STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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| DEPARTMENT OF HEALTH, BOARD OF MEDICINE, | ) | |
| Petitioner, | ) | |
| vs. | ) | Case No. 07-2539PL |
| JORGE RIVERA, M.D., | ) | |
| Respondent. | ) | |

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on October 15, 2007, in Fort Myers, Florida, before Susan B. Harrell, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Diane K. Kiesling, Esquire
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For Respondent: John W. Bocchino, Esquire
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## STATEMENT OF THE ISSUES

The issues in this case are whether Respondent violated Subsection 458.331(1)(t), Florida Statutes (2001),[1] and, if so, what discipline should be imposed.

## PRELIMINARY STATEMENT

On February 7, 2005, Petitioner, Department of Health (Department), filed an Amended Administrative Complaint against Respondent, Jorge Manuel Rivera, M.D. (Dr. Rivera), alleging that Dr. Rivera violated Subsection 458.331(1)(t), Florida Statutes. The case was originally forwarded to the Division of Administrative Hearings (DOAH) on September 8, 2005, and was assigned DOAH Case No. 05-3250PL. On December 21, 2005, Petitioner filed a Motion to Relinquish Jurisdiction for the purpose of presenting the case to the Probable Cause Panel of the Board of Medicine (Board) for reconsideration. The motion was granted, and the file of DOAH was closed. The Probable Cause Panel did not dismiss the case.

On September 8, 2007, the Department again forwarded the case to DOAH for assignment to an Administrative Law Judge to conduct the final hearing.

On September 19, 2007, the Department filed a Motion to Amend Administrative Complaint. The motion was granted, and the Second Amended Administrative Complaint was filed as of October 3, 2007.

The parties agreed to certain facts contained in paragraphs A through E, H, and I of Section 5 of Petitioner's Unilateral Pre-hearing Statement and paragraphs (a) through (d) and (i) of Respondent's Unilateral Pre-hearing Statement. To the extent relevant, those facts are incorporated into this Recommended Order.

At the final hearing, Joint Exhibits 1, 2, and 3 were admitted in evidence. The Department called the following witnesses: Pat McClure; Tracy Vo, M.D.; Jorge Rivera, M.D.; Brian Kurland, M.D.; and Minnea Kalra, M.D. Petitioner's Exhibits 1 and 2 were admitted in evidence. Dr. Rivera called John Patrick, M.D., as his witness. Respondent's Exhibits 1 through 8, 9A, 9B, and 10 were admitted in evidence.

At the final hearing, the parties agreed to file their proposed recommended orders within ten days of the filing of the transcript. The two-volume Transcript was filed on December 12, 2007. The parties filed their proposed recommended orders on December 24, 2007.

On December 24, 2007, Dr. Rivera filed Respondent Jorge Rivera, M.D.'s Motion to Have Hearing Transcript Redone and Retranscribed. The motion was heard by telephonic conference call on January 7, 2008. Both parties agreed that the Transcript contains many errors. The motion was granted. The one-volume Amended Transcript was filed on January 25, 2008.

The parties were allowed ten days after the filing of the Amended Transcript to file any amendments to their proposed recommended orders based on the corrections made to the Transcript. The parties timely filed amended proposed recommended orders.

## FINDINGS OF FACT

1. The Department is the state agency charged with the regulation of the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to the allegations in the Second Amended Administrative Complaint, Dr. Rivera was a licensed physician in the State of Florida, having been issued license number ME 0054619. Dr. Rivera is an anesthesiologist.

3. On May 11, 2002, Patient A.V., an 82-year-old male, presented to the emergency room of Gulf Coast Hospital (Gulf Coast) with complaints of shortness of breath. A.V. had a history of chronic obstructive pulmonary disease. A.V. was admitted to the hospital by Michele Candelore, D.O.

4. Gulf Coast is a small community hospital with approximately 150 beds. Southwest Florida Regional Medical Center (Southwest), a larger tertiary care hospital, is located three to five miles away from Gulf Coast.

5. On May 16, 2002, Dr. Rivera provided anesthesia services to A.V. in association with a bronchoscopy. As a result of providing services to A.V., Dr. Rivera was familiar with A.V.'s medical conditions and risk factors for anesthesia.

6. On May 18, 2002, Tracy Vo, D.O., was the physician on call at Gulf Coast. She was providing coverage for A.V.'s physician, and, around noon on that date, she discharged A.V. Dr. Vo left Gulf Coast and received a call between 5:00 and 5:15 p.m. that A.V. was complaining of abdominal pain and nausea. Dr. Vo ordered tests for A.V., including an abdominal ultrasound.

7. Dr. Vo arrived at Gulf Coast between 5:15 and 5:30 p.m. She found A.V. to be hypotensive with rapidly decreasing systolic blood pressure. The results of the ultrasound showed that A.V. had a 5.3 centimeter abdominal aortic aneurysm (AAA) with a surrounding collection of fluid. An AAA is a life-threatening condition. Dr. Vo transferred A.V. to the intensive care unit (ICU), where she began infusions of fluids and dopamine in an attempt to elevate A.C.'s blood pressure and to resuscitate him.

8. Dr. Vo requested a surgical consult. Dr. Harry Black, the on-call surgeon was not available, and the consult was referred to Dr. DeMoya, a general surgeon who was covering for Dr. Black. Dr. DeMoya was in surgery at another hospital and

could not come to Gulf Coast. He was advised that A.C. had an AAA. Dr. DeMoya recommended that A.C. be transferred to Southwest, which was better equipped to handle an AAA. Dr. Vo felt that A.C. was too unstable to transfer at that time.

9. In order to rapidly pump fluids into A.C., Dr. Vo asked the supervising nurse to contact the on-call anesthesiologist for a consult for placing a central line. A central line is a catheter that is passed through a vein, ending up in the thoracic portion of the vena cava or in the right atrium of the heart.

10. Dr. Rivera was an employee of Dr. John Patrick, who was the chief of Anesthesiology at Gulf Coast. Dr. Patrick was out of town on May 18, 2002, and Dr. Rivera was the on-call anesthesiologist. Being on call means that the physician gets called when anesthesia services are needed.

11. Dr. Rivera was contacted concerning the placement of a central line for A.V. Dr. Rivera got to Gulf Coast between 6:00 and 6:30 p.m. He went to the bedside of A.V. and recognized A.V. from having provided anesthesia services to A.V. earlier in A.V.'s admission. Dr. Rivera told Dr. Vo that he did not feel comfortable placing a central line and refused to do so. Although he had been taught as a resident to place a central line, he had not placed a central line since his residency in 1983.

12. Dr. Vo asked the supervising nurse, Ellen Haviland, to continue her efforts to locate a vascular surgeon. Nurse Haviland contacted Dr. Brian Kurland, a vascular surgeon. Dr. Kurland agreed to come to Gulf Coast. Nurse Haviland told Dr. Rivera that Dr. Kurland was on his way to the hospital, and Dr. Rivera said that if Dr. Kurland was on his way that Dr. Kurland could place the central line.

13. Dr. Kurland told the nurse to make sure that the patient and his family wanted the patient to undergo the surgery because of the severity of the operation and the risk of not having a successful outcome. He also ordered that the operating team be mobilized.

14. After speaking with Dr. Kurland, Nurse Haviland went to the surgical supply room to make sure that the grafts needed for the operation were available.

15. Dr. Vo told Dr. Rivera that Dr. Kurland was coming and that she was going to transfer A.V. to the operating room. General anesthesia is necessary for an AAA repair. Dr. Rivera recommended that A.C. be transferred to another hospital and refused to provide anesthesia to A.C. because he felt that the risk of giving anesthesia at Gulf Coast was unacceptable. Dr. Rivera noted his recommendation in the progress notes for A.V. at 7:00 p.m. Dr. Rivera then left the hospital and went home. He did not attempt to contact Dr. Kurland directly to

advise Dr. Kurland of his concerns and that he was not going to provide anesthesia services.

16. Dr. Kurland arrived at the hospital and went directly to the operating room, where he expected to find the patient and the operating team. However, no one was in the operating room. Dr. Kurland went to the ICU, where A.C. was. Dr. Kurland was advised that A.V. was not in the operating room because Dr. Rivera had refused to do the anesthesia.

17. Dr. Kurland telephoned Dr. Rivera and told Dr. Rivera that although A.V. was a high-risk patient and would probably die, the best chance for saving A.V.'s life was to perform the surgery at Gulf Coast rather than transferring A.V. to another hospital. Dr. Rivera refused to come to the hospital to provide the anesthesia services.

18. Dr. Kurland told the nursing staff to try to get another anesthesiologist and the chief of surgery. Dr. Kurland spoke with Dr. Patrick and told him that A.V. needed to have emergency surgery.

19. Dr. Kurland placed a central line in A.V. to facilitate the giving of medications and fluids. Dr. Kurland told A.V.'s family that because they could not get an anesthesiologist that they had two options, either not to operate and let A.V. pass away or transfer him to another hospital for surgery.

20. It was decided to transfer A.V. to Southwest. The Emergency Medical Services (EMS) personnel were called to transfer the patient. When the EMS staff arrived, A.V. was intubated. Shortly thereafter, A.V. went into cardiac arrest and unsuccessful efforts were made to resuscitate A.V. A.V. was pronounced dead at 8:16 p.m.

21. After talking with Dr. Kurland, Dr. Patrick called Dr. Rivera and told him to go to the hospital and provide the anesthesia because Dr. Kurland had declared an emergency and was going to perform surgery. Dr. Rivera obeyed Dr. Patrick because Dr. Patrick "was paying his paycheck" and left his home to go to the hospital. Shortly after his conversation with Dr. Rivera, Dr. Patrick was advised that A.V. had died. Dr. Patrick called Dr. Rivera and told him not to go to the hospital because A.V. had died.

22. John Downs, M.D., testified as an expert witness for Dr. Rivera. He is a professor at the University of South Florida. Dr. Downs is a nationally recognized expert in anesthesiology, but the last time that he was an on-call anesthesiologist in a small community hospital similar to Gulf Coast was in 1985.

23. It was Dr. Down's opinion that Dr Rivera did not violate the standard of care by leaving the hospital, by refusing to perform anesthesia services, and by not telling Dr.

Kurland that he was not going to do the anesthesia prior to Dr. Kurland's telephone call to him. It was Dr. Down's opinion that Dr. Rivera was not required to give the anesthesia because the patient would die. Dr. Down's opinion misses the mark. A.V. was in a life or death situation. Without surgery, A.V. was going to die. A.V. was not stable enough to transfer to another hospital; thus, emergent surgery was necessary if there was going to be any chance for survival. Dr. Down's opinion that Dr. Rivera was not required to perform the anesthesia services is not credited.

24. Minnea B. Kalra, M.D., testified as the Department's expert. Dr. Kalra has practiced for approximately 30 years and has practiced as an on-call anesthesiologist in small community hospitals similar to Gulf Coast. In 2002, she was practicing as an on-call anesthesiologist in a 150-bed community hospital comparable to Gulf Coast. She has been the on-call anesthesiologist called to treat emergency AAA's in small facilities such as Gulf Coast.

25. It was Dr. Kalra's opinion that Dr. Rivera should have tried to get someone else to place the central line if he was unable to do so.

26. Dr. Kalra opined that Dr. Rivera violated the standard of care by not staying at the hospital when he knew that

Dr. Kurland, a vascular surgeon, was on his way to the hospital. An AAA calls for surgery, and it was Dr. Rivera's duty to stay with the patient and provide the necessary anesthesia. Dr. Kalra testified that Dr. Rivera's last chance to do his duty and agree to provide anesthesia was when Dr. Kurland advised Dr. Rivera by telephone that he was taking A.V. to surgery. Dr. Rivera failed to perform his duty when he told Dr. Kurland that he was not going to do the anesthesia.

27. Dr. Kalra opined that Dr. Rivera had a duty to remain at the hospital until Dr. Kurland arrived so that he could discuss his concerns and the risks of providing anesthesia to A.V. directly with Dr. Kurland. Dr. Rivera failed to perform his duty.

28. Dr. Kalra opined that Dr. Rivera had a duty to help find someone to provide anesthesia services such as placing the central line when Dr. Rivera could not place the central line because of lack of competence and would not provide surgical anesthesia services. Dr. Rivera was the on-call anesthesiologist, and it was his responsibility to provide the services or assist in finding an anesthesiologist who could provide the services. Dr. Rivera failed to do his duty.

29. Dr. Kalra's opinions that Dr. Rivera did not provide care to A.V. at a level a reasonably prudent physician under

similar conditions and circumstances is expected to meet are credited.

## CONCLUSIONS OF LAW

30. 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).

31. The Department has the burden to establish the allegations in the Second Amended Administrative Complaint by clear and convincing evidence. See Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996).

32. The Department alleges that Dr. Rivera violated Subsection 458.331(1)(t), Florida Statutes, which provides that the following acts are grounds for disciplinary action:

> (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 involve the 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.

33. The Department alleges that Dr. Rivera 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 by the following acts:

> a. By refusing to insert a central line in Patient A.V.;
> b. After refusing to insert a central line in Patient A.V., by failing to offer suggestions or assistance to Patient A.V.;
> c. By ordering transfer for a patient who was not his patient;
> d. By leaving the hospital and going home when surgery was imminent for A.V.;
> e. By failing to attempt to find other qualified personnel to come to the hospital to assist in the care of Patient A.V.;
> f. By leaving the hospital without speaking with the vascular surgeon and telling him that no anesthesiologist would be there when he arrived;
> g. By refusing to return to the hospital and administer anesthesia to Patient A.V.

34. The Department conceded in its Proposed Recommended Order that it failed to establish that Dr. Rivera's refusal to insert a central line fail below the standard of care, stating that Dr. Rivera was not credentialed to insert central lines and had a valid reason for refusing to insert a central line.

35. The Department failed to establish that Dr. Rivera ordered the transfer of A.V. Dr. Rivera recommended that A.V. be transferred.

36. The Department established by clear and convincing evidence that Dr. Rivera left the hospital after he was told that Dr. Kurland was coming to the hospital and that surgery was imminent for A.V. His leaving the hospital fell below the standard of care.

37. The Department established by clear and convincing evidence that Dr. Rivera failed to assist in locating another anesthesiologist to insert the central line and to assist during an operation on A.V. for the AAA. His failure to assist fell below the standard of care.

38. The Department established by clear and convincing evidence that Dr. Rivera failed to remain at the hospital to discuss his concerns with Dr. Kurland and failed to contact Dr. Kurland directly prior to Dr. Kurland’s arrival at the hospital to let Dr. Kurland know that he was not going to provide anesthesia services. His failure to contact Dr. Kurland fell below the standard of care.

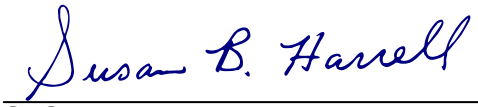
39. The Department established by clear and convincing evidence that Dr. Rivera refused to come to the hospital to provide anesthesia services when Dr. Kurland telephoned him and told him that he was needed to provide anesthesia services. Dr. Rivera’s refusal to return to the hospital fell below the standard of care.

40. The Department has established by clear and convincing evidence that Dr. Rivera violated Subsection 458.331(1)(t), Florida Statutes, 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.

## RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a final order be entered finding that Dr. Rivera violated Subsection 458.331(1)(t), Florida Statutes; suspending his license for one year followed by a two-year probation on whatever terms the Board of Medicine sees fit; imposing a fine of $10,000; requiring that Dr. Rivera complete three hours of continuing medical education in medical ethics and five hours in risk management; and requiring that Dr. Rivera complete 100 hours of community service.

DONE AND ENTERED this 13th day of March, 2008, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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this 13th day of March, 2008.

## ENDNOTE

[1/] Unless otherwise indicated, all references to the Florida Statutes are to the 2001 version.

## 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.