STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 15-6206PL

SIMION TSINKER, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

On January 4 and 5, 2016, the final hearing was held in Ft. Lauderdale, Florida, before F. Scott Boyd, an Administrative Law Judge assigned by the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Corynn Colleen Gasbarro, Esquire
Michael Jovane Williams, Esquire
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Prosecution Services Unit
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For Respondent: Simion Z. Tsinker, M.D., pro se
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent violated section 458.331(1), Florida Statutes, by committing medical malpractice or by failing to keep legible medical records that

justify the course of treatment of a patient, as set forth in the Amended Administrative Complaint, and, if so, what is the appropriate sanction.

PRELIMINARY STATEMENT

On November 5, 2015, Petitioner Department of Health (Department) issued an Amended Administrative Complaint against Respondent Simion Tsinker, M.D. The two-count complaint related to Dr. Tsinker's provision of medical care to patient D.G., who delivered a stillborn child. Dr. Tsinker disputed allegations of fact in the complaint and requested a formal hearing.

The final hearing took place on January 4 and 5, 2016. The Department offered the testimony of three witnesses: patient D.G.; Norman Donald Diebel, M.D., accepted as an expert in obstetrics and gynecology; and Respondent. The Department also offered Exhibits 1 through 4, which were accepted into evidence without objection. Respondent testified himself, over objection from Petitioner, and offered the testimony of two other witnesses: Corina Fitch, a licensed midwife and registered nurse (R.N.) who provided prenatal care to patient D.G.; and Radhiya Walther, the labor and delivery nurse. Respondent also offered 27 exhibits. Exhibits B, C, F, I, L, N, O, P, Q, and U were admitted without objection. Exhibits A, D, E, G, J, R, S, T, V, W, and AA were rejected. Exhibit H was withdrawn. Exhibit K was admitted over objection, subject to the caveat that it was

hearsay and could not alone support a finding of fact, but could only be used to supplement or explain other evidence. As to the objection that Exhibit K was not authenticated, it was found that its distinctive characteristics, including markings indicating that it was printed from records belonging to the Broward General Medical Center, along with the document's contents--which closely correlated to the information contained in Exhibits F and I, previously admitted--gave sufficient assurance that the document was genuinely what it purported to be, given the relaxed requirements for authentication in an administrative hearing. Exhibits M, X, and Y were admitted over objection, the latter two only for purposes of recommending an appropriate penalty should a violation be found. Exhibit Z was not admitted as substantive evidence, but solely for impeachment.

The parties were directed to submit proposed recommended orders within ten days after the transcript was filed with the Clerk of the Division of Administrative Hearings. The two-volume final hearing Transcript was filed on January 27, 2016. Both parties timely filed proposed recommended orders, which were considered in preparation of this Recommended Order.

Unless otherwise indicated, citations to the Florida Statutes or rules of the Florida Administrative Code refer to the versions in effect in December 2013, at the time the violations were allegedly committed.

FINDINGS OF FACT

1. The Department is the state agency charged with regulating the practice of medicine pursuant to section 20.43, chapter 456, and chapter 458, Florida Statutes (2015). The Board of Medicine is charged with final agency action with respect to physicians licensed pursuant to chapter 458.

2. At all times material to the complaint, Dr. Tsinker was a licensed medical doctor within the state of Florida, having been issued license number ME 39408.

3. Dr. Tsinker's address of record is 2500 East Hallandale Beach Boulevard, Suite 207, Hallandale Beach, Florida 33160.

4. D.G. was pregnant and sought care from Bellymama Midwifery Services (Bellymama Midwifery). On May 16, 2013, she signed a Bellymama Midwifery Services VBAC Consent Form. It generally advised of risks and benefits in attempting a vaginal birth after having had a cesarean section (VBAC). It included the following statements, among others:

> 3. I understand that 70-80% of women who undergo VBAC will successfully deliver vaginally, and that this percentage increases in relation to the amount of support women receive in making the decision to try a VBAC.
>
> * * *
>
> 7. The exact frequency of death or permanent injury to the baby when the uterus ruptures is uncertain, but has been reported to be as high as 50% in cases of complete rupture.

* * *

> 9. Probable contraindications to VBAC include a classical uterine incision, multiple gestations, and breech.

Each of these statements on the form was initialed by D.G. At the end of the form was a place for the patient to choose to either attempt VBAC or elect a repeat cesarean, as well as a place to explain that choice. After the form's statement "I want to attempt a VBAC because," the following entry was made in script, "I don't agree that my previous C-section was necessary and I disagree w/ interventions for the sake of convenience." D.G.'s printed name and her signature appear at the bottom of the form. At hearing, D.G. testified that the cesarean section with her first daughter had been a difficult experience. The baby had complications arising from induction which led to the emergency cesarean. D.G. stated that she wished to avoid interventions unless they were medically necessary.

5. D.G.'s first prenatal visit was conducted on May 17, 2013, by Corina Fitch, R.N., a licensed midwife. Nurse Fitch has a degree in midwifery and provides prenatal care and assistance with home deliveries. She has worked with many patients wanting to attempt a VBAC.

6. D.G. testified that after it was determined, at about 35 and one-half weeks gestation, that the fetus was in breech position, she had a discussion with Nurse Fitch as to the best

way to proceed. They decided that they should wait to see if the baby changed position. Nurse Fitch testified that the baby did change to vertex position, but then changed again, back to breech.

7. Nurse Fitch testified that she had advised D.G. generally of the risks and benefits of a vaginal delivery and that she specifically briefed D.G. about some of the additional risks of TOLAC[1/] with a breech presentation, but not completely:

> Well, I think that I--according to what I told you before, I didn't give her all the risks. I talked about cord prolapse, and I talked about head entrapment. So, potentially, no, she did not receive enough information.

8. At slightly over 40 weeks, D.G. telephoned Nurse Fitch to advise that her water had broken (spontaneous rupture of membrane (SROM)). D.G. and Nurse Fitch decided that D.G. should to go to the hospital to deliver there. Based upon information that Dr. Tsinker had successfully delivered breech babies vaginally, D.G. and her husband had decided to seek care from Dr. Tsinker.

9. Nurse Fitch called Dr. Tsinker. She told Dr. Tsinker that D.G. was a 37-year-old pregnant woman at 40 weeks and four days gestation, that D.G. had previously undergone a cesarean section with her first child, that the fetus was in frank breech presentation, and that she wished to deliver vaginally if

possible. Nurse Fitch testified that she did not believe that her conversation with Dr. Tsinker included discussion about consent forms or whether the patient had been advised of the risks of attempting a VBAC under all of these circumstances. However, Nurse Fitch testified that Dr. Tsinker had accepted patients from her before and that she always provided a copy of the consent form that her patients signed to him on those occasions, so he was generally familiar with the consent form.

10. Dr. Tsinker agreed to accept D.G. as a patient.

11. Records of Bellymama Midwifery dated December 10, 2013, indicate:

> Received T.C. from pt reporting SROM @ 10 a.m., mild cramping. Home visit made. FHT's 140's, all VS WNL, baby in breech presentation, VE done to report findings to OB for transfer of care, 1 cm, 100%, 0 station. Dr. Tsinker called as pt desires vaginal birth, he agreed to do delivery, pt transported to hospital in own car in stable condition for augmentation and delivery, CF.

12. At about 1247 hours on December 10, 2013, D.G. presented to the Broward Health Medical Center in Fort Lauderdale with ruptured membrane and fetus in breech position. Her husband was with her. Based upon communications from Dr. Tsinker, she was expected, and the hospital had the admissions paperwork ready for her. D.G. signed a General Consent form at the time of her admission.

13. At about 1320 hours, a labor assessment was conducted by nursing staff. It indicated, among other things, that the reason for admission was spontaneous rupture of membrane, that D.G. was calm, and that her obstetrical history included a previous cesarean section due to low amniotic fluid at 37 weeks. Electronic fetal monitoring begun at 1317 hours showed no decelerations and active movement. Examination confirmed that the fetus was in breech presentation. D.G. told the nursing staff that she wanted to labor without pain medications.

14. The LD-Flowsheet BG indicates that at about 1334 hours, Dr. Tsinker was made aware of the examination and that he issued orders. Dr. Tsinker testified that he was told that the baby was in frank breech position and that there was only "mild" labor activity. Dr. Tsinker testified that he gave the order to start D.G. on oxytocin (or Pitocin).

15. A Maternal Child Inter-Disciplinary Patient Education Record indicates that D.G. was advised of potential side effects from the use of Pitocin at about 1400 hours. This was the only entry in the "Medications" content area. The form contains the initials "SY" and contains a signature that appears to read "Simone Young, RN." The form contains no mention of misoprostol (or Cytotec).

16. D.G. signed a Vaginal Delivery Consent form at about 1410 hours on December 10, 2013. The form had Dr. Tsinker's name

filled in and, in a typed line which had been added, indicated that he was authorized to perform "delivery of baby, possible cesarean section, possible use of forceps or vacuum extractor, possible episiotomy." The form itself contained no information about the risks of vaginal delivery, no information about the risks of vaginal delivery after cesarean section, and no information about the risks of vaginal delivery after cesarean section with a baby in breech presentation. The only provision related to risks stated:

> The Physician has explained to me, and I understand, the potential benefits, risks, or side effects of the procedure, including potential problems related to recuperation; the likelihood of achieving goals; the reasonable alternatives to the procedure; and the relevant risks, benefits, and side effects related to alternatives, including the possible results of not having the procedure.

The document contains a signature in the "witness" space which appears to read "S. Young, RN." It was uncontroverted, however, that D.G. had not actually talked with the attending physician about anything before she signed the form. Dr. Tsinker testified that it is his signature which appears at the bottom of the form in the "Physician Signature" space.

17. While there was some question about the date Dr. Tsinker signed the form, this is of no significance. The form does not show that Dr. Tsinker advised D.G. of the risks of

TOLAC under her circumstances, and its statement that this had been done was completely rebutted by all of the other evidence, including testimony of Dr. Tsinker.

18. Dr. Tsinker never advised D.G. of the particular risks involved in a vaginal delivery, given her previous cesarean section and breech presentation. He never advised her that a cesarean section was indicated.

19. Further, he admitted that D.G. never told him she was unwilling to have a cesarean section. He simply assumed, based upon the information that had been provided to him by others, that she would decline a cesarean section even if he strongly recommended it to her. He testified that he came to that conclusion because:

> The patient never, A, asked me any additional questions that she may have had--you know I'm not her mind reader--at time when she was admitted and I showed up after that, right. She knew about her right to ask these questions and to have them answered to her full satisfaction.
>
> When I showed up, she didn't have that opportunity when she came in because I wasn't there. But when I showed up, she had all in the world opportunity, if she was even a little bit still in the dark or had reservations or any problems, she had the opportunity to ask me that and I would have definitely given her a complete answer. She never mentioned she had regret her opinion or she wants to stop and revert to a cesarean section, or to do anything but to continue the trial of TOLAC.

20. Some of D.G.'s medical records, such as the medications list, suggest that misoprostol, a drug used to make the patient more receptive to oxytocin, was never ordered in D.G.'s case. Other records suggest that it may have been administered to D.G. Dr. Tsinker stated in response to interrogatories and testified at hearing that misoprostol was not used in D.G.'s case. As for entries appearing to indicate that misoprostol was discontinued, Dr. Tsinker's uncontroverted testimony was that you cannot "discontinue" misoprostol because it is introduced intravaginally in the form of a small pill. The only drug that could be discontinued is oxytocin, which is introduced intravenously. Dr. Tsinker maintained that any references to "discontinue" are references to oxytocin, not misoprostol. He further maintained that misoprostol is used when the cervix needs ripening and noted that, in this case, it was already thinned, with D.G's records showing 100 percent effacement, so that there would have been no need to order misoprostol.

21. Hospital records of Pharmacy Orders reference that administration of Pitocin through continuous infusion began at 1514 hours. An accompanying note provided, "6 milliunit/min = 0.3 mL/min = 18 mL/hr – Start at 6 milliunit/min. Increase by 3 milliunit Q15 min until contractions are Q2 min apart, 40 sec in duration & moderate to strong by palpation – continuous

infusion (not to exceed 20 MU/min). Hold for non reassuring FHR pattern or tachysystole."

22. Dr. Tsinker did not perform an examination of D.G. in order to determine whether D.G.'s fetus was in frank, footling, or some other breech position prior to the administration of Pitocin to D.G. As Dr. Tsinker testified, he had been informed that the fetus was in frank breech position.

23. There was some conflicting evidence as to whether the fetus was in frank breech or in foot breech position. The Discharge Summary form, dictated by Dr. Siegel and signed by Dr. Tsinker, indicates that the "patient was delivered vaginally, foot breech," and the Newborn Consultation form of Dr. Otero similarly had a block indicating "foot breech" checked. However, Nurse Fitch testified that she determined the baby was in frank breech position earlier, and, consistent with the testimony of Dr. Tsinker, the Baby's Delivery Record indicated "Breech Position: Frank." Norman Donald Diebel, M.D., later testified that although he could not be sure, he concluded that the baby was in frank breech position.

24. Dr. Tsinker had never met D.G. in person, or spoken to D.G. prior to December 10, 2013. He saw her for the first time around 1635 hours on that day.

25. At some point, Dr. Tsinker prepared an OB/GYN History and Physical form. It was dated December 10, 2013, but no time

was given. No pelvic examination was recorded which could be used to determine when it was prepared. As Dr. Tsinker admitted, the notes are untimed and mostly abbreviated. It records the presentation as "breech" and the membranes as "ruptured." While it has a few spaces left blank, it was substantially completed, albeit with little detail.

26. During D.G.'s labor, Dr. Tsinker did not dictate or write any progress notes. Dr. Tsinker maintained that because he believed everything was progressing well, he did not think it necessary.

27. At 2031 hours, the flowsheet records Dr. Tsinker at bedside and indicates that he reviewed the fetal strip.

28. At 2051 hours, the flowsheet records that Dr. Tsinker responded to a page and was "notified/updated" and notes that there were "no new orders." Nurse Radhiya Walther could not remember these entries when asked about them, or recall if they were in fact entered about ten hours after the events they describe. Dr. Tsinker disputed that he was ever contacted at this time.

29. At 2130 hours, the flowsheet records that "augmentation D?c'd unable to continuously monitor doula and pt instructed to assist with FHR monitoring while on ball." Nurse Walther stated she discontinued oxytocin because the patient was sitting on the ball, and she was unable to monitor the strip. She admitted in

cross-examination that if oxytocin was discontinued, the physician should be notified. She admitted that the records did not indicate that Dr. Tsinker was notified.

30. The fetal monitor strip indicates noticeable loss of variability in the trace and some early decelerations. These were not yet clear signs of fetal distress, but as Dr. Diebel testified, would have caused a reasonably prudent obstetrician/gynecologist to remain with the patient.

31. At 2203 hours, the flowsheet records a vaginal exam by Dr. Tsinker, with dilatation at 10 cms, and effacement at 100 percent. Dr. Tsinker requested that D.G. demonstrate how she was going to push so that he could evaluate the effectiveness of her pushing. D.G. testified later, "Dr. Tsinker asked me to push, I attempted to push with all of my might, they were unproductive pushes. He told me continue to labor, I'll come back later and he left the room."

32. Dr. Tsinker testified that at that time he directed the delivery nurse to have D.G. start pushing, but neither D.G. nor Nurse Walther recall that order. Additional comments recorded for this time indicate "Dr. Tsinker at bedside strip reviewed Pt attempted pushing will labor down."

33. Nurse Fitch, who had arrived in the labor and delivery room about 2000 hours, did not recall Dr. Tsinker ever telling

D.G. or the labor and delivery nurse that D.G. could "labor down." As Nurse Fitch testified:

> I don't recall that. What I do recall is, when [Dr. Tsinker] left the room, she was very distraught because the exam was extremely painful and she didn't have a sensation to push that was very--she tried. She gave it her best. And she said "Corina, I don't know if I can do this."
>
> And the nurse--I remember the nurse saying, "Don't worry. There's no urgency. We'll just let her wait till she has the urge.

34. Nurse Walther recalled that D.G. stated she did not want to push because she did not feel any pressure, which is why Nurse Walther recorded the "labor down" comment. Nurse Walther testified she would have called Dr. Tsinker if she had felt this was contrary to his orders in any way, but she did not, because she had not been told to make the patient push.

35. D.G. spent much of her labor on the birthing ball, next to the bed. With D.G. in this position, it was more difficult to monitor fetal heart rate because the monitoring belts can more easily shift and not provide clear readings. Also, D.G., who declined a bedpan, made several trips to the bathroom. Portions of the fetal monitor strips have missing or sketchy readings.

36. By 2230 hours on December 10, 2013, D.G.'s fetal monitor had begun to show clear signs of fetal distress, evidenced by late decelerations.

37. D.G. was never advised by anyone that there were signs of fetal distress, or told of the advisability of having a cesarean section in light of that new information.

38. At 2300 hours, under "Interventions," in D.G.'s records, it is stated that "IV Bolus; Discontinue Uterine Stimulants; O2 On; other Interventions – Please Annotate Annotation: Pitocin remains off O2 remains in place."

39. At 2304 hours, the flowsheet records "MD notified that patient is on ball and unable to get cont tracing and having variable decelerations. Pt instructed to return to bed." Under care provider status it is recorded, "Responded to Page; Report Given; In Department; Notified/Updated See SBAR; No New Orders." Dr. Tsinker again disputes that he was given this notification. Nurse Walther stated she could not remember how Dr. Tsinker was notified. She could not recall if Dr. Tsinker showed up personally in response, or called. She could not remember if she repeated the call to him.

40. The flowsheet records a late deceleration at 2316 hours and another at 2320 hours. As Nurse Walther acknowledged in cross-examination, repetitive late decelerations are dangerous and constitute "category 3," the most serious category. Nurse Walther stated she did not know if she notified Dr. Tsinker after these decelerations. She later conceded that three late decelerations constitute an emergency that required that the

attending physician be notified. Nurse Walther testified she walked outside to tell the charge nurse, but could not recall what the charge nurse told her in response. There was no evidence of any actions taken by the charge nurse.

41. Under Additional Comments at 2330 hours, it is noted, "Pt found off monitor in restroom, family at bedside safety precautions maintained. Pt instructed to return to bed, assisted to Labor Bed."

42. Nurse Walther's testimony was generally not very clear or credible and many of the entries in the flowsheet record are found to be unreliable, especially those concerning events that supposedly took place after the visit at 2203 hours by Dr. Tsinker. The stored fetal strip, incomplete in places as it is, is the best evidence of the progress of labor. It was not clearly shown that Dr. Tsinker ever reviewed the fetal monitor strip or was otherwise made aware of the late decelerations occurring after 2200 hours at any time before his return to the room shortly before midnight.

43. When Dr. Tsinker returned to the room before midnight, D.G. and Nurse Fitch were in the bathroom. He asked D.G. to come out.

44. The patient was returned to bed. At about 0003 hours, D.G. was placed in foot pedals and partially elevated. Under

Additional Comments, it is noted "audable fhr 147 pt prepped for pushing Dr. Tsinker."

45. The Mother's Delivery Record prepared by Nurse Walther indicated that the Neonatal Intensive Care Unit (NICU) was called at midnight and arrived at 0005 hours.

46. Dr. Tsinker asked D.G. to push. There was some difficulty in hearing the fetal heart monitor. It was a fairly quick delivery, taking about 11 minutes or so. On December 11, 2013, around 0014 hours, D.G. delivered a stillborn male infant.

47. NICU recorded "0" for all Apgar score factors at both one minute and five minutes after birth. Despite multiple efforts, the NICU was unable to resuscitate the baby. The efforts of the NICU team caused D.G. to have feelings of panic; she testified that she was expecting to hear a baby crying and did not realize until then that there was any issue. After about 20 minutes or half an hour, the NICU team came to D.G.'s bedside and informed her that they were unable to resuscitate the baby.

48. A Vaginal Delivery Summary form completed by Dr. Tsinker and dated December 11, 2013, at 1214 hours, briefly described the placenta, blood loss, laceration, and suturing after delivery, as well as the failure of the NICU team to resuscitate the stillborn child, but it said almost nothing of the labor and delivery itself, noting only that Dr. Tsinker "assisted breech delivery" and that the Apgar scores were "0" at

one and five minutes. There was no evidence of any other delivery note prepared by Dr. Tsinker.

49. Dr. Tsinker did not talk with D.G. after the delivery, or at any time on December 11, 2013, although D.G. had been requesting to speak with him to find out what had happened.

50. On the morning of December 12, 2013, Dr. Tsinker came to D.G.'s hospital room, but D.G. was in the bathroom. Dr. Tsinker told D.G.'s husband that he would return. D.G. came out of the bathroom and waited for Dr. Tsinker to return. When he did not, D.G. went to the nurse's station and again asked to see him. When D.G. learned that he was no longer in the ward, she asked for her discharge papers. Dr. Tsinker appeared, and they returned to D.G.'s room.

51. In the brief discussion about the course of labor and delivery which followed, D.G. believed that Dr. Tsinker was insensitive and blamed her for the outcome.

52. After receiving further care not relevant to this case, D.G. was discharged from Broward General Medical Center at 1220 hours on December 12, 2013.

Standards

53. Dr. Diebel is an obstetrician/gynecologist who has been licensed in Florida since 1977. He is board-certified by the American Board of Obstetrics and Gynecology and was an examiner for the board for 18 years. He has previously served as an

expert witness in administrative proceedings for the state of Florida.

54. Dr. Diebel is an expert in obstetrics/gynecology and has knowledge, skill, experience, training, and education in the prevailing professional standard of care recognized as acceptable and appropriate by reasonably prudent obstetricians/gynecologists in Florida.

55. Dr. Diebel reviewed D.G.'s medical records from Broward Health, the fetal monitor tracings, the midwife records, the autopsy report, and the Amended Administrative Complaint filed in this case.

56. As Dr. Diebel testified, a vaginal delivery after cesarean section has some risks, but they are still performed. A vaginal delivery with breech presentation has some risks, but they are performed. However, he testified that to attempt a VBAC with a breech presentation was below the standard of care recognized as acceptable and appropriate by reasonably prudent obstetricians/gynecologists in Florida. As Dr. Diebel testified, you have two risky procedures, and "nobody would recommend" doing TOLAC and breech together. While Dr. Diebel acknowledged that this standard of care was not expressly set forth in American Congress of Obstetricians and Gynecologists' Practice Bulletin Number 115, August 2010, entitled "Vaginal Birth After Previous

Cesarean Delivery," Dr. Diebel's testimony was clear and convincing and is credited.[2/]

57. Dr. Diebel credibly testified that it was below the standard of care to place the burden on the patient to "ask" about a cesarean section. The standard of care in labor and delivery requires that there be an agreement between the physician and the patient, as a part of which the patient is clearly presented with the potential hazards of what she is about to undertake. Dr. Tsinker should have discussed the potential benefits and risks of D.G. undergoing TOLAC, as well as the option to elect a repeat cesarean delivery, with D.G. as soon as possible after her arrival at the hospital. As Dr. Diebel testified, Dr. Tsinker should have advised D.G. that it was a very risky procedure for D.G. to undergo TOLAC because the baby was in breech position, that this is not currently an acceptable procedure, and that she should have a cesarean section. The standard of care required Dr. Tsinker to advise D.G. of the additional risks involved in attempting a VBAC due to her breech presentation. It was Dr. Tsinker's responsibility to fully explain those risks, recommend a cesarean section, and affirmatively ascertain and document her response.

58. Dr. Diebel testified that if a patient refused to follow the physician's recommendations or was uncooperative in this regard:

> You would document it profusely if a patient--you know, I explain to the patient that this is what's happening, this is what can happen, this is what the effects can be. I explained all that, she expressed understanding. Yeah, if only to cover myself, I want it to be very clear that we had this discussion and still her decision was otherwise.

59. Dr. Tsinker's testimony that he believed that others had previously had discussions with D.G. about these risks and benefits did not satisfy this standard of care. Dr. Tsinker failed to have the appropriate discussions with D.G. or to document them, as he was required to do.

60. Dr. Diebel's testimony that misoprostol should not be used to induce labor in patients who have had an earlier cesarean delivery was unrefuted and is accepted.

61. Dr. Diebel also testified that the ordering of Pitocin for D.G. violated the standard of care. This conclusion was contested, however, and the basis for Dr. Diebel's conclusion was not carefully explained. While Dr. Diebel did describe risks of uterine rupture, as well as risks of causing contractions to be too close together, it was not explained in what way these risks were unique or increased with a TOLAC with breech presentation. Dr. Diebel testified:

> Q. Are there any risks associated with administering Pitocin to a patient attempting trial of labor after cesarean with breech presentation?

> A. Well, you won't find papers devoted to that particular thing, because it is not done. It's not--breeches are not allowed to have a TOLAC.
>
> * * *
>
> Q. Why would it not be done? Why would Pitocin not be given in that situation?
>
> A. Well, because you wouldn't allow the situation to happen to begin with.
>
> Q. Right.
>
> A. Where you've got a breech and a previous cesarean section. So there'd be no reason to give Pitocin.

This explanation does not provide a logical basis to support a separate charge of medical malpractice. Accepting Dr. Diebel's position that simply undertaking a TOLAC with breech constitutes medical malpractice, it does not follow that every other related, but distinct, element in the labor and delivery procedure would necessarily constitute a separate violation of the standard of care.

62. Dr. Diebel acknowledged that it was appropriate to use a little Pitocin in a (non-breech) TOLAC where the patient is not having any contractions, but that it is run for only a short time, and then once the patient is in labor, discontinued. Dr. Diebel then contrasted that limited use with what was done in this case:

> In this situation, it was continued all day, even though she was having, in some place on

> the tracing, contractions a minute to a minute and a half apart, which are too close together.

The basis of Dr. Diebel's concern with the use of Pitocin in this case thus appears to be that it was used for too long. However, that was not the charge in this case. The evidence was not clear or convincing that initially ordering Pitocin for D.G., as opposed to continuing its administration for too long, constituted medical malpractice.

63. Dr. Diebel's testimony that D.G.'s admission history and physical was inadequately documented was not clear and convincing. He noted that the form was not properly timed, but the form itself appeared to be substantially completed, and Dr. Diebel did not sufficiently elaborate on what additional information should have been present.

64. Dr. Diebel testified that the standard of care requires that a physician keep progress notes during the labor of their patients. Under cross-examination, Dr. Diebel admitted that as long as everything was going well, there was no need to write a progress note. However, he also testified that the fetal monitor indicated that after 1700 hours, everything was not going well in D.G.'s case. There were missed signals on the monitor, a loss of variability in the trace, and some decelerations before 2200 hours. It was undisputed that Dr. Tsinker failed to keep any progress notes on D.G.'s labor. Under these circumstances,

Dr. Diebel's testimony that Dr. Tsinker failed to maintain adequate progress notes was clear and convincing.

65. Dr. Diebel also credibly testified that Dr. Tsinker's delivery note describing what took place during D.G.'s delivery was inadequate. The stillborn child created a duty for Dr. Tsinker to fully document what took place during the course of labor and delivery, with careful attention to documentation of any possible factors that it might appear in retrospect to have contributed to the tragic outcome. Dr. Tsinker's Vaginal Delivery Summary, while briefly describing the placenta, blood loss, laceration, and suturing after delivery, as well as the failure of the NICU team to resuscitate the stillborn child, says almost nothing of the labor and delivery itself, noting only that Dr. Tsinker "assisted breech delivery" and that the baby was stillborn. This was not sufficient under the circumstances.

66. Dr. Tsinker was charged with violating the standard of care in performing as an obstetrician/gynecologist during D.G.'s labor and delivery, and he failed to keep medical records reflecting his participation in the treatment of D.G. during that time.

Prior Discipline

67. No evidence was introduced to show that Dr. Tsinker has had any prior discipline imposed upon his license.

68. Dr. Tsinker was not under any legal restraints on December 10, 2013.

69. It was not shown that Dr. Tsinker received any special pecuniary benefit or self-gain from his actions on December 10, 2013.

70. It was not shown that the actions of Dr. Tsinker on December 10, 2013, involved any trade or sale of controlled substances.

71. On August 25, 2014, Dr. Tsinker completed an independent self-study course in Advanced Electronic Fetal Monitoring offered by PESI, Inc., consisting of 6.25 hours of instructional content.

72. On April 6, 2015, Dr. Tsinker completed medical continuing education courses Documentation 154 and Documentation 155, consisting of one hour and two hours of instructional content, respectively, offered by OnlineContinuingEd, LLC.

CONCLUSIONS OF LAW

73. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes (2015).

74. A proceeding to suspend, revoke, or impose other discipline upon a license is penal in nature. State ex rel. Vining v. Fla. Real Estate Comm'n, 281 So. 2d 487, 491 (Fla. 1973). Petitioner must therefore prove the charges against

Respondent by clear and convincing evidence. Fox v. Dep't of Health, 994 So. 2d 416, 418 (Fla. 1st DCA 2008)(citing Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996)).

75. The clear and convincing standard of proof has been described by the Florida Supreme Court:

> Clear 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 testimony 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 a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Davey, 645 So. 2d 398, 404 (Fla. 1994)(quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

76. Disciplinary statutes and rules "must always be construed strictly in favor of the one against whom the penalty would be imposed and are never to be extended by construction." Griffis v. Fish & Wildlife Conserv. Comm'n, 57 So. 3d 929, 931 (Fla. 1st DCA 2011); Munch v. Dep't of Prof'l Reg., Div. of Real Estate, 592 So. 2d 1136 (Fla. 1st DCA 1992).

77. Petitioner charged Respondent under section 458.331, Florida Statutes, which provided, in relevant part:

> (1) The following acts constitute grounds for . . . disciplinary action. . . .

* * *

(m) 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.

* * *

(t)1. Committing medical malpractice as defined in s. 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.

Count I

78. Count I of the Amended Administrative Complaint alleged that Respondent committed medical malpractice. Section 456.50(1)(g), Florida Statutes, defined "medical malpractice" in relevant part 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.

79. Section 766.102(1), Florida Statutes, provided in part that 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.

80. Petitioner first alleged that Respondent committed medical malpractice by failing to advise D.G. that she was not a candidate for VBAC due to her breech presentation and previous cesarean. Dr. Diebel testified that the applicable standard of care required that the obstetrician advise a patient with a prior cesarean and a breech presentation who desired to undergo TOLAC that it was not currently an acceptable procedure under those circumstances and that she should have a cesarean section. Dr. Diebel's expert testimony was credited. Petitioner proved this allegation.

81. Even had TOLAC not been contraindicated with breech presentation, the standard of care certainly required that Respondent advise D.G. of the additional risks involved in attempting a VBAC due to her breech presentation. It was uncontroverted that Respondent did not do so. This was the basis for the second charge of medical malpractice. Respondent's argument that he had no duty to advise D.G. of these risks under the circumstances here, because he believed that D.G. was already aware of the risks, and she had not asked him any questions is rejected, consistent with the testimony of Dr. Diebel. Petitioner also proved this charge.

82. Petitioner alleges, in a related third charge, that Respondent committed medical malpractice by allowing D.G. to undergo a trial of labor with a history of cesarean and a breech presentation. If a patient, fully advised by her physician and despite his contrary advice, nevertheless insisted upon TOLAC, it would not constitute medical malpractice for a doctor to fully document those steps and then proceed, as Dr. Diebel testified. Under the facts shown here, however, it constituted medical malpractice to allow D.G., with her prior cesarean and breech presentation, to undergo a trial of labor without first advising against that course or even specifically informing her of the additional risks.

83. The Amended Administrative Complaint next charged that Respondent committed medical malpractice by ordering misoprostol and Pitocin for D.G. to stimulate her labor when both were contraindicated given D.G.'s presentation and previous cesarean.

84. Petitioner showed that misoprostol was contraindicated, but failed to clearly show that it was actually used. On the other hand, Petitioner showed that Pitocin was administered, but failed to clearly show that ordering it (as opposed to continuing it too long) was contraindicated. As both of these elements were required to show medical malpractice with respect to each drug, Petitioner failed to show by clear and convincing evidence that

Respondent committed medical malpractice through the administration of these drugs.

85. The complaint charged that Respondent committed medical malpractice by failing to review and/or appropriately interpret the fetal monitor when signs of fetal distress began. The exact wording of this allegation must be considered. It charges that Respondent failed to meet a standard of care when signs of fetal distress began. The evidence did not clearly show, however, when Respondent became aware, or should have been aware, of the beginning of the signs of fetal distress. Dr. Diebel testified:

> Q. I guess my question to you would be, at what point did it become apparent to you that there was some fetal distress that was starting?
>
> A. Okay, Bear in mind that you're going to see little harbingers like that along the way before you see something major.
>
> Page 57, 58, 59 I can't tell because its--she may have been off for a while. Well, look at page 62.
>
> Dr. Tsinker: What time?
>
> The Witness: This is now about 22:07 or something; a couple of large decelerations. Then these are now--this is a category 3 strip. Page 63 right at the beginning, there is another one. That's a late--you see how base of it--

Thus the earliest time that signs of fetal distress began, according to Dr. Diebel's testimony, was after 2207 hours. These

signs therefore appeared after Respondent reviewed the fetal monitoring strip at 2203 hours.

86. While Dr. Diebel testified at one point that the tracing showed decreased variability shortly after 2000 hours, and at another that these earlier tracings were not completely normal, he agreed during cross-examination that he would not do a cesarean section at that time.[3/] Dr. Diebel also testified that during the period prior to the examination at 2203 hours, the fetal strip would have caused him to "want to stay by the patient's side." However, taking Dr. Diebel's testimony as a whole, these earlier tracings cannot be said to constitute "fetal distress" as this charge specifies.

87. It also was not clearly shown that after 2203 hours, when signs of fetal distress began, that Respondent was notified by Nurse Walther that this was happening, nor was it clear how he would otherwise have become aware of signs of fetal distress. Dr. Diebel's testimony did not clearly and convincingly show what the standard of care requires when signs of fetal distress begin but the physician is unaware of them. It was not clearly shown that Respondent's "failure to review and/or appropriately interpret the fetal monitor" constituted medical malpractice under these circumstances.

88. Similarly, the complaint charged that Respondent committed medical malpractice by allowing D.G. to continue to

labor when the fetal monitor began showing signs of fetal distress. Again, Dr. Diebel's testimony did not clearly and convincingly show what the standard of care requires when signs of fetal distress begin but the physician is unaware of them. It was not clearly shown that Respondent's allowing D.G. to continue to labor at this point constituted medical malpractice under these circumstances.

89. Respondent argued that he was unaware of the signs of fetal distress on the monitor and claimed that the labor and delivery nurse failed in her responsibility to notify him. The testimony of Nurse Walther that he had been notified was not clear or convincing. Petitioner did not prove these last two charges of medical malpractice.

90. Petitioner established by clear and convincing evidence that Respondent committed medical malpractice in violation of section 458.331(1)(t)1., as charged in the Amended Administrative Complaint.

Count II

91. Petitioner alleged in Count II that Respondent failed to keep legible medical records. Petitioner first charges that Respondent failed to document a proper admission history and physical for D.G. While the admission history and physical form was not properly timed, almost all of the blocks were completed with the basic information that was relevant. It was not clearly

or convincingly shown that Respondent failed to document the admission history and physical.

92. The complaint next alleges that Respondent failed to dictate or write any progress notes during the course of D.G.'s labor. Dr. Diebel's testimony that a physician must keep progress notes during the labor of their patients, except when everything was going well, was clear. It was also clear that everything went well in D.G.'s labor only until about 1700 hours, when the first signs, such as loss of variability in the trace, began to indicate that things were deteriorating. In failing to make any progress notes, Respondent violated the requirement to maintain records that justified the course of treatment of D.G.

93. Finally, the complaint charged that Respondent failed to dictate or write a delivery note describing what took place during D.G.'s delivery. Dr. Diebel's testimony that Respondent's delivery note was not sufficient under the tragic circumstances was clear and convincing.

94. Petitioner showed by clear and convincing evidence that Respondent failed to keep legible and accurate medical records that justified the course of treatment of D.G., including progress notes on D.G.'s labor and a sufficient delivery note, in violation of section 458.331(1)(m), as charged in the Amended Administrative Complaint.

Penalty

95. Petitioner imposes penalties upon licensees consistent with disciplinary guidelines prescribed by rule. See Parrot Heads, Inc. v. Dep't of Bus. & Prof'l Reg., 741 So. 2d 1231, 1233-34 (Fla. 5th DCA 1999).

96. Penalties in a licensure discipline case may not exceed those in effect at the time the violations were committed. Willner v. Dep't of Prof. Reg., Bd. of Med., 563 So. 2d 805, 806 (Fla. 1st DCA 1990), rev. denied, 576 So. 2d 295 (Fla. 1991). At the time of the incidents, Florida Administrative Code Rule 64B8-8.001(2)(m) provided that for a first-time offender failing to keep required medical records, as described in section 458.331(1)(m), the prescribed penalty range was "[f]rom a reprimand to denial or two (2) years suspension followed by probation and an administrative fine from $1,000.00 to $10,000.00."

97. Rule 64B8-8.001(2)(t) provided that for a first-time offender committing medical malpractice, as described in section 458.331(1)(t), the prescribed penalty range was "[f]rom one (1) year probation to revocation or denial, and an administrative fine from $1,000.00 to $10,000.00."

98. Rule 64B8-8.001(3) provided that, in applying the penalty guidelines, the following aggravating and mitigating circumstances should also be taken into account:

(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, F.S., of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure.

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

(i) Any other relevant mitigating factors.

99. A significant aggravating factor was that Respondent's actions exposed the unborn child to severe injury or death. In addition, under paragraph (h), Respondent here was charged with violating the standard of care and it was found that he failed to keep adequate medical records.[4/]

100. On the other hand, Respondent was not under any legal restraints at the time of the incident. There was no evidence of any prior disciplinary history in any jurisdiction over a long and successful career. Respondent received no special pecuniary benefit or self-gain from his actions. The incidents did not involve any trade or sale of controlled substances. Respondent voluntarily undertook continuing medical education in relevant areas.

101. The evidence also suggests that a major contributing factor to the tragic outcome in this case was that Respondent may not have been not notified of the clear signs of fetal distress occurring after 2230 hours. While this does not serve as a legal defense to the proven charges, it is relevant in determining an appropriate penalty.

102. Taken as a whole, the evidence presented does not warrant deviation in penalty from the wide range of discipline contained within the rule.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a final order be entered by the Board of Medicine finding that Dr. Simion Tsinker violated sections 458.331(1)(m) and (t), Florida Statutes (2013), as charged in the Amended Administrative Complaint; suspending his license to practice medicine for a period of four months; imposing an administrative fine in the amount of $20,000; and requiring that he complete continuing medical education as deemed appropriate by the Board.

DONE AND ENTERED this 12th day of February, 2016, in Tallahassee, Leon County, Florida.

F. SCOTT BOYD
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 12th day of February, 2016.

ENDNOTES

[1/] The acronyms TOLAC (trial of labor after cesarean) and VBAC (vaginal birth after cesarean) are used in this Order

interchangeably, although testimony suggested that technically the term VBAC refers to a successful vaginal birth.

[2/] Practice Bulletin 115, although offered as Respondent's Exhibit D, was rejected as substantive evidence; there was no other independent evidence admitted that it could supplement or explain.

[3/] It is not clear that this testimony was completely consistent with Dr. Diebel's earlier testimony that a cesarean section should have been performed as soon as D.G. was admitted. His later testimony is interpreted to mean that at that time the fetal strip was not giving any indications of fetal distress that independently warranted intervention by cesarean.

[4/] Compare Public Health Trust of Dade County v. Valcin, 507 So. 2d 596 (Fla. 1987), in which the Florida Supreme Court held that the unavailability of medical records due to an adverse party's negligence may create a shifting of the burden of proof in a civil medical malpractice case.

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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.