STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,
BOARD OF MEDICINE,

Petitioner,

vs. Case No. 14-0001PL

NORRIS MICHAEL ALLEN, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

On May 13 through 15, 2014, a final administrative hearing in this case was held in Fort Myers, Florida, before J. Lawrence Johnston, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Alicia Elaine Adams, Esquire
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STATEMENT OF THE ISSUE

The issue in this case is whether the Respondent should be disciplined for not meeting the "standard of care" by not

responding appropriately to calls to him, as an on-call obstetrician, to come to the hospital and assist with a delivery.

PRELIMINARY STATEMENT

The Respondent disputed specific allegations and requested a hearing on the Second Amended Complaint filed against him in this case (DOH Case 2011-10808) by the Department of Health (DOH). The Second Amended Complaint charged a violation of section 458.331(1)(t)1., Florida Statutes (2010),[1/] for failure to meet the standard of care.

The parties filed a pre-hearing stipulation that included statements of position, admitted facts, and agreed law. At the final hearing, DOH called several witnesses, including two certified nurse midwives, two registered nurses, and two physicians (one as an expert on the standard of care). The Respondent testified and called two physicians as expert witnesses on the standard of care. The patient records were received in evidence as Petitioner's Exhibit 1. Respondent's Exhibits 8, 12, and 42 also were received in evidence.

The Transcript of the final hearing was filed, and the parties filed proposed recommended orders, which have been considered.

FINDINGS OF FACT

1. The Respondent is licensed to practice medicine in Florida. He holds license ME 100568. He is board-certified in

obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

2. In March 2011, the Respondent was one of two obstetrician-gynecologists (ob-gyns) employed by Family Health Centers of Southwest Florida (Family Health). Family Health also employed certified nurse midwives (CNM) and had agreements with two area hospitals owned by Lee Memorial System, Health Park and Gulf Coast. Health Park is a Level 3 hospital and has the means to provide the medical services needed for premature and high-risk deliveries. Gulf Coast is a Level 1 hospital and does not provide those services.

3. On March 21, 2011, the Respondent was the on-call ob-gyn for the Family Health practice from 7:00 p.m. that evening until 7:00 a.m. the next morning.

4. At 7:53 p.m. on March 21, 2011, Family Health obstetrical patient, M.T., was admitted to Gulf Coast's emergency room, where she reported that she had been having contractions for two hours and was experiencing pain at the level of nine on a scale of ten.

5. M.T. was a high-risk patient. She suffered a stillbirth in 2008 and a miscarriage in 2009. Yet, she had late and minimal prenatal care for being high-risk (having been seen by the Family Health practice only twice, not until the second or third trimester, and not by one of the doctors). The standard for

viability at the time was 24 weeks, assuming good prenatal care and delivery in a Level 3 hospital with all needed specialists available, which was not the case at Gulf Coast.

6. After triage in the emergency department of Gulf Coast, M.T. was admitted to the hospital and taken to labor and delivery. Barbara Carroll, a CNM employed by Family Health, was on duty there. Labor and delivery was busy that evening, and CNM Carroll saw M.T. at approximately 8:55 p.m. CNM Carroll took the patient's history and noted in the patient's medical record that an ultrasound done on February 24, 2011, indicated that the patient was 20 weeks and five days pregnant at that time, with a margin of error of plus or minus two weeks. Based on that ultrasound, CNM Carroll noted that the gestational age of the fetus on March 21, 2011, was 23 weeks and four days. (There was no evidence addressing the apparent miscalculation--if the gestational age on February 24 was 20 weeks and five days, it would have been 24 weeks and 2 days on March 21.) CNM Carroll then did a speculum examination, which revealed that the patient was in active labor, fully dilated and fully effaced, with a bulging bag of water (i.e., amniotic fluid). The type of examination performed did not allow CNM Carroll to determine the presenting part. CNM Carroll wrote these observations and impressions in the patient's medical record.

7. At approximately 9:00 p.m., CNM Carroll telephoned the Respondent, who was at Health Park at the time. It was not clear from the evidence what was said during their conversation. CNM Carroll testified that she reported what she had written in the medical record and asked the Respondent to come to the hospital immediately to assist with the delivery because she was not comfortable doing it herself. She testified that she thought the fetus was potentially viable, with a gestational age of 27 or 28 weeks, based on her examination and fetal heart monitor tracings. However, she did not recall telling the Respondent her belief as to the actual gestational age of the fetus.

8. CNM Carroll testified that, in response to her report, the Respondent told her to start Pitocin, which would accelerate the labor and delivery process, and turn off the fetal monitor. She testified that when she balked, he said, "I told you what to do," and she responded, "and I told you, I need you to come in." She testified that it was clear to her that the Respondent knew from this curt exchange that she was not going to follow his orders. She testified that she declined to "argue" with the Respondent, which she had done on other occasions in the past. She testified that she thought he would change his mind and call back with new orders, which she claimed was a pattern of his.

9. The Respondent recalled the conversation somewhat differently. He denied telling CNM Carroll to start Pitocin or

to turn off the fetal monitor. He testified that he anticipated active labor would proceed and result in an abortion, since the fetus was not viable and would not survive a delivery at Gulf Coast that night. His plan was to give the patient pain medication for comfort and to manage the patient expectantly--meaning do nothing, and continue to monitor the patient. He testified that he hoped labor might cease and the baby might possibly get to 24 weeks and be viable, if the labor and delivery could be arranged to occur at a Level 3 facility like Health Park.

10. After the conversation, CNM Carroll completed her entries in the patient's medical record. She wrote her impression that the patient was in active labor and her plan that the patient would be monitored, that the Respondent was aware and anticipated a spontaneous vaginal delivery, and that she expected a normal spontaneous vaginal delivery. She testified that she wrote "normal" unintentionally due to the stress she was feeling about the prospect of doing the delivery herself, without the Respondent being there to assist. Her notations make no reference to an order to start Pitocin or to turn off the fetal monitor.

11. CNM Carroll testified that in the same approximate timeframe that she talked to the Respondent, she had Health Park's transport team called to arrange for transportation to

that facility's neonatal nursery immediately after childbirth and had Gulf Coast's high-risk delivery team (consisting of a neonatologist, a respiratory therapist, and an anesthesiologist) called to be ready for the delivery and transport to Health Park. She did not tell the Respondent she was doing this.

12. CNM Carroll's testimony about her telephone conversation with the Respondent at or about 9:00 p.m. that night is inconsistent with some of her entries in the patient's medical record. If CNM Carroll's testimony was not false in those respects, it may be mistaken, and it could be that CNM Carroll was confusing this telephone conversation with one later in the evening. CNM Carroll was very busy that evening, attending to several patients at the same time.

13. Although not reflected in CNM Carroll's entries in the medical record, and unbeknownst to her, the Respondent initially ordered an ultrasound and comprehensive blood test. The ultrasound results indicated at about 9:40 p.m. that the baby was in a breech position. The blood test results, which were communicated to the Respondent at about 10:00 p.m., indicated that the patient had an active infection (i.e., chorioamnionitis). At that point, the Respondent no longer believed that expectant management was appropriate and, at 10:05 p.m., ordered Pitocin to be administered to speed the

delivery of the fetus before the infection spread. He reasonably did not expect the baby to survive.

14. It is not clear from the evidence that the Respondent was told during these communications, at about 10:00 p.m., that the baby was breech. The Respondent claims that he was not told. It also is unclear whether the Respondent ordered the fetal monitoring to cease at that time. The Respondent said he did not. Some of the other witnesses recalled that he did, but there is no indication of such an order in the medical record. In any event, there was no clear and convincing evidence that it would have been inappropriate to turn off the fetal monitor at that point.

15. At about the same time that the Respondent was ordering Pitocin, CNM Teresa Buckley returned to the hospital. CNM Buckley's shift had started at 7:00 a.m. that morning, but CNM Carroll covered for her in the middle of the shift, so CNM Buckley could attend a child's basketball game. CNM Buckley took report from CNM Carroll on the patient, M.T., and was told the gestational age of the fetus, the status of labor (active), and the imminence of delivery. She probably was told that CNM Carroll thought the fetus could be viable, despite its gestational age based on the heartbeat and monitor tracings, and that the Respondent had been called earlier and asked to come to the hospital to help with the delivery.

16. After taking report, CNM Buckley examined the patient, reviewed the monitor tracings, talked to the patient, palpated the contractions, and examined the patient to determine the position of the fetus. During, or shortly after, the examination, the patient's membrane ruptured. The rupture of the membrane may have been caused or hastened by CNM Buckley's examination. Shortly after the membrane ruptured, at approximately 10:20 p.m., the baby's foot appeared. CNM Buckley attempted to facilitate the breech delivery by sweeping the baby's arms down and rotating. Both feet and legs and the torso were delivered, but the baby's head was stuck and could not be delivered. At that point, at about 10:30 p.m., CNM Buckley asked the charge nurse to telephone the Respondent to say she needed him to come in to help with the delivery.

17. The charge nurse telephoned the Respondent. The evidence is unclear exactly what she told him. The medical record states that she asked him to come in to assist with the delivery. The charge nurse testified that she informed him that the patient's membrane had ruptured and asked if he was coming in. The Respondent's best recollection is being told that CNM Buckley, who he did not know was on the case, needed his help with a breech delivery. He denies being told that the patient's membrane had broken or that it was a footling breech delivery with the head stuck. The Respondent testified that he would have

immediately agreed to proceed to the hospital had he been told either of those facts. He testified that he interpreted what he was told to mean he was being asked to help the CNM perform a breech extraction and that he said, "no," his orders were to start Pitocin. The charge nurse testified that the Respondent asked if Pitocin was running, said to make sure it was running, and hung up.

18. It is unclear from the evidence exactly when Pitocin was started. The medical record indicates that it was not started until 10:30 p.m., some 25 minutes after the Respondent ordered it. This would have been about the time when the Respondent asked the charge nurse about it.

19. When the charge nurse reported to bedside, the CNM asked if the Respondent was coming in and if he was almost there. The charge nurse said she didn't know, he didn't say. The CNM had her call back to find out.

20. According to the medical record, the charge nurse's second call was made at 10:33 p.m., the Respondent was asked to "come in for breech delivery," and the Respondent said, "no." According to the testimony of the charge nurse, she told the Respondent that the CNM wanted the Respondent at bedside because she was having difficulty with the breech delivery and the baby's head was stuck. The Respondent denied being told this in either of the two telephone calls. He testified that, still thinking

the membrane was intact and the fetus was in the patient's pelvis, he repeated his instruction, "no," to a breech extraction. It was not proven by clear and convincing evidence that the Respondent was not being truthful about what he understood from the communications to him in the 10:30 and 10:33 p.m. telephone calls.

21. When the charge nurse heard what the Respondent had to say, she hung up and reported to the CNM and others that the Respondent was not coming in. They paged Dr. Garner, the other ob-gyn employed by Family Health. Dr. Garner promptly answered the page and was asked to come in to assist with the delivery. He proceeded to the hospital and arrived at bedside at 10:55 p.m. The baby died during the delivery process and was delivered at 11:06 p.m.

22. The Respondent testified that notwithstanding his inaccurate understanding of the status of the patient as a result of the telephone calls at 10:30 and 10:33 p.m., and his negative responses to the charge nurse, he actually proceeded to Gulf Coast. He stated that he telephoned the hospital on the way and was told that Dr. Garner was at bedside. At that point, he decided there was no need for him to go to the hospital and turned around to return to Health Park.

23. During the hearing, DOH did not challenge or refute the Respondent's testimony regarding his last phone call, but DOH's

proposed recommended order questions the Respondent's veracity on the ground that the medical record does not mention it, and none of the other witnesses testified to knowing about it. Neither party produced other evidence that might establish whether the telephone call actually occurred. On this record, it was not proven by clear and convincing evidence that the Respondent did not proceed to Gulf Coast in response to the telephone call at 10:33 p.m., only to turn around when told that Dr. Garner was at bedside.

24. DOH called an expert, Dr. Babu Veerendra Chitriki, who is a board-certified ob-gyn, to testify that the standard of care required that the Respondent, as the on-call ob-gyn, respond to each and every request for assistance he received from a CNM or nurse on the evening of March 21, 2011, by agreeing to come to the hospital.

25. Dr. Chitriki's testimony was refuted persuasively by the Respondent's two experts, also board-certified ob-gyns, Drs. Mark Spence and Allison Thresher. They opined that it would be within the standard of care for the Respondent to ask questions, get an accurate understanding of the medical situation, and exercise medical judgment based on that understanding. Neither thought it was required by the standard of care for the Respondent to drop everything and come to the

hospital as a result of the telephone calls he received on March 21, 2011, no questions asked.

26. As to the telephone call from CNM Carroll at 9:00 p.m., it was not proven by clear and convincing evidence that it resulted in a clear request requiring the Respondent to accede and proceed to the hospital immediately. Rather, at most, it appears to have resulted in an unresolved disagreement between the health care professionals as to the appropriate plan of action.

27. As to the 10:30 and 10:33 p.m. telephone calls, Drs. Spence and Thresher, as well as the Respondent, agreed that the standard of care would have required a positive response from the Respondent, had he been told what was occurring with the patient at the time. Instead, they viewed those telephone calls as evidence of an unfortunate failure of communication between the Respondent and the CNMs and nurses.

28. It was not proven by clear and convincing evidence that the Respondent was lying when he testified that he was not told what was occurring at 10:30 and 10:33 p.m. It also was not proven by clear and convincing evidence that the facts were clearly communicated to the Respondent during those telephone calls. Finally, it was not proven by clear and convincing evidence that despite the failure to communicate, the Respondent did not in fact proceed to the hospital in response to those

telephone calls, only to turn around when he learned that Dr. Garner was at beside.

29. The Respondent is not without his share of fault for the miscommunications that occurred on March 21, 2011. Conflicts between him and the Family Health practice may have been a factor. He could have been a better listener, and he could have asked more and better questions to make sure he was getting the full picture of what was going on with the patient, particularly at the time of the 10:30 and 10:33 p.m. telephone calls. However, DOH did not charge him with practicing below the standard of care by not communicating. Rather, DOH charged him with failure to come to the hospital to assist with a difficult delivery after receiving a clear request to do so, a charge that was not proven by clear and convincing evidence.

CONCLUSIONS OF LAW

30. Because it seeks to impose license discipline, DOH has the burden to prove its allegations by clear and convincing evidence. See Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987). This "entails both a qualitative and quantitative standard. The evidence must be credible; the memories of the witnesses must be clear and without confusion; and the sum total of the evidence must be of sufficient weight to convince the trier of fact without hesitancy." In re Henson, 913 So. 2d 579,

590 (Fla. 2005)(quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)). "Although this standard of proof may be met where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous." Westinghouse Electric Corp. v. Shuler Bros., 590 So. 2d 986, 988 (Fla. 1st DCA 1991).

31. DOH charges the Respondent with medical malpractice as defined in section 456.50, Florida Statutes (2010), for not responding appropriately to requests for assistance on March 21, 2011, in violation of section 458.331(1)(t), Florida Statutes. Section 456.50(1)(g), Florida Statutes, defines medical malpractice 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." According to section 766.102(1), Florida Statutes, such a failure occurs upon:

> [A] breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be 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.

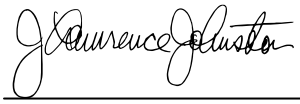
32. In this case, DOH did not prove by clear and convincing evidence that the Respondent did not meet the standard of care, as charged. DOH did not charge the Respondent with having a role in the failure of communication between him and the Family Health CNMs and nurses. See Trevisani v. Dep't of Health, 908 So. 2d

1108 (Fla. 1st DCA 2005); Aldrete v. Dep't of Health, Bd. of Med., 879 So. 2d 1244 (Fla. 1st DCA 2004); Ghani v. Dep't of Health, 714 So. 2d 1113 (Fla. 1st DCA 1998); Willner v. Dep't of Prof'l Reg., Bd. of Med., 563 So. 2d 805 (Fla. 1st DCA 1990).

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a final order dismissing the charges against the Respondent in this case.

DONE AND ENTERED this 18th day of July, 2014, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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this 18th day of July, 2014.

ENDNOTE

[1/] Unless otherwise noted, all statutory references are to Florida Statutes (2010), which were the statutes in effect during the relevant conduct of the Respondent.

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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.