. Alvarado's treatment and care of Patient O.C. violated the Standard of Care as alleged in paragraphs 26(c) and (d) of the Administrative Complaint.

65. As to Dr. Alvarado's diagnosis of Patient O.C., in most respects his diagnosis was within the Standard of Care. His Proposed Findings of Facts and Conclusions of Law, paragraphs A1 through A4 accurately describe incidents where his diagnosis of Patient O.C. was adequate. Where Dr. Alvarado

violated the Standard of Care is when he failed to adequately reevaluate her condition through the results of the internal fetal heart monitor and the intrauterine pressure catheter. As explained by Dr. Danna, Dr. Alvarado violated the Standard:

> A. Because of the strip or her fetal heart monitor continued to deteriorate and there was no resolution of her late decelerations. Once he monitored her using the fetal scalp IUPC [intrauterine pressure catheter], it should have been re-evaluated by him soon after that to see if those late decelerations revolved [sic].
>
> Q. How soon after he had applied the IUPC should she have been re-evaluated?
>
> A. At least within thirty minutes to an hour.
>
> Q. Do you believe that to be the standard of practice with respect to obstetrical patients at this point?
>
> A. Yes.

Transcript, Volume I, Page 162, Lines 15 through 25. She also stated the following in this regard:

> I believe that a reasonable physician would have re-evaluated the strip once the internal leads were placed, the scalp lead and the intrauterine pressure catheter, and re-evaluated the strip to see if these issues of non-reassuring surveillance resolved and if they didn't resolve then a cesarean section should have been ordered, especially, since she was remote from delivery.

Transcript, Volume I, Page 160, Lines 16 through 22.

66. Dr. Alvarado also failed to meet the Standard of Care when he left Leesburg Memorial as soon after rupturing Patient O.C.'s membrane as he did. This violation is predicated on the same error committed by Dr. Alvarado, which is the basis of his violation of the Standard of Care in his failure to properly diagnose Patient O.C.'s condition. Again, Dr. Alvarado's violated the Standard of Care when he went home from the hospital because he failed to adequately monitor the fetal heart monitoring strip for an adequate period of time after the internal heart monitor was initiated before he did so.

67. Dr. Alvarado's position on this issue misses the mark. Dr. Alvarado has argued that there was no testimony from any expert that a doctor must remain at a hospital after initiating labor by rupturing a patient's membranes. Dr. Alvarado also argued that it is acceptable for a physician to rely upon a trained obstetrical nurse who can notify him of a patient's condition. While these arguments are correct, Dr. Alvarado failed to establish that it was within the Standard of Care to leave a patient in Patient O.C.'s condition without first obtaining adequate fetal heart monitoring data and data from the intrauterine pressure catheter.

68. The evidence failed to prove that Dr. Alvarado violated the Standard of Care by failing to diagnose fetal heart

distress. The evidence failed to prove clearly and convincingly that Patient O.C.'s fetus suffered fetal heart distress.

69. Finally, Dr. Alvarado did not violate the Standard of Care by failing to accurately diagnose the risk to Patient O.C.'s baby when he noted meconium fluid upon rupture of Patient O.C.'s membranes. Even the Department's expert agreed. Dr. Danna, when asked whether Dr. Alvarado violated the Standard of Care when he failed "to accurately diagnose the risk to the fetus when meconium fluid was noted upon the rupture of those membranes" answered as follows: "I don't think that is -- no, I don't think that is the case." Transcript, Volume 1, Page 163, Lines 15 and 16.

CONCLUSIONS OF LAW

A. Jurisdiction.

70. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569, 120.57(1), and 456.073(5), Florida Statutes (2005).

B. The Charges of the Administrative Complaint.

71. Section 458.331(1), Florida Statutes, authorizes the Board of Medicine (hereinafter referred to as the "Board"), to impose penalties ranging from the issuance of a letter of concern to revocation of a physician's license to practice

medicine in Florida, if a physician commits one or more acts specified therein.

72. In its Administrative Complaint, as amended, the Department has alleged that Dr. Alvarado has violated Section 458.331(1)(t), Florida Statutes.

C. The Burden and Standard of Proof.

73. The Department seeks to impose penalties against Dr. Alvarado through the Administrative Complaint that include suspension or revocation of his license and/or the imposition of an administrative fine. Therefore, the Department has the burden of proving the specific allegations of fact that support its charge that Dr. Alvarado violated Section 458.331(1)(t), Florida Statutes, by clear and convincing evidence. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Pou v. Department of Insurance and Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998); and Section 120.57(1)(j), Florida Statutes (2005)("Findings of fact shall be based on a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute.").

74. What constitutes "clear and convincing" evidence was described by the court in Evans Packing Co. v. Department of

Agriculture and Consumer Services, 550 So. 2d 112, 116, n. 5 (Fla. 1st DCA 1989), as follows:

> . . . [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the evidence 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 the 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).

See also In re Graziano, 696 So. 2d 744 (Fla. 1997); In re Davey, 645 So. 2d 398 (Fla. 1994); and Walker v. Florida Department of Business and Professional Regulation, 705 So. 2d 652 (Fla. 5th DCA 1998)(Sharp, J., dissenting).

D. Section 458.331(1)(t), Florida Statutes; The Standard of Care.

75. Section 458.331(1)(t), Florida Statutes, defines the following disciplinable offense:

> (t) . . . [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. . . .

76. In paragraph 26 of the Administrative Complaint, it has been alleged that Dr. Alvarado violated the Standard of Care by one or more of the following:

(a) Failing to accurately diagnose Patient O.C.'s condition;
(b) Failing to remain in the hospital after initiating labor by rupturing Patient O.C.'s membranes;
(c) Failing to accurately diagnose fetal heart distress;
(d) Failing to accurately diagnose [the] risk to [the] fetus when meconium fluid was noted upon rupture of membranes.

77. The evidence has clearly and convincingly proved that Dr. has violated the Standard of Care as alleged in paragraphs 26(a) and (b) as described in the Findings of Fact. Although treated in the Administrative Complaint as two violations, both of the violations arise from the same error: Dr. Alvarado failed to adequately reevaluate Patient O.C.'s condition through the results of the internal fetal heart monitor and the intrauterine pressure catheter. In particular, he failed to wait until he had at least 30 to 60 minutes of data from the internal monitors. By failing to do so, he failed to make an adequate diagnosis and left for home before doing so.

E. The Appropriate Penalty.

78. In determining the appropriate punitive action to recommend to the Board in this case, it is necessary to consult the Board's "disciplinary guidelines," which impose restrictions and limitations on the exercise of the Board's disciplinary authority under Section 458.331, Florida Statutes. See Parrot

Heads, Inc. v. Department of Business and Professional Regulation, 741 So. 2d 1231 (Fla. 5th DCA 1999).

79. The Board's guidelines are set out in Florida Administrative Code Rule 64B8-8.001, which provides the following "purpose" and instruction on the application of the penalty ranges provided in the Rule:

> (1) Purpose. Pursuant to Section 456.079, F.S., the Board provides within this rule disciplinary guidelines which shall be imposed upon applicants or licensees whom it regulates under Chapter 458, F.S. The purpose of this rule is to notify applicants and licensees of the ranges of penalties which will routinely be imposed unless the Board finds it necessary to deviate from the guidelines for the stated reasons given within this rule. The ranges of penalties provided below are based upon a single count violation of each provision listed; multiple counts of the violated provisions or a combination of the violations may result in a higher penalty than that for a single, isolated violation. Each range includes the lowest and highest penalty and all penalties falling between. The purposes of the imposition of discipline are to punish the applicants or licensees for violations and to deter them from future violations; to offer opportunities for rehabilitation, when appropriate; and to deter other applicants or licensees from violations.
>
> (2) Violations and Range of Penalties. In imposing discipline upon applicants and licensees, in proceedings pursuant to Section 120.57(1) and 120.57(2), F.S., the Board shall act in accordance with the following disciplinary guidelines and shall impose a penalty within the range corresponding to the violations set forth

below. The verbal identification of offenses are descriptive only; the full language of each statutory provision cited must be consulted in order to determine the conduct included.

80. Florida Administrative Code Rule 64B8-8.001(2) goes on to provide, in pertinent part, the following penalty guidelines for the violation proved in this case: For a violation of Section 458.331(1)(t), Florida Statutes, a range of relevant penalties from two years' probation to revocation, and an administrative fine from $1,000.00 to $10,000.00.

81. Florida Administrative Code Rule 64B8-8.001(3) provides that, in applying the penalty guidelines, the following aggravating and mitigating circumstances are to be taken into account:

> (3) Aggravating and Mitigating Circumstances. Based upon consideration of aggravating and mitigating factors present in an individual case, the Board may deviate from the penalties recommended above. The Board shall consider as aggravating or mitigating factors the following:
> (a) Exposure of patient or public to injury or potential injury, physical or otherwise: none, slight, severe, or death;
> (b) Legal status at the time of the offense: no restraints, or legal constraints;
> (c) The number of counts or separate offenses established;
> (d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;
> (e) The disciplinary history of the applicant or licensee in any jurisdiction and the length of practice;

> (f) Pecuniary benefit or self-gain inuring to the applicant or licensee;
> (g) The involvement in any violation of Section 458.331, Florida Statutes, of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure;
> (h) Any other relevant mitigating factors.

82. In Petitioner's Proposed Recommended Order, the Department has requested that it be recommended that the following discipline be imposed upon Dr. Alvarado's license:

> a reprimand, $10,000.00 fine, suspension for one year followed by probation for two years with terms and conditions to be established by the Board at the hearing when the Recommended Order is presented, and a minimum of 200 hours of community service within two years of the entry of the Final Order.

The Department has not explained in Petitioner's Proposed Recommended Order what factors it relied upon in making the foregoing recommendation other than to argue that Dr. Alvarado failed to respond to Nurse Wimberly's effort to locate him at his home during the early hours of August 19, 2003. The Department's reliance on this apparent aggravating circumstance is misplaced and ignores the evidence. While Nurse Wimberly did telephone Dr. Alvarado at approximately 4:20 a.m., she did so on his "home" or "personal" telephone and not at the second home telephone phone number, which Dr. Alvarado had instructed the

nurses to call, his cell-phone, or his pager. The phone number which Dr. Alvarado had instructed the nurses to use is one that is dedicated for use in his practice. See Endnote 15.

83. Having carefully considered the facts of this matter in light of the provisions of Florida Administrative Code Rule 64B8-8.001, it is concluded that the Department's suggested penalty is excessive. First, Dr. Alvarado has committed only one violation of the Standard of Care. Although characterized in two different ways (failure to diagnose and going home too early), the violation consists of one error: failing to review the results of the internal monitors for a long enough period of time. This is, therefore, Dr. Alvarado's first statutory violation. Secondly, the evidence failed to prove why Patient O.C.'s baby did not survive or what specific role Dr. Alvarado's error of judgment had in the baby's death, if any. Finally, no explanation of why Dr. Alvarado should be required to provide community service has been given by the Department, and the facts do not support such discipline.

RECOMMENDATION

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

RECOMMENDED that the a final order be entered by the Board of Medicine finding that Manuel Alvarado, M.D., has violated Section 458.331(1)(t), Florida Statutes, as described in this

Recommended Order; issuing him a letter of concern; requiring that he pay an administrative fine of $5,000.00; placing his license to practice medicine on probation for two years; and requiring that he attend continuing education classes in an amount and of a nature to be determined by the Board.

DONE AND ENTERED this 9th day of June, 2006, in Tallahassee, Leon County, Florida.

LARRY J. SARTIN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 9th day of June, 2006.

ENDNOTES

[1]/ All references to Sections of the Florida Statutes are to the 2003 version unless otherwise noted.

[2]/ The Department of Health letter referring this matter to the Division of Administrative Hearings indicates that a copy of "Respondent's Petition for Hearing" was included with the referral letter. While a copy of Respondent's "Response to Administrative Complaint" was filed, the Petition was not.

[3]/ At the time of the events at issue in this case, Nurse Wimberly's name was Anna Willis. At the time of the final hearing of this matter, her name was Anna Willis Wimberly,

having subsequently married. She will be referred to as Nurse Wimberly in this Recommended Order.

[4]/ On page 3 of Volume I of the Transcript of the final hearing, Dr. Danna is incorrectly identified as "Penny Anna, M.D."

[5]/ Dr. Danna was offered as "an expert in the standard of care for OB patients in Florida." Because there was no objection, the proffer was accepted. The proffered expertise, while sounding more like an expertise in the law relevant to this case, which Dr. Danna is not an expert in, has been viewed as relating to Dr. Danna's expertise in obstetrics and gynecology, an expertise which justifies her giving opinions as to whether Dr. Alvarado 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." § 458.331(1)(t), Fla. Stat.

[6]/ Petitioner's Exhibit 3 is a composite exhibit consisting of law pertinent to this matter. The exhibit was admitted even though it does not constitute "evidence" pertinent to this case.

[7]/ The Preeclampsia Foundation defines "Preeclampsia" as follows: "Preeclampsia is a disorder that occurs only during pregnancy and the postpartum period and affects both the mother and the unborn baby. Affecting at least 5-8% of all pregnancies, it is a rapidly progressive condition characterized by high blood pressure and the presence of protein in the urine. Swelling, sudden weight gain, headaches and changes in vision are important symptoms; however, some women with rapidly advancing disease report few symptoms." http://www.preeclampsia.org/about.asp.

[8]/ Mucus discharge is not uncommon. When it is accompanied by decreased fetal movement, however, a physician should have heightened awareness of the patient.

[9]/ A non-stress test entails external fetal monitoring for 20 minutes. There should be 15 beats over the fetus' baseline heart rate twice during the test to be considered reassuring.

[10]/ A baseline in excess of 160 beats per minute, such as Patient O.C.'s fetus was experiencing, is referred to as Tachycardia. Tachycardia can indicate maternal problems such as fever or problems with the fetus such as some type of cardiac

abnormality. It can also be a sign of hypoxia on the part of the fetus.

[11]/ There are Admitted Facts that "[a] nitrazine test was performed on Patient O.C., and reported to Respondent as negative." It is not clear whether this Admitted Fact is accurate or, if it is, when the negative test occurred. Little weight, therefore, has been given to this admitted fact.

[12]/ Dr. Danna testified that because of the reported decrease in fetal movement, the evidence of a ruptured membrane (positive nitrazine test), Patient O.C. should have been admitted as early as 10:35 p.m., August 18, 2003. She did not, however, opine that the failure to admit Patient O.C. until later constituted a violation of Section 458.331(1)(t), Florida Statutes. Nor does the Administrative Complaint allege that Dr. Alvarado's failure to admit Patient O.C. earlier than he did constituted a violations of Chapter 458, Florida Statutes.

[13]/ Again, while Dr. Danna testified that Dr. Alvarado should have ruptured Patient O.C.'s membrane and placed an internal fetal heart rate monitor earlier than he did, she did not offer any opinion that his failure to do so constituted a violation of Section 458.331(1)(t), Florida Statutes. Nor does the Administrative Complaint contain such an allegation.

[14]/ Dr. Alvarado maintained two home telephone numbers. One was used for personal phone calls. The other was one that was dedicated to his practice. The nurses at the hospital had been instructed to use his home telephone number that had been dedicated for calls related to his practice. If unable to reach him on that number, they were to call him on his pager or his cell-phone. Nurse Wimberly telephoned Dr. Alvarado at his personal home telephone number. She made no effort to contact him at the telephone number dedicated to his practice or to call him on his cell-phone or his pager.

[15]/ Central Florida Investments, Inc. v. Orange County Code Enforcement Board, 790 So. 2d 593 (Fla. 5th DCA 2001).; and Department of Revenue v. Young American Builders, 330 So. 2d 864 (Fla. 1st DCA 1976).

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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 these cases.