STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. GUILLERMO ACHONG, Respondent.	)	Case No. 09-2722PL

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on August 31, 2009, and September 1, 2009, by video teleconference, with the parties appearing in Miami, Florida, before Patricia M. Hart, a duly-designated Administrative Law Judge of the Division of Administrative Hearings, who presided in Tallahassee, Florida.

APPEARANCES

For Petitioner: Christopher C. Torres, Esquire
Diane K. Kiesling, Esquire
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

For Respondent: Charles B. Patrick, Esquire
1648 South Bayshore Drive
Miami, Florida 33133

STATEMENT OF THE ISSUE

Whether the Respondent committed the violations alleged in the Administrative Complaint December 19, 2005, and, if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

In an Administrative Complaint dated December 19, 2005, the Department of Health, Board of Medicine ("Department") charged Guillermo Achong, M.D., with violating Section 458.331(1)(t), Florida Statutes (2003)[1] by committing the following acts:

> a. Failure to personally evaluate Patient L.H. in a timely manner;
>
> b. Failed to telephonically elicit sufficient information regarding Patient L.H.'s clinical status;
>
> c. Failed to consider whether Patient L.H. had presented with placental abruption and treat her appropriately for that condition;
>
> d. Failed to provide appropriate, timely medical assistance to Patient L.H.

Dr. Achong timely requested an administrative hearing to resolve disputed issues of material fact, and the Department transmitted the matter to the Division of Administrative Hearings for the assignment of an administrative law judge. After several continuances, the final hearing was held on August 31, 2009, and September 1, 2009.

At the hearing, the Department presented the testimony of Jennifer Williams; John Dubok; and Linda Greene, M.D.

Petitioner's Exhibits 1 through 7, 10, and 12 through 14 were offered and received into evidence. Dr. Achong testified on his own behalf and presented the testimony of Ramon Hechavarria, M.D., and Nabil Matar, M.D. Respondent's Exhibits 1 and 3 through 10 were offered and received into evidence.

The three-volume transcript of the proceedings was filed with the Division of Administrative Hearings on September 16, 2009, and the parties timely filed proposed findings of fact and conclusions of law, which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The Department is the state agency responsible for the investigation and prosecution of complaints involving physicians licensed to practice medicine in Florida. See § 455.225, Fla. Stat. (2009). The Board is the entity responsible for regulating the practice of medicine in Florida and for imposing penalties on physicians found to have violated the provisions of Section 458.331(1), Florida Statutes. See § 458.331(2), Fla. Stat. (2009).

2. At the times pertinent to this proceeding, Dr. Achong was a physician licensed by the State of Florida, having been

issued license number ME38304, and his medical office was located at 690 East 49th Street, Hialeah, Florida. Dr. Achong specialized in obstetrics and gynecology, although he was not board-certified in these areas of practice. Dr. Achong has not previously been the subject of disciplinary action by the Board of Medicine, and he is not currently practicing medicine, having retired with a disability in 2006.

3. At the times pertinent to this proceeding, Dr. Achong had hospital privileges at Hialeah Hospital and at North Shore Medical Center ("Medical Center"). Both facilities had his home telephone number and his beeper number. It was his practice to keep his beeper close to him at all times. When he was in the delivery room, it was his practice to give his beeper to the circulating nurse, who would be responsible for alerting him whenever someone tried to reach him on his beeper. The beeper he used in 2004 gave only the telephone number of the person trying to reach him, but he was able to recognize the number of Hialeah Hospital and the Medical Center.

4. On February 12, 2004, Patient L.H. went to her gynecologist, Ramon Hechavarria, M.D., for a routine examination. Patient L.H. was, at the time, a 27-year-old who was 32 weeks' pregnant, and she had previously had one live birth. Dr. Hechavarria's examination revealed that

Patient L.H.'s blood pressure was elevated, and Dr. Hechavarria admitted her to Medical Center for 24 hours for observation.

5. On February 12, 2004, Dr. Hechavarria ordered blood and laboratory tests done in the Medical Center. The blood tests included a Disseminated Intravascular Coagulopathy ("DIC") profile and a Fibrinogen Degradation Profile ("FDP"); the results of these blood tests were normal. Patient L.H.'s hemoglobin and her platelet count were normal, and, although there was a slight trace of protein in her urine, that is considered normal.

6. On February 13, 2004, Dr. Hechavarria discharged Patient L.H. with a diagnosis of chronic hypertension and a prescription for 250 milligram tablets of Aldomet, to be taken three times per day. Aldomet is a medication that treats hypertension by lowering the blood pressure.

7. Patient L.H. was in good, stable condition when she was discharged on February 13, 2004. Readings from a fetal heart monitor taken during the time Patient L.H. was in the Medical Center indicated that the fetus was alive.

8. Dr. Hechavarria considered Patient L.H.'s to be a high risk pregnancy in part because of her hypertension but also because she came in late for prenatal care, missed two appointments, and was overweight.

9. Dr. Hechavarria left town for a vacation on February 13, 2004, and Dr. Achong was to cover his patients during his absence under an arrangement whereby Dr. Hechavarria and Dr. Achong provided coverage for each other when one or the other was out of town or otherwise unavailable to see patients. Under the arrangement, Dr. Achong was expected to go to the hospital if one of Dr. Hechavarria's patients were in labor or if a patient were to go to the emergency room complaining of vaginal bleeding or any other obstetrical or gynecological condition.

10. Whenever coverage of patients was passing from one physician to the other, Dr. Hechavarria and Dr. Achong advised each other of any patient that was in the hospital for gynecological, obstetrical, or any other medical reason. They did not advise each other of patients that had recently been discharged from the hospital, and, therefore, Dr. Hechavarria did not discuss Patient L.H. with Dr. Achong because she had been discharged from the Medical Center before Dr. Achong began covering Dr. Hechavarria's patients.

11. Patient L.H. presented at the Medical Center at approximately 2:00 a.m. on February 15, 2004, complaining of abdominal pains. She was seen by labor and delivery nurse Jennifer Williams, a registered nurse with 20 years' nursing experience, with 13 years' experience in the Medical Center's

labor room, and with training as a mid-wife. Nurse Williams had worked with Dr. Achong at the Medical Center since 1991.

12. Subsequent to Patient L.H.'s arrival at the Medical Center, Nurse Williams interviewed her, took her medical history, examined her, and entered the pertinent information on the Medical Center's Admission Assessment. The Admission Assessment form was dated February 15, 2004, and the time was noted as 2:45 a.m. The time written by Nurse Williams' signature on the Admission Assessment form was 3:00 a.m., and it appears that the information was obtained and entered on the form between 2:00 a.m. and 3:00 a.m.

13. Pertinent to this matter, Nurse Williams maintained several other documents recording Patient L.H.'s condition and observations and actions taken by Nurse Williams relating to Patient L.H. Nurse Williams began maintaining a Labor Flow Record at 2:07 a.m. and she made periodic entries on the Labor Flow Record related to, among other things, Patient L.H.'s vital signs, the results of vaginal examinations and fetal monitoring, uterine activity, and pain intensity at different times during the night and morning. In addition, Nurse Williams entered on the Labor Flow Record the time and content of her communications with Dr. Achong; the first recorded contact between Dr. Achong and Nurse Williams was recorded on the Labor Flow Record as 2:30 a.m. Nurse Williams also maintained Progress Notes in

which she recorded her observations of Patient L.H. and her conversations with Patient L.H. The first entry in the Progress Notes was at 2:35 a.m.[2]

14. Nurse Williams' Progress Notes reflect that, at 2:35 a.m., Patient L.H. advised Nurse Williams that she had contractions and believed she had been in labor since 6:00 p.m. the previous evening but had waited to come to the Medical Center until she was certain she was in labor. Patient L.H. also reported abdominal pain in her upper abdomen that did "not go away," and Nurse Williams observed that Patient L.H. was distressed by the pain in her abdomen. Patient L.H. also told Nurse Williams that she had no ruptured membranes or vaginal bleeding. Nurse Williams noted that she examined Patient L.H. and felt contractions but was unable to detect a fetal heart tone.

15. Nurse Williams reported in the Admission Assessment form that Patient L.H. was having uterine contractions of moderate intensity and 60 seconds' duration, that her cervix was dilated 1-to-2 centimeters, that she had vaginal bleeding that was bright red, that her blood pressure was 159/118, which she described as "elevated," and that Patient L.H.'s abdominal pain was the "worse" pain on a pain scale ranging from 1 to 10; there is, however, no indication on the Admission Assessment form that

the pain was constant. Nurse Williams also noted on the Admission Assessment form that she heard no fetal heart rate.

16. Although the time noted on the Admission Assessment form was 2:45 a.m., it is apparent from a review of the relevant records that the information included on the Admission Assessment form was obtained by Nurse Williams over a period of time extending from the time Patient L.H. presented to her until 3:00 a.m., the time on the Admission Assessment form beside Nurse Williams' signature.

17. Nurse Williams reported in the "Physician /CNM in/Called Report" section of the Labor Flow Record that she contacted Dr. Achong at 2:30 a.m. and conveyed to him the following information: "[P]atient arrived in ER c/o contractions since 6 pm last night & observation that no FHT [fetal heart tone] and contractions palpated." Nurse Williams telephoned Dr. Achong using his home telephone, even though his beeper number was also on file at the Medical Center. There is nothing in the report Nurse Williams gave to Dr. Achong at 2:30 a.m. that would require that he proceed to the Medical Center and examine Patient L.H., and he did not violate the standard of care by failing to do so.

18. Because Dr. Achong did not know Patient L.H., Nurse Williams' normal procedure would have been to advise Dr. Achong of Patient L.H.'s history, including the medications

she was taking, and her vital signs, including her blood pressure. No notation appears in the Labor Flow Record to confirm that she gave Dr. Achong this information during her conversation with him at 2:30 a.m., nor is there a notation in the 2:30 a.m. entry in the Labor Flow Record that Nurse Williams told Dr. Achong about the results of her examination of Patient L.H.'s cervix, Patient L.H.'s complaint of abdominal pain, or the presence of vaginal bleeding of bright red blood.[3]

19. Nurse Williams indicated in her entry in the "Physician/CNM in/Called Report" section of the Labor Flow Record that Dr. Achong ordered a "stat," or expedited, obstetrical sonogram during the 2:30 a.m. contact with Nurse Williams. The purpose of the obstetrical sonogram was to determine if the fetus was alive.

20. Although not noted in the Labor Flow Record, the Labor and Delivery Orders form completed by Nurse Williams indicates that, at 2:30 a.m., Dr. Achong ordered a complete blood count, which is routine with a patient in labor; a DIC profile; and a Comprehensive Metabolic Panel ("CMP"). The Labor and Delivery Orders form contains standard orders for a woman in labor, but the DIC profile and the CMP tests were not included on the form but were ordered specifically by Dr. Achong.

21. A DIC profile is used to determine if a patient has a problem with blood clotting. The DIC includes an assessment of

prothrombin time and partial thromboplastin time, both of which indicate different levels at which a patient's blood is able to clot. It is important to know whether a woman in labor and delivery has a clotting problem, or coagulopathy, because of the danger of bleeding, and the classic situation in which DIC profiles are ordered is when there is fetal demise. Because Patient L.H. had the high risk factors of overweight and hypertension and because Nurse Williams could detect no fetal heart tone, Dr. Achong's order for the DIC profile was appropriate and met the standard of care.

22. It is also appropriate to order a DIC profile when there is a concern about placental abruption, which is the separation of the placenta from the walls of the vagina. A placental abruption causes a great deal of bleeding, and can cause death when not treated, because the fetus is still in the womb and the uterus is not able to contract and constrict the large blood vessels that attach to the placenta. Although hypertension is one risk factor for placental abruption, the symptoms of placental abruption also include fetal demise, bleeding, constant pain, a decrease in hematocrit, and a number of other conditions. There is no indication in Patient L.H.'s medical records that Dr. Achong had sufficient information at 2:30 a.m. that would indicate that Patient L.H. had a possible

placental abruption, and he ordered the DIC profile because of the lack of fetal heart tones.[4]

23. The CMP includes tests for kidney and liver function and for uric acid. It is used to determine if a woman has pre-eclampsia, or pregnancy-induced hypertension. Given Patient L.H.'s history of hypertension and the level of her blood pressure as reflected in the Admission Assessment form, Dr. Achong's order for the CMP was appropriate and met the standard of care in ordering the CMP.

24. All orders for blood tests for women in labor and delivery are treated as "stat" orders and are processed ahead of all other test orders except those from the emergency room. When the situation warrants, a physician may order that the tests be performed more quickly than the usual "stat" order would require, and it would be possible to obtain blood-test results within 45 minutes. There is, however, no indication in Patient L.H.'s medical records that Dr. Achong had any information at 2:30 a.m. that might indicate that he should further expedite Patient L.H.'s blood tests.

25. Nurse Williams reported in her Progress Notes that, at 2:40 a.m., Patient L.H. reported a "gush of something down there," and Nurse Williams noted that she observed a large amount of blood; there is, however, no notation in the Progress Notes regarding the color of the blood. Nurse Williams also

included a notation in the Progress Notes that Patient L.H.'s cervix was "3cm dilated, 50% effaced, -3 station" to describe the progress of Patient L.H.'s labor.

26. Nurse Williams reported in the Labor Flow Record that she contacted Dr. Achong at 2:45 a.m. and conveyed to him the following information: "Dr. Achong notified of gush of vaginal bleeding. VE [vaginal examination] 2-3, 50% effaced, -3 station and that we are awaiting sonogram." The results of Nurse Williams' vaginal examination of Patient L.H. showed that Patient L.H. was in active labor. The information that Patient L.H. experienced a "gush of vaginal bleeding" did not indicate to Dr. Achong that there was anything more than one episode of bleeding, which he attributed to an especially heavy "bloody show," which is the bleeding that occurs when the cervix is dilating. The notation indicates that Dr. Achong told Nurse Williams to call him if Patient L.H. went to delivery.

27. The information conveyed to Dr. Achong at 2:45 a.m., as reflected in the notation in the Labor Flow Record, was not sufficient to indicate that Patient L.H. was not proceeding through labor normally to a vaginal delivery of the dead fetus, which is preferred over delivery by a Cesarean Section. Nurse Williams did not include in her records a notation that she advised Dr. Achong that the "gush of vaginal bleeding"

consisted of a large amount of bright red blood, which would have been an indication of a possible placental abruption.

28. Some bleeding is normal during labor, but it is usually a dark color from having been in the uterus and in a small amount or tickle, although there could be a "gush of blood" during normal labor. When Dr. Achong was advised by Nurse Williams that Patient L.H. had a "gush of blood," however, it was his responsibility to inquire into the amount of blood, the color of the blood, and the persistency of the bleeding to determine if Patient L.H. was proceeding with normal labor or if she was experiencing a hemorrhage or other abnormal condition.

29. Nurse Williams made no entries in the Progress Notes for Patient L.H. between 2:40 a.m. and 3:40 a.m., when she reported that the ultrasound had been completed. She further noted in her Progress Notes: "Report of no fetal heart tones to Dr. Achong. Orders given." Nurse Williams additionally made a notation in the Labor Flow Record that, at 3:40 a.m., she contacted Dr. Achong and reported to him the following: "Ultrasound report No FHT's given to Dr. Achong. Orders received." Nurse Williams did not, however, indicate in her notations what orders were given. Nurse Williams contacted Dr. Achong through his home telephone number, which was normal procedure during the nighttime hours.

30. When the sonographer, that is, the person performing the sonogram, entered Patient L.H.'s room to perform the sonogram, he noted that Patient L.H. was sitting upright in bed, was combative, and was in a lot of pain. He also noted that there was a fair amount of blood on the bed sheets. The sonographer was able to get Patient L.H. to lie on the bed, and he performed "a very short ultrasound,"[5] and pulled the machine out of the room and into the hall. He powered the machine back up and read the numbers off the worksheet on the machine. He confirmed that the fetus was dead and that the placenta appeared to be balled up rather than lying smoothly against the uterine wall, as is normal. While he was writing down the information from the worksheet on the machine, Nurse Williams approached him and told him that she had Dr. Achong on the telephone. He told her that he had "a placental abruption and fetal demise."[6] He then wrote up his report, left a copy for Nurse Williams, and went downstairs to process the sonogram images.[7]

31. The results of the sonogram were reported on a form headed "Obstetrical Preliminary Report," which was completed by the sonographer. A radiologist is usually present at the Medical Center during daytime hours to read sonograms, but on the off-hours, it is the practice of the sonographer to present a sonographer's impression of what was seen during the sonogram. The sonographer who performed the sonogram on Patient L.H. noted

on the report that her history included obesity, hypertension, heavy vaginal bleeding, and contractions. He included the following comments in the report: "Ant/Rt [unintelligible] placenta appears to be 'balled up[.]' Suggestion of placental abruption," and, on a separate line, "NO FETAL HEART MOTION SEEN PT IS COMBATIVE." Finally, at the bottom of the report, the sonographer noted that a copy of the report was given to Nurse Williams. There was no notation as to the time the sonographer gave the report to Nurse Williams, but, even if she had the report, she did not read it to Dr. Achong; rather, she put the copy of the report in Patient L.H.'s chart for Dr. Achong to review when he came to the hospital and gave him only a verbal report.

32. Nurse Williams did not tell Dr. Achong during the 3:40 a.m. telephone conversation that the sonographer had reported a possible placental abruption.[8] Dr. Achong was familiar with and had treated placental abruptions prior to February 15, 2004, and he always treated patients with placental abruptions on an emergency basis because both the mother and the baby could die if treatment was not received as soon as possible. Had Nurse Williams advised Dr. Achong that the sonographer had told her that he found a placental abruption or that the sonogram report included a reference to a possible

placental abruption, he would have gone to the Medical Center immediately.

33. At 3:45 a.m., Nurse Williams noted in her Progress Notes that she gave Patient L.H. Nubain and Phenergan for her painful contractions. There is no mention of continued vaginal bleeding in this entry in the Progress Notes.

34. At 4:15 a.m., Nurse Williams noted in her progress notes that Patient L.H. was sleeping quietly and was relaxed and that Pitocin had been administered in accordance with Dr. Achong's orders. Pitocin is used to induce labor, augment labor, or to stop bleeding. In this case, Dr. Achong ordered the Pitocin to regulate Patient L.H.'s contractions. There is no mention in the 4:15 a.m. entry in the Progress Notes of continued vaginal bleeding.

35. The next entry in Nurse Williams' Progress Notes was made at 5:15 a.m., when Nurse Williams reported that she had observed vaginal bleeding, that a vaginal examination showed dilation of four centimeters, and that Patient L.H. was very restless and moving around the bed.

36. Nurse Williams received the laboratory report showing the results of the blood tests ordered by Dr. Achong at or around 5:00 a.m. According to the laboratory report, the blood for these tests was drawn at or about 3:20 a.m.; the report did not show any critical values in the blood sample.

Nurse Williams attempted to contact Dr. Achong to convey these results to him. She noted on the Labor Flow Record that, at 5:15 a.m. "Dr. Achong beeped re lab results. Phone message left on home phone to call LR [Labor Room]." Nurse Williams made another entry on the Labor Flow Record that, at 6:55 a.m., she left a "message to Dr. Achong answering machine at home re labor progress update and labs."

37. Dr. Achong was not, however, at home to receive the telephone calls or the messages. At or about 5:00 a.m. on February 15, 2004, Dr. Achong received a telephone call on his home telephone from Hialeah Hospital advising him that one of his patients or one of Dr. Hechavarria's patients was in active labor and about to deliver. Shortly after receiving the telephone call, Dr. Achong left his home to travel to Hialeah Hospital. He carried his beeper with him, but he did not receive any calls on the beeper. When he arrived at Hialeah Hospital and prepared to go into the delivery room, he gave it to the circulating nurse in case he should receive a beeper call while he was in the delivery room.

38. Nurse Hayes, who had replaced Nurse Williams when Nurse Williams' shift had ended at 7:00 a.m., made a notation on the Labor Flow Record that, at 7:15 a.m., she called Dr. Achong and left a message.

39. At 7:25 a.m., while he was in the delivery room, Nurse Hayes called his beeper. The circulating nurse had his beeper, and she notified him that he had received a call and told him the number. He recognized the number of the Medical Center, and he told the nurse to call the Medical Center and let them know that he was in the delivery room at Hialeah Hospital. Nurse Hayes asked that he call back as soon as possible.

40. Blood for additional blood tests was drawn at or about 7:30 a.m., and the results, which were available within 15 minutes, showed several critical values that indicated that Patient L.H. was entering coagulopathy.

41. At 7:38 a.m., as soon as he finished the delivery, he called the Medical Center and spoke with Nurse Hayes, who gave him a report on the status of Patient L.H. She told him that Patient L.H. had heavy bleeding and that the vaginal examination showed no change in the cervix. Dr. Achong ordered the Pitocin turned off.

42. When Dr. Achong arrived at the Medical Center at 7:56 a.m., he found Patient L.H. very combative, bleeding, and with very bad vital signs. He ordered a "stat" Cesarean Section and ordered a blood transfusion. Patient L.H. died at 8:38 a.m., before any of the measures ordered by Dr. Achong could be implemented. The cause of death was recorded as placental abruption.

Summary

43. In summary, the evidence presented by the Department is not of sufficient weight to establish that Nurse Williams conveyed to Dr. Achong the information necessary for him to conclude that he should personally conduct a clinical evaluation of Patient L.H.; that he should consider the possibility that Patient L.H. had placental abruption; or that he should have provided medical assistance to Patient L.H. prior to his contact with Nurse Hayes at 7:38 a.m. Nurse Williams' Progress Notes report only two remarkable items: There were no fetal heart tones detected by physical examination or by sonogram; and, at 2:40 a.m., Patient L.H. reported a "gush of something" and Nurse Williams observed a large amount of blood.

44. Neither Nurse Williams' entries in the Labor Flow Record regarding her contacts with Dr. Achong nor her testimony, to the extent that it has been found persuasive, is sufficient to establish that she advised Dr. Achong that she had observed a large amount of red blood at 2:40 a.m. or that the sonographer detected a possible placental abruption in the sonogram.

45. Finally, Nurse Williams did not follow the protocol that required her to contact Dr. Achong through his beeper when she did not get an answer on his home telephone; she tried his beeper only once, at 5:15 a.m., and when she failed to reach him, left three messages on his home telephone. The Department

presented no evidence to establish that Nurse Williams attempted to reach Dr. Achong by beeper between 5:15 a.m. and 7:55 a.m., the time of her last call to Dr. Achong's home telephone.

46. Furthermore, the Department did not present evidence of sufficient weight to establish that Dr. Achong failed to initiate the appropriate procedures after he arrived at the Medical Center and examined Patient L.H. at or around 8:00 a.m.

47. The evidence presented by the Department is, however, of sufficient weight to establish that Dr. Achong should have questioned Nurse Williams further when she advised him at 2:45 a.m. that she had observed a "gush" of vaginal bleeding. Even though vaginal bleeding may not be not unusual during labor, a report of a "gush" of blood should have alerted Dr. Achong to a potential problem. Although a physician practicing obstetrics is meeting the standard of care when relying on labor room nurses to advise him or her of the clinical status of labor and delivery patients and of any unusual symptoms exhibited by the patients, it is also incumbent on the physician to inquire further if a patient is presenting unusual symptoms. The persuasive evidence establishes that Dr. Achong violated the standard of care when he failed to ask Nurse Williams for additional information on Patient L.H.'s status during their 2:45 a.m. telephone conversation. Had he inquired further, Dr. Achong would have been alerted to the

possibility that Patient L.H. had a placental abruption and would have gone to the hospital to provide appropriate care for Patient L.H.

CONCLUSIONS OF LAW

48. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2009).

49. Section 458.331(1), Florida Statutes, authorizes 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. In its Administrative Complaint, the Department has alleged that Dr. Achong violated Section 458.331(1)(t), Florida Statutes, which provides that the following acts constitute grounds for disciplinary action by the Board:

> (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 $50,000 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. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances," or any combination thereof, and any publication by the board must so specify.

50. The "level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances" is commonly referred to as the "standard of care."

51. The Department seeks to impose penalties against Dr. Achong 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 violations alleged in the Administrative Complaint 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 (2009)("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.").

52. "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).

53. The Department alleged in the Administrative Complaint that Dr. Achong violated Section 458.331(1)(t), Florida Statutes, because he violated the standard of care by failing to personally evaluation Patient L.H. in a timely manner. Based on the findings of fact herein, the Department failed to prove this allegation by clear and convincing evidence. Based on the

information conveyed to him by Nurse Williams, on whom he appropriately relied, Dr. Achong had no reason to present himself at the Medical Center and personally examine Patient L.H. According to the information provided by Nurse Williams, Patient L.H. was progressing normally with labor; Patient L.H.'s report of abdominal pain and her hypertension were not sufficient risk factors, of themselves, to alert Dr. Achong that Patient L.H. needed his personal attention. The fact that the fetus was dead was also not a sufficient risk factor, even taken together with Patient L.H.'s abdominal pain and history of hypertension, to alert Dr. Achong that Patient L.H. needed his personal attention. It was within the standard of care for Dr. Achong to plan to deliver the fetus vaginally and to rely on Nurse Williams to monitor and report to him on the status of her labor. Finally, based on the findings of fact herein, Dr. Achong did not violate the standard of care by failing to personally attend Patient L.H. based on the Nurse Williams' notifying him that the sonogram showed no fetal motion. This merely confirmed Nurse Williams' earlier report that she had detected no fetal heart tones.

54. The Department alleged in the Administrative Complaint that Dr. Achong violated Section 458.331(1)(t), Florida Statutes, because he violated the standard of care by failing to elicit by telephone sufficient information regarding

Patient L.H.'s clinical status. Based on the findings of fact herein, the Department proved this allegation by clear and convincing evidence. Based on the information conveyed to him by Nurse Williams that Patient L.H. had experienced a "gush" of vaginal bleeding, Dr. Achong failed to meet the standard of care because he failed to inquire into the color, volume, and persistency of the blood. Had he learned at 2:45 a.m. that Patient L.H.'s bleeding consisted of a large amount of red blood, he would have been more alert to the possibility that Patient L.H. had a placental abruption and needed his personal attention. He may not, however, have reached this conclusion because Nurse Williams' Progress Notes fail to indicate that the vaginal bleeding was constant, which would be one symptom of placental abruption.

55. The Department alleged in the Administrative Complaint that Dr. Achong violated Section 458.331(1)(t), Florida Statutes, because he violated the standard of care by failing to consider whether Patient L.H. had presented with placental abruption and treat her appropriately for that condition. Based on the findings of fact herein, the Department failed to prove this allegation by clear and convincing evidence. Setting aside his failure to elicit further information about the vaginal bleeding, Dr. Achong had no reason to suspect that Patient L.H. had a placental abruption based on the information conveyed to

him by Nurse Williams, on whom he appropriately relied for complete information regarding Patient L.H.'s clinical status. Nurse Williams' notes do not reflect that she advised Dr. Achong of the amount or color of Patient L.H.'s vaginal bleeding, and the contention that Nurse Williams advised Dr. Achong at 3:40 a.m. that the sonographer found a "suggestion" of placental abruption is not supported by credible evidence.

56. The Department alleged in the Administrative Complaint that Dr. Achong violated Section 458.331(1)(t), Florida Statutes, because he violated the standard of care by failing to provide appropriate, timely medical assistance to Patient L.H. Based on the findings of fact herein, the Department failed to prove this allegation by clear and convincing evidence. When Dr. Achong examined Patient L.H. at approximately 8:00 a.m., the measures he took fell within the standard of care for treating a patient with placental abruption.

57. The disciplinary guidelines for the Board of Medicine are found in Florida Administrative Code Rule 64B8-8.001(1). The penalties provided for a violation of Section 458.331(1)(t), Florida Statutes, range from "two (2) years['] probation to revocation and denial, and an administrative fine from $1,000.00 to $10,000.00." Fla. Admin. Code R. 648-8.001(1)(a).

58. The Department's proposed penalty in this case includes elements not found in the penalty guidelines, so it is

necessary to consider Florida Administrative Code Rule 64B8-8.001(3), which provides that the Board of Medicine may consider aggravating and mitigating factors in determining whether to deviate from the penalties provided in Florida Administrative Code Rule 64B8-8.001(1). Florida Administrative Code Rule 64B8-8.001(3) provides:

> (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.

59. The significant aggravating factor in this case is the death of Patient L.H. Mitigating factors include the Department's proving one violation of the standard of care among the four identified in the Administrative Complaint; the fact that Dr. Achong had not previously been charged with or found guilty of committing any of the offenses alleged in the Administrative Complaint; and the lack of any previous disciplinary actions taken against Dr. Achong. These aggravating and mitigating factors have been considered in determining the recommended penalty, which deviates from the penalty range specified in Florida Administrative Code Rule 64B-8.001(1)(t).

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health, Board of Medicine, enter a final order finding that Dr. Achong violated Section 458.331(1)(t), Florida Statutes, by failing to elicit further information from Nurse Williams regarding the gush of blood she observed in Patient L.H and imposing the following penalties:

(a) Issuance of a letter of reprimand;

(b) Imposition of administrative fine in the amount of $2,500.00; and

(c) Six months' probation under such conditions as the Board of Medicine determines appropriate, should Dr. Achong ever resume the practice of medicine.

DONE AND ENTERED this 4th day of January, 2010, in Tallahassee, Leon County, Florida.

PATRICIA M. HART
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 4th day of January, 2010.

ENDNOTES

[1]/ All references to the Florida Statutes are to the 2003 edition unless otherwise indicated.

[2]/ In attempting to compile a chronological record of the events that took place after Patient L.H. was admitted to the Medical Center labor room, it become apparent that there are discrepancies in the times logged for various events. These discrepancies are, for the most part, insignificant, and the times at which certain events took place are included in the findings of fact only when relevant to the issues presented.

[3]/ Nurse Williams testified as follows:

> I told Dr. Achong -- he doesn't know this lady, so I would've told him what she complains of; her past history regarding her high blood pressure; the vaginal examination because that was one of the questions he should've asked me -- he would've asked me -- I'm sorry. So I would've had that ready to tell him. And what medication if she was on any for her high blood pressure; how she presented; whether she was in pain or not and I would've told him that I didn't hear a fetal heart rate and the vaginal examination included that there was bright red blood.

Transcript at page 47. Nowhere in her testimony did Nurse Williams indicate that she recalled telling Dr. Achong that Patient L.H. had vaginal bleeding of bright red blood.

[4]/ Even though Nurse Williams recorded Patient L.H.'s blood pressure on the Labor Flow Record as 159/118 at 2:25 a.m., Patient L.H.'s blood pressure had decreased to 149/87 by 2:30 a.m. There is nothing in the record to indicate which blood pressure level was reported to Dr. Achong during the 2:30 a.m. telephone call between him and Nurse Williams, and it is not evident from the record that Dr. Achong ordered the DIC profile because of Patient L.H.'s history of hypertension.

[5]/ Transcript at page 94.

[6]/ Transcript at page 95.

[7]/ The testimony of the sonographer that he heard Nurse Williams tell whoever was on the telephone that there was placental abruption and fetal demise is not sufficient to establish that Nurse Williams told Dr. Achong that Patient L.H. had a placental abruption. First, the sonographer did not establish in his testimony that he was standing close enough to Nurse Williams when she was on the telephone to overhear her conversation. Second, he did not have personal knowledge of the identity of the person to whom Nurse Williams was speaking on the telephone.

[8]/ There is no indication in Nurse Williams' Progress Notes or in the Labor Flow Record that she advised Dr. Achong at 3:40 a.m. that the sonogram showed that Patient L.H. had a possible placental abruption; her notes referred only to the lack of fetal heart tones. In addition, during her testimony, Nurse Williams was given a copy of the sonographer's report before she had a chance to testify from her memory of the events, and she testified only that the sonographer wrote in the report that there was a suspicion of placental abruption, that Dr. Achong was notified of the report at 3:40 a.m., and that she was certain she told Dr. Achong about the placental abruption because it was included in the sonographer's report. Transcript at pages 54-56. It is significant in assessing the credibility of her testimony on this point that Nurse Williams could not have received a copy of the sonographer's report at the time she was on the telephone with Dr. Achong and that she could not provide a reason for her failure to include reference to the placental abruption in the Labor Flow Record or Progress Notes. Transcript at page 57. The unexplained absence in the Labor Flow Record and Progress Notes of any mention of placental abruption renders it more likely than not that Nurse Williams failed to tell Dr. Achong about a possible placental abruption during her conversation with him about the results of the sonogram at 3:40 a.m.

COPIES FURNISHED:

Charles B. Patrick, Esquire
1648 South Bayshore Drive
Miami, Florida 33133

William Webster, Esquire
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3250

Christopher C. Torres, Esquire
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

Dr. Ana M. Viamonte Ros, Secretary
State Surgeon General
Department Of Health
4052 Bald Cypress Way, Bin A00
Tallahassee, Florida 32399 1701

Josefina M. Tamayo, General Counsel
Department Of Health
4052 Bald Cypress Way, Bin A02
Tallahassee, Florida 32399 1701

R. S. Power Agency Clerk
Department Of Health
4052 Bald Cypress Way, Bin A00
Tallahassee, Florida 32399 1701

Larry Mcpherson, Executive Director
Board Of Medicine
Department Of Health
4052 Bald Cypress Way, Bin C03
Tallahassee, Florida 32399 1701

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.