STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 07-1724PL
VASUNDHARA IYENGAR, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

On September 20, 2007, a formal administrative hearing in this case was held in Orlando, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues in this case are whether the allegations of the Administrative Complaint are correct, and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Amended Administrative Complaint dated January 16, 2007, the Department of Health (Petitioner) alleged that Vasundhara Iyengar, M.D. (Respondent), violated Subsection 458.331(1)(t), Florida Statutes (2002), by failing to adequately assess or treat a patient's condition on March 17 and 18, 2003. The Respondent disputed the allegations and requested a formal administrative hearing. By letter dated April 17, 2007, the Petitioner forwarded the matter to the Division of Administrative Hearings, which scheduled and conducted the hearing.

At the hearing, the Petitioner presented the testimony of one witness and had Exhibits lettered A through E admitted into evidence. The Respondent presented the testimony of two witnesses, testified on her own behalf, and had Exhibits numbered 1 and 2 admitted into evidence.

The hearing Transcript was filed on October 15, 2007. As stipulated by the parties, both parties filed Proposed Recommended Orders on November 27, 2007, that have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. The Respondent is a licensed medical doctor, holding license number 44726.

2. At all times material to this case, the Respondent was a physician holding board certifications in internal medicine, hematology, and oncology.

3. Patient 1 was a patient of another hematologist, Dr. Thomas Katta. On March 17, 2003, Dr. Katta had Patient 1 admitted via the patient's internist (Dr. Frank Leiva) to Sand Lake Hospital in Orlando.

4. The patient was anemic and thrombocytopenic and had been previously diagnosed with autoimmune hemolytic anemia, the treatment for which was transfusion. Failure to transfuse a person suffering from autoimmune hemolytic anemia can lead to death, and such a transfusion had been ordered for the patient.

5. Dr. Katta apparently had personal obligations for the evening of March 17, 2003, and for the following day, and, in the late afternoon of March 17, 2003, he asked the Respondent to "cover" his hospitalized patients. The Respondent agreed to do so.

6. Dr. Katta's office transmitted a list of the patients by fax to the Respondent's office. The list contained the full names and locations of Dr. Katta's other hospitalized patients, but identified Patient 1 only by last name and diagnosis

("AIHA"). The fax did not indicate the patient's first name or gender and did not specifically identify the patient's location.

7. The Respondent made no attempt to obtain additional information from Dr. Katta or his staff.

8. The lab work performed upon admission to the hospital indicated that the patient was severely anemic and had a critically low platelet count.

9. At approximately 6:30 p.m. on March 17, 2003, the Respondent received a telephone call through her answering service from a hospital nurse who reported that the patient was severely anemic and that there were problems obtaining a proper blood match for the transfusion. The Respondent advised the nurse to call the blood bank and tell them to find the least incompatible blood and get the transfusion done. The Respondent did not inquire as to the patient's name or location.

10. At about 10:19 p.m. on March 17, 2003, the Respondent was again contacted by a hospital nurse, who advised that the patient was short of breath and had tachycardia at 133 beats per minute. The nurse also advised that the blood bank had been unable to find an appropriate match for the previously ordered transfusion and that the transfusion remained uncompleted.

11. The Respondent directed the nurse to contact the patient's primary care physician or the cardiologist on call, but did not ask the identity of either practitioner. The

nursing notes indicate that the Respondent stated that she did not provide treatment for tachycardia and did not believe that Dr. Katta did either.

12. The Respondent also advised the nurse to call the blood bank and direct them to find the least incompatible blood and perform the transfusion. The Respondent did not inquire as to the patient's name or location and provided no other direction to the reporting nurse.

13. On the next day, March 18, 2003, at about 6:15 a.m., the Respondent was contacted by a hospital nurse, who advised that the transfusion had still not taken place. The Respondent took no action and provided no direction to the reporting nurse. The Respondent did not inquire as to the patient's name or location.

14. Later during the morning of March 18, 2003, the Respondent attempted to locate the patient while making her rounds but was unsuccessful.

15. In attempting to locate the patient, the Respondent talked with various hospital personnel, but had no information other than the patient's last name and diagnosis. Based on her inability to obtain any additional information, the Respondent assumed that the patient had been transfused and discharged.

16. The patient had not been discharged, but had been transferred to an intensive care unit in the hospital. The transfusion had not yet occurred.

17. Patient 1 died on March 20, 2003.

18. The Respondent was unaware of the patient's death until she saw Dr. Katta at the hospital, at which time he questioned her about the patient and informed her that the patient was dead.

19. The Petitioner presented the testimony of Dr. Howard Abel, M.D., regarding whether the Respondent met the standard of care in her treatment of the patient. Dr. Abel's testimony regarding the standard of care issues is credited and is accepted.

20. As to the issue of the uncompleted transfusion, the evidence establishes that the transfusion did not occur while the Respondent provided hematological care for Patient 1. The Respondent should have personally contacted the blood bank to identify the cause of the inability to provide blood for the transfusion and determine whether another option was available.

21. The Respondent should have responded to the 10:19 p.m. call on March 17 by personally examining the patient and reviewing the history and lab test results. While the Respondent's directive to contact a cardiologist was not inappropriate, breathing difficulties and tachycardia are

symptomatic of severe anemia for which hematological care was required. If the Respondent determined that the symptoms were cardiac-related, the Respondent should have personally made the cardiology referral and provided the information to the cardiologist. The Respondent did not do so and was unaware of the cardiologist's identity.

22. A review of additional lab test results including observation and evaluation of blood smears would have provided useful information as to whether the patient's condition was deteriorating and to whether the patient was developing thrombotic thrombocytopenic purpura ("TTP"), a serious condition which, left untreated, is fatal in not less than 90 percent of cases. The blood smears had been performed by the time of the phone call, but the Respondent reviewed no lab test results and made no inquiries related to the results.

23. The failure to review lab test results may have delayed a diagnosis of TTP. While there was some disagreement between testifying witnesses as to whether or not the patient had TTP, Dr. Katta ordered that the patient be treated for TTP immediately upon his return on March 19, 2003, and there is no evidence that Dr. Katta treated the patient for TTP without reasonable cause to do so. The evidence clearly establishes that the Respondent failed to review the patient's test results

that could have provided timely and useful information regarding the patient's condition.

24. As to the Respondent's failure to locate the patient on March 18, 2003, the Respondent testified that the patient's last name was common, but the Respondent had not called Dr. Katta at the time she received the faxed list of his hospitalized patients to obtain additional identifying information.

25. The Respondent did not request the information from the nursing staff during any of the telephone calls and made no effort to obtain the information prior to arriving at the hospital to make her rounds.

26. The Respondent would have become aware of the patient's location had she attended to the patient's breathing difficulties and tachycardia on the night of March 17. She would have also likely reviewed the medical records and would have become aware of the admitting physician as well as other information regarding the patient's condition.

27. The Respondent consulted with hospital personnel on March 18, 2003, in attempting to identify those patients admitted by Dr. Katta. There were approximately ten to 12 other hospitalized patients with the same last name, none of which had been admitted by Dr. Katta. The Respondent was unaware that the patient had been admitted under Dr. Leiva's name. The

Respondent did not visit the ten to 12 patients with the same last name to locate the one for which she was responsible.

28. The Respondent did not contact the blood bank, which had been having difficulty providing transfusion blood to the patient. It is reasonable to assume that the blood bank, charged with the responsibility to provide the appropriate blood supplies to the patient, would have been aware of the patient's location, and could have provided it to the Respondent.

29. The Respondent made no effort to identify patients located in the hospital's intensive care units, despite the critical nature of the patient's condition at last report. Had she done so, she would have located the patient.

30. The Respondent presented testimony that it was not uncommon for a physician, unable to locate a hospitalized patient, to routinely assume that the patient has been appropriately treated and has been discharged, or is deceased. However, the Respondent testified that it was unusual for her not to be able to identify and locate a patient.

31. Even assuming that such practice is routine, it is unlikely that such an assumption could reasonably be made in the case at issue here, where the Respondent did not know the patient's name, had never seen the patient, had personally reviewed no medical records, was unable to find anyone in the hospital who could provide her with any information, and at last

communication with the nursing staff had been told that a critically-needed transfusion had not occurred. The testimony is not credited and is rejected.

CONCLUSIONS OF LAW

32. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat. (2007).

33. The Respondent is the state agency charged with regulating the practice of medicine. § 20.43 and Ch. 456 and Ch. 458, Fla. Stat. (2003).

34. The Administrative Complaint charges the Respondent with a violation of Subsection 458.331(1)(t), Florida Statutes (2002), which provides in relevant part as follows:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $25,000 each to the claimant in a judgment or settlement and which incidents

> involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

35. The Administrative Complaint alleges that the Respondent violated the referenced statute by failing to adequately assess or treat the patient's condition on March 17 and 18, 2003.

36. The Petitioner has the burden of proving by clear and convincing evidence the allegations set forth in the Administrative Complaint against the Respondent. Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932, 935 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

37. Clear and convincing evidence is that which is credible, precise, explicit, and lacking 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 of conviction, without hesitancy, as to the truth of the

allegations. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983). In this case, the burden has been met.

38. The evidence establishes 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.

39. The Respondent failed to properly identify and locate the patient, failed to examine or properly treat the patient, failed to review lab test results, and failed to contact the blood bank to assess the cause for the failure to perform critical medical treatment. Additionally, the Respondent, absent any supporting information, inappropriately assumed that a patient, who had been moved into an intensive care unit, had been discharged from the hospital.

40. Florida Administrative Code Rule 64B8-8.001 sets forth the disciplinary guidelines applicable to the statutory violations relevant to this proceeding.

41. Florida Administrative Code Rule 64B8-8.001(2)(t)3. provides that the penalty for a first offense of Subsection 458.331(1)(t), Florida Statutes, ranges from a minimum penalty of two years' probation to revocation or denial of licensure and an administrative fine of $1,000 to $10,000.

42. Florida Administrative Code Rule 64B8-8.001(3) provides as follows:

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, F.S., 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) Where a licensee has been charged with violating the standard of care pursuant to Section 458.331(1)(t), F.S., but the licensee, who is also the records owner pursuant to Section 456.057(1), F.S., fails to keep and/or produce the medical records.

(i) Any other relevant mitigating factors.

43. The Respondent has had no prior disciplinary action taken against her license.

44. The evidence establishes that the patient's medical condition was complex, and there were multiple systemic issues that may have contributed to the outcome. However, the risk of injury or potential injury related to the Respondent's actions in this case is clear. The Respondent failed to appropriately respond to the information provided telephonically by the nurse and failed to review medical records and examine the patient. The patient's condition deteriorated during the time that the Respondent was responsible for Dr. Katta's hospitalized patients. Further, upon being unable to locate the patient at the hospital when making her rounds on March 18, 2003, the Respondent assumed, without any supporting information, that the patient had been transfused and discharged, essentially abandoning her responsibility to treat the patient. Accordingly, the following disposition is recommended.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health enter a final order finding Vasundhara Iyengar, M.D., in violation of Subsection 458.331(1)(t), Florida Statutes (2002), and imposing a penalty as follows: a three-year period of probation; a fine of $10,000; and such additional community service and continuing

education requirements as the Department of Health determines necessary.

DONE AND ENTERED this 31st day of January, 2008, in Tallahassee, Leon County, Florida.

William F. Quattlebaum

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 31st day of January, 2008.

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.