STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case Nos. 09-4678PL
	)	09-4679PL
MATTHEW J. KACHINAS, M.D.,	)	09-4680PL
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in these cases on, November 18 and 19, 2009, in Sarasota, Florida, before Susan B. Harrell, a designated Administrative Law Judge of the Division of Administrative Hearings (DOAH).

APPEARANCES

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

For Respondent: Matthew J. Kachinas, M.D., pro se
1590 Harbor Cay Lane
Longboat Key, Florida 34228

STATEMENT OF THE ISSUES

The issues in these cases are whether Respondent violated Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes (2002), in DOAH Case No. 09-4678PL; Subsections 456.072(1)(l),

458.331(1)(m), and 458.331(1)(t), Florida Statutes (2003), in DOAH Case No. 09-4679PL; and Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes (2005), in DOAH Case No. 09-4680PL, and, if so, what discipline should be imposed.

PRELIMINARY STATEMENT

On December 13, 2006, the Department of Health (Department) filed a two-count Administrative Complaint before the Board of Medicine (Board) against Respondent, Matthew J. Kachinas, M.D. (Dr. Kachinas), alleging that Dr. Kachinas violated Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes (2002). Dr. Kachinas requested an administrative hearing, and the case was forwarded to DOAH on August 26, 2009, for assignment to an Administrative Law Judge. The case was assigned DOAH Case No. 09-4678PL.

On February 27, 2007, the Department filed a three-count Administrative Complaint before the Board against Dr. Kachinas, alleging that Dr. Kachinas violated Subsections 456.072(1)(l), 458.331(1)(m), and 458.331(1)(t), Florida Statutes (2003). Dr. Kachinas requested an administrative hearing, and the case was forwarded to DOAH on August 26, 2009, for assignment to an Administrative Law Judge. The case was assigned DOAH Case No. 09-4679PL.

On May 1, 2008, the Department filed a two-count Administrative Complaint before the Board against Dr. Kachinas,

alleging that Dr. Kachinas violated Subsections 458.331(1)(m) and 458.331(1)(t), Florida Statutes (2005). Dr. Kachinas requested an administrative hearing, and the case was forwarded to DOAH on August 26, 2009, for assignment to an Administrative Law Judge. The case was assigned DOAH Case No. 09-4680PL.

On August 31, 2009, the Department filed Requests for Admissions in each of the three cases. By Order of Consolidation dated September 22, 2009, the three cases were consolidated. On October 7, 2009, the Department filed Petitioner's Motion to Compel, requesting, among other things, that Dr. Kachinas be compelled to respond to the Requests for Admissions. The motion was heard by telephonic conference call on October 26, 2009. During the motion hearing, the undersigned explained to Dr. Kachinas that a failure to respond to the Requests for Admissions would result in the requests being deemed admitted. An Order was entered on October 26, 2009, requiring Dr. Kachinas to respond to the Requests for Admissions on or before November 2, 2009. The time for serving the responses to the Requests for Admissions was extended to November 4, 2009, by an Order dated November 2, 2009.

On November 10, 2009, the Department filed Petitioner's Renewed Motion to Compel. Dr. Kachinas failed to file responses to some of the Requests for Admissions, and the requests for

which no responses were filed were deemed admitted by Order dated November 13, 2009.

At the final hearing, the Department called the following witnesses: Edgard Ramos-Santos, M.D.; Roberta Elaine Bruce; Jorge Gomez, M.D.; Carol Petraski; and Babette Smith Agett. Petitioner's Exhibits 1 through 11 and 13 through 17 were admitted in evidence. At the final hearing, Dr. Kachinas testified in his own behalf. Respondent's Exhibit 1 was admitted in evidence.

The three-volume Transcript of the final hearing was filed on December 15, 2009. The parties agreed to file their proposed recommended orders within ten days of the filing of the Transcript. Petitioner filed its Proposed Recommended Order on December 28, 2009. On December 28, 2009, Dr. Kachinas filed a post-hearing submittal, which included a blank Monthly Report of Induced Terminations of Pregnancy and a letter dated October 6, 2008, from the Agency for Health Care Administration to Dr. Kachinas. To the extent that Dr. Kachinas may have been relying on the report and letter as exhibits, those documents are not admitted in evidence.

FINDINGS OF FACT

1. At all times relating to the three Administrative Complaints at issue, Dr. Kachinas was a licensed medical doctor within the State of Florida, having been issued license number

ME 65595. He is board-certified by the American Board of Obstetrics and Gynecology.

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2. In 2002, Dr. Kachinas was working at several clinics that were owned by the same individual. He received payment from Sarasota Women's Health Center and Tampa Women's Health Center. His primary office was located in Sarasota, but he rotated through the offices located in Clearwater and Tampa.

3. He was advised that he would be attending a patient in the Tampa office. One of the medications that he used in his method of sedating patients, Propofol, was not available in the Tampa office. He took a vial of the Propofol and took it to the Tampa office, holding the vial in his hand.

4. While at the Tampa office, Dr. Kachinas drew the Propofol into a syringe. He did not have to use the Propofol for the patient. He placed the syringe filled with Propofol inside the sock that he was wearing. Dr. Kachinas transported the syringe back to the Tampa office. He used this method of transport so that the office manager in the Tampa office would not know that he was transporting the drug.

5. When he got back to the Tampa office, he placed the filled syringe in a secure place. Propofol must be used within 24 hours after being drawn into a syringe. The next day it was decided that the drug would not be used on another patient, and

Dr. Kachinas wasted the syringe filled with Propofol. At the clinics where Dr. Kachinas worked, there were no logs to keep track of the drugs, except for the drug Fentanyl.

6. Dr. Kachinas acknowledged in a letter dated January 30, 2007, to the Department of Health that his method of transporting Propofol was "unorthodox." In the same letter, Dr. Kachinas acknowledged that "a reasonable and prudent doctor would not generally transport medication in that manner, but foolishness seemed reasonable in that aberrant environment."

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7. On March 26, 2004, B.S. presented to Premier Institute for Women's Health (Premier) for an elective termination of pregnancy. Dr. Kachinas was the physician who handled the procedure.

8. Dr. Kachinas maintained records relating to B.S. at Premier. In 2004, Petitioner subpoenaed B.S.'s records from Dr. Kachinas' office. Petitioner received a packet of documents, which purported to be B.S.'s medical records. In July 2006, Lori Jacobs, an employee of Premier, sent Petitioner another copy of the documents sent in 2004. Neither the records provided in 2004 nor the records provided in 2006 contain progress notes for B.S.'s treatment on March 26, 2004, and March 27, 2004.

9. For the first time on November 5, 2009, Dr. Kachinas produced a three-page document, which he claimed was part of B.S.'s medical records that had been misplaced in B.S.'s insurance file. Two of the pages purported to be progress notes for March 26 and 27, 2004. The third page, which is also labeled as a progress note, is dated June 29, 2004, and appears to relate to insurance claims. The two pages relating to March 26 and 27 are on paper which is a different color from the progress note relating to insurance claims and the progress notes which were previously furnished in 2004 and 2006.[1] Additionally, the progress notes for March 26 and 27, 2004, contain a break in each of the ruled lines on the sheets on both the right and left sides of the sheets. The insurance progress note and the progress notes furnished in 2004 and 2006 do not have such breaks in the ruled lines.

10. Dr. Kachinas completed a Laminaria Insertion report documenting procedures done on March 26, 2004, and March 27, 2004. The March 26, 2004, report documents the insertion of Laminaria and administration of medications. The comment section of the report documents the removal of the Laminaria and administration of medications on March 27, 2004. The comment section continues to document the administration of medications and the taking of vital signs after the removal of the Laminaria and also the transfer of the patient to Doctors Hospital. The

detail on the comment sections suggests that Dr. Kachinas was making his progress notes in the Laminaria Insertion report.

11. The failure to produce the purported progress notes for March 26 and 27, 2004, until November 5, 2009; the difference in the color of the paper of the March 26 and 27, 2004, purported progress notes and the other progress notes in Dr. Kachinas' records; the presence of breaks in the ruled lines on the March 26 and 27, 2004, purported progress reports, which do not appear on the other progress notes; and the detail of the comments on the Laminaria Insertion report support the conclusion that the progress notes submitted as Respondent's Exhibit 1 were not done contemporaneously with the treatment given to B.S. on March 26 and 27, 2004, but were prepared for this proceeding. Thus, the progress notes for March 26 and 27, 2004, are not credited.

12. Dr. Kachinas determined B.S.'s pregnancy to be at approximately 23½-to-24 weeks' gestation, the last week of the second trimester. He confirmed by sonogram that the gestation period was 24 weeks.

13. On March 26, 2004, Dr. Kachinas began the induction of labor ordering the insertion of ten Laminaria, which are osomotic cervical dilators which cause the cervix to open and allow easier emptying of the uterus.

14. Dr. Kachinas' records do not show that B.S.'s medical history was taken prior to the insertion of the Laminaria. However, Dr. Kachinas did take a medical history of B.S. at the time of her admission to Doctors Hospital, and the history is recorded in the medical records.

15. Prior to the insertion of the Laminaria, Dr. Kachinas' records do show that a limited physical examination of B.S. was done. The Laminaria Insertion report shows that B.S.'s baseline blood pressure, temperature, and pulse were taken and recorded. There was no expert testimony of what other physical examination should have been done.

16. Dr. Kachinas injected the fetus with Digoxin, which is injected directly into the fetus to stop the fetal heartbeat, causing an Intrauterine Fetal Demise (IUFD). The injection of the Digoxin was not documented in B.S.'s medical records. B.S. was then released from Premier.

17. On March 27, 2004, B.S. returned to Premier. Prior to removing the Laminaria, Dr. Kachinas did an ultrasound and determined that there was still fetal heart activity and fetal movements. Dr. Kachinas continued the labor induction procedure by removing the Laminaria and administering Cytotec and high dosages of Pitocin. When the Laminaria were removed, there was a rupture of membranes with a loss of essentially all the amniotic fluid.

18. Sometime during the afternoon of March 27, 2004, Dr. Kachinas did another ultrasound and determined that there was no fetal heart activity. Based on the length of time from the Digoxin injection to the ultrasound showing no fetal heart activity, the loss of amniotic fluid, and the administering of medication to cause contractions, Dr. Kachinas determined that the Digoxin injection was not the cause of death.

19. On March 27, 2004, at approximately 6:30 p.m., Dr. Kachinas transferred B.S. to Doctors Hospital and had her admitted to the hospital for failure to progress with the induction of labor procedure. While at the hospital, B.S. continued to experience pain.

20. On March 28, 2004, Dr. Kachinas performed the following procedures on B.S.: mini-laparotomy, hysterotomy, removal of products of conception, and a modified Pomeroy bilateral tubal ligation. In his description of the procedures, he stated that the fetal demise was at least of 48 hours duration. However, Dr. Kachinas' records do not reflect the time of the fetal demise. Jorge Gomez, M.D., Petitioner's expert witness, credibly testified that a physician is required to document the time of the fetal demise.

21. In the hospital records following B.S.'s surgery, Dr. Kachinas listed the post-operative diagnosis as a failure to induce labor, an intrauterine fetal demise, a thin umbilical

cord, and asymmetric intrauterine growth retardation, a condition in which the fetus is smaller than expected for the number of weeks of pregnancy.

22. An autopsy was performed on the fetus. A surgical pathology report was also issued. The pathology report showed mild infarcts on the maternal side.

23. On the fetal death certificate, Dr. Kachinas listed the immediate causes for the IUFD as a possible cord incident and multiple placental infarctions. Dr. Kachinas did not document the elective termination or the Digoxin injection on the fetal death certificate.

24. Dr. Gomez disagrees with the reasons for IUFD given on the death certificate. His credible reading of the pathology report does not indicate that the infarcts were severe enough to have contributed to the fetal demise. His credible reading of the pathology report does not indicate that there was any evidence of a cord incident. Dr. Gomez is of the opinion that the cause of death should have been listed as elective termination. Dr. Gomez' opinion is credited. However, Dr. Gomez did not give an opinion on whether the fetal demise was caused by the injection of Digoxin.

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25. On December 13, 2005, K.M. was seen by Walter J. Morales, M.D., at Florida Perinatal Associates, which

specializes in internal fetal medicine. Dr. Morales performed an ultrasound on K.M., who was pregnant with twins as a result of in vitro fertilization.

26. The ultrasound revealed that the twins were fraternal, meaning that each twin had a separate placenta and a separate sac. One of the twins, Twin A, had an anomaly called a cystic hygroma, which results from an obstruction, causing the lymphatic fluid, which normally drains into the juglar vein, to accumulate in the neck area. Approximately 50 percent of the fetuses which have this anomaly in the first trimester also have a chromosomal anomaly, such as Down syndrome.

27. The decision was made to have K.M. return to Florida Perinatal Associates in three weeks for further evaluation. On January 3, 2006, Edgard Ramos-Santos, M.D., a partner of Dr. Morales, performed another ultrasound on K.M. Dr. Ramos-Santos found that Twin A, a male, had a cystic hydroma, a thickening of the nuchal fold[2], and shortened femur and humerus. These findings are soft markers for abnormal chromosomes. The ultrasound also revealed a possible heart defect. At the time of the ultrasound, Twin A was cephalic bottom, meaning that Twin A was positioned lowest in the uterus.

28. Dr. Ramos-Santos also performed an amniocentesis on Twin A on the same date as the ultrasound. The amniocentesis

showed that Twin A had an abnormal chromosome pattern compatible with trisomy 21 or Down syndrome.

29. Both ultrasounds showed that Twin B, a female, appeared to be normal. At the request of K.M., no amniocentesis was performed on Twin B on January 3, 2006. At the time of the ultrasound performed on January 3, 2006, the presentation of Twin B was cephalic right.

30. The findings of the January 3, 2006, ultrasound were discussed with K.M. and her husband. On January 9, 2006, Dr. Ramos-Santos discussed the results of the amniocentesis with K.M.'s husband. It was decided that a selective feticide would be performed on Twin A. Selective feticide is a procedure in which a solution of potassium hydroxide is injected into the fetus' heart to make the heart stop beating. K.M. was referred to Dr. Kachinas at Premier for the selective feticide.

31. On January 10, 2006, Roberta Bruce, a nurse at Florida Perinatal Associates, sent to Premier by facsimile transmission the January 3, 2006, ultrasound report for K.M. and K.M.'s insurance information. The cover page for the facsimile transmission included a note from Ms. Bruce, which stated: "* FYI Fetus have different gender. The male is the affected one."

32. The standard of care as specified in Section 766.102, Florida Statutes (2005), requires a physician performing a

selective feticide to correctly identify the affected fetus. Dr. Kachinas did not correctly identify Twin A prior to performing the selective feticide and performed the procedure on Twin B, the normal fetus.

33. Dr. Kachinas performed an ultrasound on K.M., but failed to identify the correct position of Twin A in relation to K.M. The ultrasound done on January 3, 2006, by Dr. Ramos-Santos showed that Twin A was located at the bottom and Twin B was located to the right of K.M. In his progress notes, Dr. Kachinas placed Twin A on the right and Twin B on the left. Although it is possible for twins to shift positions, it is not probable that the twins shifted from left to right.

34. Dr. Kachinas performed an ultrasound, but failed to identify that Twin A was the fetus with multiple anomalies. Although the standard of care required Dr. Kachinas to do a Level 2 ultrasound evaluation, a Level 1 ultrasound evaluation would have identified the cystic hygroma, the shortened long bones, and the sex of Twin A. Dr. Kachinas failed to perform an adequate ultrasound evaluation by failing to identify the anomalies and the gender of Twin A.

35. Dr. Kachinas' notes do not show whether Twin A or Twin B had anomalies. His notes did not identify the sex of each of the twins. His notes did not document the attempts that Dr. Kachinas made to identify the anomalies such as a recording

of the length of the long bones or any examination made to identify the sex of each of the twins.

36. On January 24, 2006, K.M. returned to Florida Perinatal Associates for another consultation. Dr. Morales performed another ultrasound, which revealed that Twin A, who had the anomalies, was still viable. The ultrasound revealed the continued presence of a cystic hygroma, the thickening of the nuchal fold, shortened extremities, and a congenital heart defect. The ultrasound also showed that the viable twin was male. The presentation of Twin A was shown by the ultrasound as cephalic bottom.

CONCLUSIONS OF LAW

37. 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. (2009).

38. Subsection 458.331(1)(m), Florida Statutes (2002, 2003, 2005), provides that the following acts constitute grounds for discipline:

> Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories, examination

> results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

39. Subsection 458.331(1)(t), Florida Statutes (2002, 2003), provides that disciplinary action may be taken for the following conduct:

> 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 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.

In 2003, the following provision was added to Subsection 458.331(1)(t), Florida Statutes:

> 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.

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40. In Count 1 of the Administrative Complaint, Petitioner alleges that Dr. Kachinas violated Subsection 458.331(1)(t), Florida Statutes (2002), by "remov[ing] drug vials from a clinic and transport[ing] them to another clinic by strapping them to his leg and covering the vial with his sock and pants." By his own admission in the January 30, 2007, letter to the Department, Dr. Kachinas agreed that a reasonable and prudent physician would not transport drugs in that manner. Petitioner has established by clear and convincing evidence that Dr. Kachinas failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent physician as being acceptable under similar conditions and circumstances in violation of Subsection 458.331(1)(t), Florida Statutes (2002).

41. In Count 2 of the Administrative Complaint, Petitioner alleged that Dr. Kachinas violated Subsection 458.331(1)(m), Florida Statutes (2002), by "fail[ing] to document the administration of drugs to patients that he removed from one

clinic and transported to another clinic and [by failing] to justify his course of treatment." Petitioner has not established that Dr. Kachinas failed to document the administration of drugs to patients. The evidence did not establish that any drug which he transported was administered to a patient. Since no drugs were administered, Petitioner has failed to establish that Dr. Kachinas failed to justify his course of treatment. Thus, Petitioner has failed to establish that Dr. Kachinas violated Subsection 458.331(1)(m), Florida Statutes (2002).

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42. In the Administrative Complaint, Petitioner alleges that Dr. Kachinas violated Subsection 456.072(1)(l), Florida Statutes (2003), which provides:

> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
>
> * * *
>
> (l) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, or willfully impeding or obstructing another person to do so. Such reports or records shall include only those that are signed in the capacity of a licensee.

43. Petitioner alleges that Dr. Kachinas violated Subsection 456.072(1)(l), Florida Statutes (2003), in one or more of the following ways:

> a. By listing the cause of death on the fetal death certificate as stillborn by a probable cord incident, when the actual cause of death was the Digoxin injection administered during the elective termination procedure;
>
> b. By failing to include the elective termination of pregnancy, by digoxin injection, on the fetal death certificate.

44. Petitioner has failed to establish by clear and convincing evidence that the Digoxin injection was the cause of death. Petitioner has failed to establish by clear and convincing evidence that Dr. Kachinas violated Subsection 456.072(1)(l), Florida Statutes (2003). The evidence does not establish that Dr. Kachinas knew that the cause of death which he listed was in error. He felt that the Digoxin injection did not cause the fetal demise.

45. Petitioner alleges that Dr. Kachinas violated Subsection 458.0331(1)(m), Florida Statutes (2003), in one or more of the following ways:

> a. By failing to document an adequate patient history;
>
> b. By failing to document a physical examination prior to the insertion of the Laminaria;

c. By failing to document the time of the fetal demise;

d. By falsifying the fetal death certificate.

46. Petitioner did not establish that Dr. Kachinas failed to document an adequate patient history. The evidence clearly shows that a patient history was documented at the time of B.S.'s admission to Doctors Hospital. Petitioner did not establish by clear and convincing evidence that Dr. Kachinas failed to document a physical examination of B.S. prior to the insertion of the Laminaria. The Laminaria Insertion report documents a limited physical examination. The evidence is not clear and convincing that Dr. Kachinas falsified the death certificate. Petitioner did establish by clear and convincing evidence that Dr. Kachinas failed to document the time of the fetal demise. Thus, Petitioner has established by clear and convincing evidence that Dr. Kachinas violated Subsection 458.331(1)(m), Florida Statutes (2003).

47. Petitioner alleges that Dr. Kachinas violated Subsection 458.331(1)(t), Florida Statutes (2003), in one or more of the following ways:

a. By failing to obtain an adequate patient history;

b. By failing to perform a physical examination prior to the insertion of the Laminaria;

c. By failing to document the time of the fetal demise.

48. Petitioner has failed to establish that Dr. Kachinas failed to obtain an adequate patient history. Petitioner's own expert stated that his review of the records showed that a history had been done.[3] Petitioner did not establish by clear and convincing evidence that a physical examination was not done prior to the insertion of the Laminaria. The Laminaria Insertion report shows that at least B.S.'s blood pressure, temperature, and pulse were taken. Petitioner has established that Dr. Kachinas failed to document the time of the fetal demise; however, that failure is a violation of Subsection 458.331(1)(m), Florida Statutes (2003), rather than Subsection 458.331(1)(t), Florida Statutes (2003). Thus, Petitioner has failed to establish that Dr. Kachinas violated Subsection 458.331(1)(t), Florida Statutes (2003).

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49. Subsection 458.331(1)(t), Florida Statutes (2005), provides that the following conduct may be grounds for disciplinary action:

> Notwithstanding s. 456.072(2), but as specified in 456.50(2):
>
> 1. Committing medical malpractice as defined in 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed to

require more than one instance, event, or act.

2. Committing gross medical malpractice.

3. Committing repeated medical malpractice as defined in 456.50. A person found by the board to have committed repeated medical malpractice based on s. 456.50 may not be licensed or continue to be licensed by this state to provide health care services as a medical doctor in this state.

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 medical malpractice,” “repeated medical malpractice,” or “medical malpractice,” or any combination thereof, and any publication by the board must so specify.

50. “Medical malpractice” is defined in Subsection 456.50(1)(g), Florida Statutes (2005), as the “failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.” Subsection 456.50(1)(e), Florida Statutes (2005), defines "level of care, skill, and treatment recognized in general law related to health care licensure" as ”the standard of care specified in s. 766.102.” Subsection 766.102(1), Florida Statutes (2005), defines “the prevailing professional standard of care for a given health care provider” as “that

level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."

51. Petitioner alleges in Count 1 of the Administrative Complaint that Dr. Kachinas violated Subsection 458.331(1)(t), Florida Statutes (2005), in one or more of the following ways:

> a. By failing to identify the position of twin A in relationship to the mother, even though the ultrasound from Florida Perinatal Associates states that twin B is located toward the maternal right;
>
> b. By failing to clearly differentiate the sex of the fetuses by ultrasound even though twin A (the affected one) was a male and twin B was a female;
>
> c. By failing to identify the affected twin by ultrasound even though the affected twin had multiple anomalies including a cystic hygroma, shortened long bones, and possible A-F canal, whereas twin B's ultrasound was normal;
>
> d. By failing to perform a thorough ultrasound examination in order to identify the correct fetus;
>
> e. By failing to document his attempts to identify the sex or multiple anomalies previously reported for twin A;
>
> f. By performing a feticide in the non-affected fetus.

52. Petitioner has proved the allegations in above-paragraph 51 by clear and convincing evidence. Dr. Kachinas did

not identify the male fetus with the anomalies, did not correctly identify the position of the twins, failed to perform a thorough ultrasound examination, failed to document his attempts to identify the correct fetus, and performed a feticide on the normal twin. Thus, Petitioner has established that Dr. Kachinas violated Subsection 458.331(1)(t), Florida Statutes (2005), by committing gross medical malpractice.

53. In Count 2 of the Administrative Complaint, Petitioner alleges that Dr. Kachinas violated Subsection 458.331(1)(m), Florida Statutes (2005), by failing to document his attempts to identify the sex or multiple anomalies previously reported for Twin A. Petitioner has established this allegation by clear and convincing evidence. Dr. Kachinas violated Subsection 458.331(1)(m), Florida Statutes (2005).

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED as to DOAH Case No. 09-4678PL that a final order be entered finding that Dr. Kachinas violated Subsection 458.331(1)(t), Florida Statutes (2002), by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent physician as being acceptable under similar conditions and circumstances; finding that Dr. Kachinas did not violate Subsection 458.331(1)(m),

Florida Statutes (2002); imposing an administrative fine of $2,500; and placing Dr. Kachinas on probation for one year.

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED as to DOAH Case No. 09-4679PL that a final order be entered finding that Dr. Kachinas did not violate Subsections 456.072(1)(l) and 458.331(1)(t), Florida Statutes (2003); finding that Dr. Kachinas violated Subsection 458.331(1)(m), Florida Statutes (2003); imposing an administrative fine of $1,000; and placing Dr. Kachinas on probation for one year.

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED as to DOAH Case No. 09-4680PL that a final order be entered finding that Dr. Kachinas violated Subsection 458.331(1)(t), Florida Statutes (2005), by committing gross medical malpractice; finding that Dr. Kachinas violated Subsection 458.331(1)(m), Florida Statutes (2005); imposing an administrative fine of $2,000 and placing him on probation for one year for the violation of Subsection 458.331(1)(m), Florida Statutes (2005); and revoking his license for the violation of Subsection 458.331(1)(t), Florida Statutes (2005).

DONE AND ENTERED this 26th day of January, 2010, in Tallahassee, Leon County, Florida.

SUSAN B. HARRELL
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 26th day of January, 2010.

ENDNOTES

[1/] The original documents were produced at the final hearing and were inspected by the Administrative Law Judge. Copies of the original documents were submitted in evidence. The difference in the color of the paper was evident in the original, but, obviously, is not evident in a photocopy.

[2/] The nuchal fold is the measurement of the back of the neck of the fetus of the skin to the inside part of the head.

[3/] The Administrative Complaint did not allege that no history was taken prior to the insertion of the Laminaria. The Administrative Complaint alleged only that no history was taken.

COPIES FURNISHED:

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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.