STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs.

Case No. 19-5303PL

BERTO LOPEZ, M.D.,

Respondent.
_______________________________________/

RECOMMENDED ORDER

On March 4 and June 19, 2020, Administrative Law Judge ("ALJ") Robert S. Cohen of the Division of Administrative Hearings ("DOAH") conducted a disputed-fact hearing pursuant to section 120.57(1), Florida Statutes, in West Palm Beach, Florida, and via Zoom conference.

APPEARANCES

For Petitioner: Corynn Colleen Alberto, Esquire
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For Respondent: Elena Ris, Esquire
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STATEMENT OF THE ISSUE

Whether Respondent violated section 458.331(1)(t), Florida Statutes, by committing medical malpractice.

Preliminary Statement

Petitioner, Department of Health, Board of Medicine ("Department" or "Petitioner"), filed a one-count Amended Administrative Complaint ("Complaint") against Respondent, Berto Lopez, M.D. ("Dr. Lopez" or "Respondent"). Petitioner's Complaint charged Dr. Lopez with one count of violating section 458.331(1)(t), by committing medical malpractice, as defined in section 456.50, Florida Statutes.

Dr. Lopez filed an Election of Rights on July 5, 2019, disputing the allegations of material fact contained within Petitioner's Complaint and requesting a formal hearing. On October 7, 2019, Petitioner forwarded the case to DOAH for assignment to an ALJ. By notice issued October 23, 2019, the case was scheduled for hearing December 2 and 3, 2019.

On November 22, 2019, Petitioner filed a Motion for Continuance. The motion was granted, and the hearing was rescheduled for January 14 and 15, 2020. On January 3, 2020, Petitioner filed a second Motion for Continuance, which was granted, and the hearing was rescheduled for March 4 through 6, 2020.

The hearing commenced on March 4, 2020, in West Palm Beach, Florida. Petitioner's Exhibits 1 and 2 were admitted into evidence, without objection, and Petitioner's Exhibit 5 was admitted, over objection. Petitioner presented two witnesses, Nurse Ryan Gavagni ("Nurse Gavagni"); and expert, Donald Diebel, M.D. ("Dr. Diebel"), each of whom testified live at the hearing. Petitioner rested its case on March 4, 2020.

Dr. Lopez's case-in-chief was scheduled to begin the following morning, March 5, 2020, at 9:00 a.m. However, Dr. Lopez did not appear at the hearing room at the appointed time. For several hours, Dr. Lopez's whereabouts were

unknown, and Petitioner's counsel was permitted to leave the hearing location until further notice. At or around 11:00 a.m., the ALJ contacted counsel for Petitioner to advise that he had been in contact with Respondent, who alleged that he had overslept after taking Benadryl for a severe toothache in the middle of the night. After conferring with Petitioner's counsel, the ALJ continued the proceedings to a date to be determined the following week.

On March 11, 2020, the ALJ issued an Order rescheduling the remainder of the hearing for March 31, 2020, via video teleconference. On March 23, 2020, Dr. Lopez filed a motion for continuance, based on the COVID-19 crisis, and its alleged impediment on his newly retained counsel's ability to travel to West Palm Beach from Alpharetta, Georgia, where she resides. The ALJ granted the motion, and the matter was rescheduled for April 27, 2020. On April 9, 2020, Respondent's counsel filed a second Motion for Continuance, requesting that the hearing be rescheduled due to travel restrictions from COVID-19. By Order dated April 21, 2020, the ALJ granted the motion and rescheduled the hearing for June 19, 2020, by video teleconference. The matter was later noticed as a Zoom conference.

On April 16, 2020, Respondent's counsel filed a Motion for Admission of Evidence, requesting that Dr. Lopez be allowed to offer the expert testimony of Dr. David Feld, M.D. ("Dr. Feld"), in his case-in-chief. Petitioner objected to this motion since Respondent had never disclosed an expert prior to the hearing on March 4, 2020, and Petitioner had already rested its case. The ALJ held a hearing on the matter, and on May 4, 2020, issued an Order granting Respondent's motion due to the fact that sufficient time existed prior to the rescheduled hearing to depose the newly-named expert; to allow Petitioner's expert to review the deposition testimony and offer rebuttal evidence at hearing; and based upon the fact that such remedy would thus minimize, if not eliminate, any prejudice to the Department caused by the

new expert being disclosed. Pursuant to the Order, Respondent was required to produce Dr. Feld for deposition prior to the hearing date, and Petitioner would be permitted to reopen its case-in-chief to present additional testimony at the final hearing. Petitioner took the deposition of Dr. Feld on May 20, 2020.

The final hearing was completed on June 19, 2020, via Zoom conference. At hearing, Respondent's Exhibits 1, 2, 5, and 6 were admitted without objection. Respondent's Exhibits 3 and 4 were admitted over objection. Respondent presented two witnesses: Dr. Lopez and his expert, Dr. Feld, each of whom testified live at the hearing. Petitioner's Exhibit 6 was admitted over objection.

The Transcript of the hearing was filed with DOAH on July 6, 2020. Respondent's Proposed Recommended Order was filed on July 15, 2020, and Petitioner's was filed on July 16, 2020. Both proposed recommended orders have been duly considered in the preparation of this Recommended Order. All references to Florida Statutes are to the version in effect at the time of the violations of law alleged in Petitioner's Complaint, the 2017 codification.

FINDINGS OF FACT

1. Petitioner is the state agency charged with the regulation of the practice of medicine pursuant to section 20.43 and chapters 456 and 458, Florida Statutes.

2. At all times material to these proceedings, Respondent was licensed as a physician in the State of Florida and held license number ME50399.

3. Dr. Lopez immigrated to the United States with his family at a young age from Cuba. Spanish is his first language, and he is completely fluent in English. He attended primary and secondary schools in the United States. He graduated from the University of Georgia with a bachelor of science degree in

chemistry. He attended medical school at the Medical College of Georgia in Augusta, Georgia, He completed his residency at Emory University in Atlanta, Georgia. Dr. Lopez has been board-certified in obstetrics and gynecology since 1990, and was so certified at the time of the incident giving rise to these proceedings.

4. At the time of the hearing, Dr. Lopez was employed by Palm Beach Medical Group. He was seeing obstetrical and gynecological patients for "in-office" only consultations and care. Although he has delivered over 10,000 babies and performed hundreds of obstetrical and/or gynecological surgeries over the course of his more than 33-year career, as of August 2017, he elected to no longer deliver babies or perform surgeries. His obstetrical patients are now delivered by hospital-based obstetricians, and he refers out all patients requiring surgery to other surgeons. He has voluntarily elected not to reactivate his hospital privileges at any hospital at this time.

5. The patient, O.C. ("O.C."), a 40-year-old female, was admitted to Good Samaritan Medical Center ("Good Samaritan") on July 25, 2017. Good Samaritan is a local community hospital. It is neither a trauma center nor a teaching hospital.

6. On that same day, at approximately 8:03 p.m., Respondent delivered the baby of O.C. after a scheduled induction.

7. During the delivery, O.C. suffered one or more cervical lacerations and developed a postpartum hemorrhage.

8. Respondent performed a postpartum cervical exam at O.C.'s bedside with a vaginal speculum. The medical records reflect that Respondent's visualization of the cervix during the exam was hampered by bleeding.

9. Respondent found multiple cervical lacerations, which he documented that he repaired. However, O.C. continued to bleed heavily and her condition deteriorated.

10. By 8:40 p.m., O.C.'s blood pressure had fallen to 95/58. Despite her worsening condition, Respondent delayed taking O.C. to the operating room ("OR") for surgical exploration.

11. At or around 9:40 p.m., O.C. was taken to the OR in an "unresponsive state," and Respondent performed a supracervical hysterectomy.

12. Following the surgery, blood was observed flowing from the incision in O.C.'s abdomen. Respondent chose not to reopen the surgical incision and instead ordered the application of pressure dressings to treat the bleeding.

13. Even though O.C. was still bleeding, Dr. Lopez left the hospital at approximately 11:42 p.m. Upon her arrival to the intensive care unit ("ICU"), O.C.'s wound dressing was saturated with blood.

14. At approximately 3:00 a.m., on July 26, 2017, ICU nurses observed blood "gushing" from the hysterectomy incision and from her vagina. Shortly thereafter, O.C. experienced cardiac arrest and expired.

<u>Experts</u>

15. Dr. Diebel, a highly accomplished physician, testified as a medical expert for Petitioner. Dr. Diebel became licensed to practice medicine in Florida in 1977.[1] During his practice, he maintained board certification in obstetrics and gynecology from the American Board of Obstetrics and Gynecology. Dr. Diebel has not practiced medicine for two years (although he was still engaged in his medical practice at the time of the incident giving rise to these proceedings); has not actively managed a patient with postpartum hemorrhage in over three years; has not participated in any specialized simulated training in the treatment and management of postpartum hemorrhages; is not affiliated with a similarly-situated local community hospital; and has only been affiliated with trauma and teaching hospitals (where doctors and medical school residents are on site 24/7 and operating rooms are staffed, equipped, and immediately accessible around the clock).

16. Dr. Feld, also a highly accomplished physician, testified as an expert for Respondent. Dr. Feld has practiced medicine in Florida since 1978. He has maintained board certification in obstetrics and gynecology from the American Board of Obstetrics and Gynecology since 1980. Dr. Feld testified that, with respect to each of the allegations contained in the Petitioner's Complaint, Respondent met the standard of care, because he practiced medicine with that level of care, skill, and treatment, which is recognized by a reasonably prudent similar physician as being acceptable and appropriate under similar circumstances.

Standard of Care

i. Failure to Take O.C. to the OR for Laceration Repair

17. Dr. Lopez testified that he had a clear and independent recollection of the patient and the events surrounding her delivery and post-delivery treatment. She had been his patient for more than a decade, and he had delivered her first child. The patient was of Cuban heritage. Dr. Lopez knew the patient's husband, mother, and aunt, who is also a medical doctor. In light of his personal relationship with the patient and her family, Dr. Lopez was motivated to perform at his highest professional level to assure a good outcome. He canceled his office appointments and spent the day at the hospital with the patient and her family.

18. O.C. suffered a small perineum tear[2] and cervical lacerations following the delivery of her baby. Dr. Lopez performed an examination and repair of the lacerations in the delivery room. He encountered difficulties during the procedures because of inadequate lighting and a view obstructed by bleeding. He violated the standard of care when he failed to take O.C. to the OR when these issues arose.

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[1] Dr. Diebel testified that he is currently retired.

[2] Perineal tears are damage to the area between the vaginal opening and anus that occur during vaginal delivery and can range in severity.

19. Bleeding following a delivery is normal, but heavy bleeding should typically stop within a few minutes. Normally, if visualization is good, repairing a cervical laceration takes two or three minutes.

20. Dr. Lopez repaired the small perineum tear and began the cervical laceration repair at 8:10 p.m. At 8:30 p.m., the medical records reflect that he remained at O.C.'s bedside and performed cervical repair.

21. Nurse Gavagni has a clear recollection of the events in this case, due to the traumatic effect it had on her. This is the first and only maternal death she had experienced in her eight years working as an obstetrics nurse.

22. Nurse Gavagni assisted Dr. Lopez during his examination and repair of O.C.'s cervical lacerations. Dr. Lopez requested that Nurse Gavagni use a metal retractor because he was having a difficult time seeing inside the vagina. Dr. Lopez requests the use of a metal retractor in cervical laceration repairs where he has difficulties seeing the upper and lower parts of the vagina.

23. A retractor is an L-shaped device used to hold the upper part of the vagina.

24. Nurse Gavagni testified that the laceration repair took a while to complete. As Dr. Lopez performed the repair, the bleeding was "kind of heavy." Dr. Lopez attempted to reduce the bleeding by placing mini lap pads ("pads") inside of O.C. to tamponade the cervix.

25. Tamponading is a technique whereby pads can be placed inside the cervix, similar to a tampon, to determine whether bleeding is coming from the cervix or somewhere else.

26. Nurse Gavagni stated that the delivery tray is usually prepared with ten pads on it.

27. During the repair, 20 soaked pads were weighed to estimate O.C.'s blood loss. The records indicate that the weight of the soaked pads was 526 grams or ccs. This estimate did not include blood collected in the bag and under O.C.'s bottom.

28. Dr. Diebel testified that the use of a pad to reduce bleeding for a moment to visualize the cervix and repair it is reasonable; however, the use of 20 pads suggests enough bleeding to move a patient into the OR to evaluate and perform the repair.

29. Dr. Lopez claims that he only used one or two of the pads to tamponade the cervix, and the others were used to "blot" the vagina. Furthermore, he asserts that most of the pads were not "soaked" but "soiled." Tr., pp. 393-395.

30. Dr. Lopez's testimony is not credible because the records clearly reflect that 20 "soaked" pads were weighed. Additionally, Nurse Gavagni confirmed that the soaked pads were used and weighed at or around the time that Dr. Lopez performed the repair.

31. The evidence is clear and convincing that 20 pads were soaked after being used during the laceration repair because Dr. Lopez was having trouble visualizing the cervix due to heavy bleeding.

32. In addition to bleeding, Dr. Lopez experienced issues with lighting in the delivery room during the laceration repair.

33. Nurse Gavagni testified that the timer on one of the overhead lights was broken, and it had to be supplemented with a portable light on wheels. She described the portable light as a "spotlight." During the repair, the portable light was knocked over several times, causing Dr. Lopez to ask everyone to leave the room. Furthermore, the charge nurse was called in to hold the timer on the broken light so that it would stay on. The evidence is clear and convincing that the broken light was problematic during laceration repair.

34. According to Dr. Diebel, good, sustained lighting is necessary when repairing a cervical laceration. Additionally, there should be no obstruction between a physician's vision and the cervix.

35. Dr. Diebel also testified that lighting in an OR is better than that in a delivery room. This would certainly be true in a delivery room with a

malfunctioning light. In this instance, Dr. Lopez needed to take O.C. to the OR to perform a thorough pelvic exam to ascertain the source of the bleeding.

36. Dr. Diebel testified clearly and credibly that the exam and repair could not be performed adequately in the delivery room, given the circumstances. The continued bleeding and inadequate lighting should have prompted Dr. Lopez to take O.C. to the OR to ascertain the source of the bleeding. Dr. Lopez's failure to do so violated the standard of care.

37. In formulating his opinion in this case, Dr. Diebel acknowledged that the standard he applied was that level of care, skill, and treatment, which, in light of all the relevant surrounding circumstances, is recognized as acceptable and appropriate by a reasonably prudent, similar healthcare provider, or what the average obstetrician/gynecologist would do under similar circumstances.

38. Dr. Lopez testified that the malfunctioning timer was part of a "decorative" light located over the head of the delivery bed. The light was not useful to him because he spent most of his time at the "south end" (the foot) of the bed. Dr. Lopez claims that the light may have been useful to Nurse Gavagni because she was probably taking the patient's vitals and entering notes into the computer at the head of the bed.

39. Dr. Lopez's testimony is inconsistent and not credible. On the one hand, he testified that Nurse Gavagni assisted in the repair by holding the retractor. Then when questioned about lighting, he stated that she was probably taking vitals and entering notes.

40. Nurse Gavagni testified clearly and credibly that she helped Dr. Lopez during the repair by holding the retractor. She never mentioned that the inadequate light interfered with her ability to take O.C.'s vitals or enter information in the computer. Her testimony about the lighting issue was in the context of Dr. Lopez's exam and laceration repair.

41. Dr. Feld testified that constant, adequate light, without obstruction, is necessary during a cervical laceration repair, and blood gushing out of the

vagina can interfere with visualization of the cervix. Dr. Feld would take a patient to the OR for a laceration repair if he could not stop the bleeding. He admitted that he has no personal knowledge of what Dr. Lopez's visualization was at the time of his repair of O.C.'s lacerations.

42. The evidence is clear and convincing that Dr. Lopez had trouble visualizing O.C.'s cervix during the laceration repair due to bleeding and inadequate lighting. He violated the standard of care by failing to take O.C. to the OR to better evaluate the source of the bleeding and to perform the repair.

ii. <u>Delay in Taking O.C. to the OR</u>

43. Following the laceration repair, O.C. continued to bleed and her condition quickly deteriorated. Still, Dr. Lopez delayed taking O.C. to the OR to address the bleeding.

44. By at or around 8:40 p.m., O.C. had received fundal massage[3] and various medications, including Pitocin[4] and Hemabate,[5] to stop the bleeding. Yet, she continued to bleed and began exhibiting deteriorating vital signs.

45. At 8:45 p.m., O.C.'s blood pressure was 95/58, and she was vomiting. O.C. was hypotensive,[6] tachycardic,[7] hypoxic,[8] and starting to turn gray. By 8:57 p.m., her blood pressure dropped to 66/46, and she was minimally responsive.

46. If Dr. Lopez had, as he testified, repaired the cervical lacerations, sewed the perineal tear, and administered proper medications, and O.C.

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[3] Fundal massage, also called uterine massage, is a technique used to reduce bleeding and cramping of the uterus after childbirth.

[4] Pitocin is a natural hormone that causes the uterus to contract and can be used after childbirth to control bleeding.

[5] Hemabate is the brand name for the drug carboprost. Carboprost is a synthetic prostaglandin with oxytocic properties. It is used to reduce bleeding during postpartum hemorrhage.

[6] Hypotensive is relating to or suffering from abnormally low blood pressure.

[7] Tachycardia is a rapid heartbeat that may be regular or irregular, but is out of proportion to age and level of exertion or activity.

[8] Hypoxia is a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level.

continued to bleed, there was nothing left to do except take her to the OR. Continued attempts at treating O.C. were futile until the source of her bleeding was addressed.

47. Dr. Diebel testified that had Dr. Lopez taken O.C. to the OR to evaluate the bleeding when attempting the laceration repair, as the standard of care required, he could have addressed O.C.'s deteriorating condition more appropriately. Since he did not take her to the OR at that time, he should have been prompted to take her at or around 8:30 p.m. Instead, Dr. Lopez waited another hour before making the decision to take O.C. to the OR.

48. Dr. Lopez claims that from 8:45 p.m. to 9:25 p.m., he was waiting for an available OR and an anesthesiologist. This testimony is inconsistent with Nurse Gavagni's recollection of the events and is also refuted by the medical records.

49. Nurse Gavagni testified that there was no wait for an OR that evening. On the Labor and Delivery floor at Good Samaritan, there was always one OR ready for an emergent patient. On the evening of this incident, an OR was available for O.C.

50. When describing the OR, Nurse Gavagni stated that it is "never left completely unprepared … most of it is set up, and then all the scrub tech does is go in and open the tools and scrub and get dressed." She also noted that hysterectomy trays were readily available.

51. The medical records do not reflect that there was any delay in taking O.C. in for surgery based on the unavailability of an OR.

52. Dr. Diebel agreed with Nurse Gavagni's testimony that most hospitals have one OR that is reserved and available for emergencies.

53. Dr. Feld testified that when he worked at Good Samaritan, he could get emergency cesarean section patients into the obstetrics OR within 15 to 20 minutes.

54. The evidence is clear and convincing that an OR was available for O.C. that evening.

55. Dr. Lopez's claim that he was waiting on an anesthesiologist between 8:45 p.m. and 9:25 p.m. also falls short of being accurate because the medical records reflect that anesthesia was not even called until 9:25 p.m.

56. Dr. Lopez attempted to minimize O.C.'s failing condition by alleging that she stopped bleeding at certain times prior to being taken to the OR. However, Nurse Gavagni testified clearly and credibly that O.C. never stopped bleeding and continued having at least a moderate trickle, or a continuous light to moderate stream. This is clearly supported by the records which indicate a consistent deterioration of her vitals from 8:45 p.m. to 9:25 p.m.

57. Dr. Lopez also attempted to minimize O.C.'s condition by noting that her blood pressure was 118/52 at 9:30 p.m., shortly before she was taken to the OR.

58. Dr. Diebel believes that O.C.'s blood pressure reading at 9:30 p.m. was a spurious result. This is based upon the fact that two minutes before that reading, at 9:28 p.m., O.C.'s blood pressure was 67/32. Furthermore, for the preceding hour, her blood pressure had gradually worsened, without any signs of significant recovery. Dr. Diebel stated that the blood pressure reading at 9:30 p.m. did not make physiologic sense, given O.C.'s condition, and it certainly, in and of itself, did not mean that she should not have been taken into surgery.

59. Dr. Lopez testified that in a postpartum hemorrhage, the rapid response team should be called if the patient experiences a change in vital signs and hemodynamic instability.

60. Rapid response is a protocol that can be initiated when trying to prevent a patient from coding (dying). A rapid response team provides a physician with additional staff, like more nurses and/or other specialties, to assist in treating an emergent patient.

61. In this case, the records reflect that rapid response was not called until 9:25 p.m., more than 40 minutes after O.C.'s vitals began to deteriorate. Thus, by Dr. Lopez's own admission, there was a delay in treating O.C.

62. O.C. was not taken to the OR until 9:38 p.m., approximately one hour and 45 minutes after the bleeding first began. When she arrived in the OR, she was cold, clammy, and had blood gushing from the vaginal canal.

63. Dr. Diebel testified that by the time she was taken to the OR, O.C. was in irreversible shock.

64. Once in the OR, O.C.'s surgery was further delayed because Dr. Lopez had to wait on his supervising physician, Dr. Alfred Tomaselli.

65. Pursuant to a prior Board Order in effect at the time of this incident, Dr. Lopez was restricted from performing any surgical procedures without supervision by another board-certified obstetrician. Therefore, Dr. Lopez could not operate on O.C. until a supervising physician arrived at the OR that evening.

66. Nurse Gavagni recalled calling Dr. Tomaselli from the OR to find out where he was. This is corroborated by the records which show that O.C. arrived at the OR at 9:38 p.m., but the first incision did not occur until 10:01 p.m.

67. Dr. Feld believes that Dr. Lopez's timing in taking O.C. to the OR was "absolutely perfect," even though the outcome was unfortunate. He testified that O.C.'s condition would not have changed if Dr. Lopez had taken her into the OR sooner because she was already in a downward spiral, due to DIC.[9] He claims that O.C. had signs of DIC as early as her admission to Good Samaritan.

68. Dr. Diebel disagrees with Dr. Feld's belief that O.C. was in DIC at the time of her admission, since there is no evidence in the medical records to

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[9] DIC, or disseminated intravascular coagulation, is a condition affecting the blood's ability to clot and stop bleeding.

support that position. Additionally, he stated that he was not convinced that O.C. experienced DIC prior to or after the hysterectomy.

69. Dr. Diebel vehemently disagreed with Dr. Feld's assertion that taking the patient to the OR earlier would not have made any difference in her outcome. He testified clearly and credibly that O.C.'s condition deteriorated steadily, which could have been avoided had Dr. Lopez taken her to the OR sooner.

70. Dr. Lopez attempted on several occasions to place blame on Good Samaritan Hospital for lack of preparedness related to treatment for postpartum hemorrhage. He also emphasized that Good Samaritan is a community hospital lacking the capabilities of an academic center like Orlando Regional, or a trauma facility. Yet, the record clearly reflects that nothing prevented him from taking O.C. to the OR sooner. Additionally, no evidence was offered to show that Good Samaritan lacked the necessary medications, infrastructure, or equipment to adequately address O.C.'s condition.

71. In light of all of the above, the evidence is clear and convincing that Dr. Lopez fell below the standard of care by not taking O.C. into the OR sooner.

iii. Performance of Supracervical Hysterectomy Instead of Total Abdominal Hysterectomy

72. At 9:40 p.m., O.C. consented, in writing, in both English and Spanish, to a total abdominal hysterectomy ("TAH"). O.C. and her husband were made aware that, after a TAH, they would not be able to have any more children. They responded that they did not intend to have any more children. The consent O.C. signed included an acknowledgement that other surgical procedures might become necessary.

73. A TAH is the surgical removal of the cervix and the uterus.

74. Instead of performing a TAH, Dr. Lopez performed a supracervical hysterectomy.

75. A supracervical hysterectomy is the surgical removal of the top part of the uterus, leaving the cervix in the patient.

76. Dr. Lopez testified that he performed a supracervical hysterectomy because it is a quicker procedure than a TAH.

77. This statement is inconsistent with testimony he gave in a prior deposition, wherein he stated that a supracervical hysterectomy is “more surgery” and takes more time to perform than a TAH.

78. When confronted with this discrepancy, Dr. Lopez claimed that his prior testimony was “wrong” and must have been a “typo” on the part of the court reporter. However, in the deposition, Dr. Lopez provided a detailed explanation as to why a supracervical hysterectomy takes longer than a TAH, clearly showing that it was not a typo.

79. Dr. Lopez does not have ICU privileges at Good Samaritan. Accordingly, he delegated the follow-up care for O.C. to Dr. Reynold Duclas, the anesthesiologist who was present in the OR for the surgery and afterwards, and to Dr. Tanvir Salaam, the intensivist who appeared via telemedicine. Dr. Lopez then left Good Samaritan to return home to find some clean clothes. Dr. Lopez believed the patient was stable and in good hands when he left Good Samaritan.

80. Dr. Lopez stayed near his cell phone when he returned home and was available when he received a call from the hospital at 3:04 a.m. He returned to the hospital where he found O.C. in the ICU bed and the code was in progress. He ended the code because the patient had died.

81. While O.C. was in the ICU, blood was drawn for lab work at 1:20 a.m. At about 2:22 a.m., the ICU received an emergency critical value telephone call that the patient’s lab work was abnormal, and that she had developed DIC. Dr. Lopez did not receive a call from the lab or the hospital until the 3:04 a.m. call described above, which was when the patient was coding.

82. An autopsy was performed that confirmed O.C. had died from DIC. Dr. Lopez testified, and the evidence reflects, that while he was actively

managing the patient, no bloodwork had indicated she was suffering from DIC. This testimony conflicts with Dr. Feld's testimony that there was nothing Dr. Lopez could have done because O.C. was already in a "downward spiral" due to DIC.

83. Dr. Lopez testified that, based on lab work performed at 1:20 a.m., "the patient had never sustained a hypoxic injury to her liver, she had not sustained a hypoxic injury to her kidneys, that she had not sustained, on the basis of the clinical parameters, any irreversible damage from the time of the surgery." The patient had, in fact, showed:

> evidence that her brain was functioning … [s]he started to show purposeful movement and followed instructions for movement by a nurse that her cerebral cortex and her mechanical physical being was capable of movement from the brain to the muscles. That her kidney function was improving was evidenced by the fact that the blood that she had once sustained in her urine had cleared and she was making urine. At no time did the delay in taking her to the operating room cause irreversible hypoxia, irreversible unsustainable conditions that would lead to her death.

84. Dr. Diebel testified that Dr. Lopez should have performed a TAH in this case, because it would have prevented the potential for any additional bleeding following the surgery. He explained that after performing a TAH, a physician must sew together the front wall and back wall of the vagina. He described this as "very straightforward," and less likely to lead to "bad bleeding." In comparison, when performing a supracervical hysterectomy, the physician must sew over the cervical stump, which consists of more substance to cinch down and suture.

85. Additionally, based on the circumstances during the laceration repair, Dr. Diebel noted that it was not clear that the cervix was not still a source of bleeding. This complements and supports his opinion that a TAH should have been performed to ensure cessation of bleeding.

86. Dr. Diebel testified clearly that the appropriate standard of care required that Dr. Lopez perform a TAH and not a supracervical hysterectomy.

87. Another reason Dr. Lopez offered for performing a supracervical hysterectomy was that the procedure was less likely to expose another organ to injury. He claimed that O.C. had a hematoma involving the lower uterine segment, and this affected his decision not to perform a TAH.

88. In his operative note ("op note") for this procedure, Dr. Lopez did not identify a hematoma as the reason for performing a supracervical hysterectomy over a TAH. The only mention of a hematoma appears after the removal of the uterus. Therefore, it could not have affected Dr. Lopez's decision-making in performing a supracervical hysterectomy.

89. Dr. Feld does not remember if there was a hematoma noted in Dr. Lopez's op note, but he believes that performance of a supracervical hysterectomy was appropriate because it is quicker and safer, given the swelling and blood clots around the cervical vaginal junction following delivery.

90. Dr. Diebel challenged Dr. Lopez's claims that a hematoma on the lower uterine segment affected his decision to perform a supracervical hysterectomy. Dr. Diebel pointed out that the op note specifically states that the bladder flap was taken down easily, and a hematoma was not noted until after Dr. Lopez removed the top of the uterus. As a result, Dr. Lopez could have performed a TAH without concern of a hematoma.

91. When asked why the hematoma appeared in his op note after the uterus was already removed, Dr. Lopez claimed that his dictation may not have been "in sequence." He testified that "a dictated operative note may indicate abnormal findings that may not be in sequence to the procedure that is performed." He also stated that whether an op note is written in sequence "depends on the op note and depends on the circumstance."

92. Dr. Feld disagreed with Dr. Lopez and stated that op notes should be dictated in the sequence that the procedure is performed, from start to finish.

93. Dr. Diebel testified that he has never heard of a surgeon dictating an op note that is not in sequence with the order in which the surgery was performed. He does not know how a surgeon would "get it out of order."

94. Dr. Lopez's attempt to justify his decision to perform a supracervical hysterectomy instead of a TAH is clearly self-serving and discredited by the medical records and expert testimony of Dr. Diebel.

95. The evidence is clear and convincing that Dr. Lopez fell below the standard of care by performing a supracervical hysterectomy instead of a TAH.

iv. Leaving the Hospital

96. Dr. Lopez left the hospital immediately following the surgery, even though O.C. was still in critical condition.

97. Nurse Gavagni testified that during O.C.'s surgery, the anesthesiologist was unable to obtain a blood pressure and could only report a heart rate and respiratory rate. This suggests that O.C.'s condition was extremely perilous.

98. Dr. Lopez completed the procedure at or around 11:00 p.m.

99. Soon after the surgery, while O.C. was still in the OR, Nurse Gavagni noticed blood coming from the incision site and reported it to Dr. Lopez. Dr. Lopez opted not to reopen and instructed Nurse Gavagni to pressure dress the wound and put ice on it. He also ordered an abdominal binder to be applied.

100. Despite the bleeding and critical condition of his patient, Dr. Lopez left the hospital at or around 11:39 p.m.

101. At 11:42 p.m., O.C. was transferred to the ICU. When O.C. arrived in the ICU, the dressing on her wound was soaked with blood.

102. In the ICU, O.C. came under the care of Dr. Salaam, the intensivist. Dr. Salaam was available via telemedicine and not physically present at the hospital.

103. Dr. Lopez testified that he left the hospital because the leg of his scrubs was contaminated with blood, and his left sock and shoe also had blood in them. He claims that there were no other scrubs available to him at Good Samaritan. He did not check to see whether there were any scrubs available on other floors of the hospital, and he did not call anyone in the hospital to ask for clean scrubs.

104. Dr. Feld testified that he would not have left the patient that evening. Also, he would not have left the hospital and gotten into his car with blood all over his scrubs. Additionally, he has never been in a situation where he could not access a clean pair of scrubs at the hospital and believes that most hospitals have extra scrubs for physicians.

105. Dr. Diebel stated that hospitals normally have scrubs "everywhere"-- in the emergency room, in the main OR, in radiology, etc. He believes that Dr. Lopez could have obtained clean scrubs without having to leave the hospital that night. In his long career, Dr. Diebel never had to go home to change his scrubs.

106. Dr. Diebel testified that Dr. Lopez violated the standard of care when he left the hospital that evening, given O.C.'s critical condition. Although O.C. was taken to the ICU, no one on the ICU team was a surgeon. Additionally, the intensivist in charge that evening was not even physically present in the hospital. Dr. Lopez should have remained at the hospital in case O.C. had to be taken back into surgery because he was her physician and the only surgeon present.

107. Dr. Lopez maintained that pursuant to Florida Administrative Code Rule 64B8-9.007, he was permitted to delegate some of his duties to another qualified medical doctor, which is exactly what he did in this case when he left the patient in the ICU. He also noted that the anesthesiologist

volunteered to stay with the patient following the surgery to monitor her recovery.

108. Rule 64B8-9.007, which relates to Standards of Practice and Delegation of Duties, states, in pertinent part, that "the operating surgeon can delegate discretionary postoperative activities to equivalently trained licensed doctors of medicine or osteopathy … . Delegation to any health care practitioner is permitted only if the other practitioner is supervised by the operating surgeon or an equivalently trained licensed doctor of medicine or osteopathy."

109. Dr. Lopez testified that he appropriately delegated responsibility to the ICU intensivist and anesthesiologist. However, he also admitted that neither the intensivist, nor the anesthesiologist, was a trained surgeon who could have taken the patient back to the OR. In fact, there were no surgeons in the ICU at that time. Thus, his argument that he delegated to an equivalently trained doctor fails.

110. The evidence is clear and convincing that Dr. Lopez fell below the standard of care by leaving the hospital while O.C. remained in critical condition.

<u>Prior Discipline</u>

111. At all times material to this incident, Dr. Lopez was restricted from performing any surgical procedure without a supervising physician, pursuant to a prior Board Order.

112. The prior Board Order, related to DOH case number 2014-15022 ("2014 case"), resulted from allegations that Dr. Lopez violated the standard of care in his treatment of two obstetrics patients.

113. The 2014 case involved two obstetrics patients who suffered complications from postpartum hemorrhage. The Administrative Complaint alleged, among other things, that Dr. Lopez committed medical malpractice by failing to timely assess, diagnose, and perform exploratory surgery. Pet. Ex. 6.

114. As is true in this case, one of the patients in the 2014 case died.

115. When asked about the 2014 case, Dr. Lopez was evasive and defensive. He claimed that he did not recall why his license was restricted. Then, when asked several times whether the 2014 case resulted in a patient's death, he refused to answer directly, until prompted by the ALJ.

116. Dr. Lopez was also disciplined by the Board in 2003, in DOH case number 2003-13635 ("2003 case"). The Administrative Complaint in that case alleged that Dr. Lopez fell below the standard of care in his performance of a uterine dilation and curettage (D&C). Specifically, the Administrative Complaint alleged that Respondent failed to perform complete evacuation of a patient's uterus and failed to give appropriate follow-up care when the patient spontaneously expelled fetal tissue.

117. As a result of the 2003 case, a fine of $10,000 was imposed on Dr. Lopez, and he was required to complete CMEs (continuing medical education credits) and perform community service.

118. Despite Dr. Lopez's history with the Board and O.C.'s death, he refused to take direct responsibility for any of his shortcomings. When asked whether he felt at all responsible for O.C.'s death, Dr. Lopez placed the blame on the ICU staff and hospital system.

CONCLUSIONS OF LAW

119. DOAH has jurisdiction over the subject matter and the parties to this action pursuant to sections 120.569 and 120.57(1), Florida Statutes (2019).

120. This is a proceeding whereby Petitioner seeks to revoke Respondent's license to practice medicine. Petitioner has the burden to prove the allegations in its Complaint by clear and convincing evidence. *Reich v. Dep't of Health,* 973 So. 2d 1233, 1235 (Fla. 4th DCA 2008)(citing *Dep't of Banking & Fin. v. Osborne Stern & Co.*, 670 So. 2d 932, 933 (Fla. 1996)); and *Ferris v. Turlington*, 510 So. 2d 292 (Fla. 1987). As stated by the Supreme Court of Florida:

> 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 lacking in confusion as to the facts at issue. The evidence must be of such a 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 Henson, 913 So. 2d 579, 590 (Fla. 2005) (quoting *Slomowitz v. Walker*, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)). This burden of proof may be met where the evidence is in conflict; however, "it seems to preclude evidence that is ambiguous." *Westinghouse Elec. Corp. v. Shuler Bros., Inc.*, 590 So. 2d 986, 988 (Fla. 1st DCA 1991).

121. Because the Medical Practice Act, section 458.331 authorizes suspension or revocation of a professional license, it is penal in nature and must be strictly construed in favor of the licensed physician. *Breesmen v. Dep't of Prof'l Reg., Bd. of Med.*, 567 So. 2d 469, 471 (Fla. 1st DCA 1990).

122. A hearing involving disputed issues of material fact under section 120.57(1) is a de novo hearing, and Petitioner's initial action carries no presumption of correctness. § 120.57(1)(k), Fla. Stat.; *Moore v. Dep't of HRS*, 596 So. 2d 759 (Fla. 1st DCA 1992).

123. The Board of Medicine's Standards of Practice under rule 64B8-9.007(4) interprets the standard of care requirement of section 458.331(1)(t) and the delegation of duties restriction of section 458.331(1)(w) with regard to surgery and, in relevant part, states as follows:

> [t]he operating surgeon can delegate discretionary postoperative activities to equivalently trained licensed doctors of medicine or osteopathy … . Delegation to any health care practitioner is permitted only if the other practitioner is supervised by the operating surgeon or other equivalently trained licensed doctor … .

124. Petitioner’s Complaint charges Respondent with violating section 458.331(1)(t). Florida law recognizes that physicians owe their patients a duty to “use the ordinary skills, means, and methods that are recognized as necessary and which are customarily followed in the particular type of case according to the standards of those who are qualified by training and experience to perform similar services in the community or in a similar community.” *Brooks v. Serrano*, 209 So. 2d 279, 280 (Fla. 4th DCA 1968). The Board may discipline a physician for “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.” §§ 458.331(1)(t) and 456.072(2), Fla. Stat.; *See also Fox v. Dep't of Health*, 994 So. 2d 416, 418 (Fla. 1st DCA 2008). Section 458.331(1)(t) further provides, “The board shall give great weight to the provisions of s.766.102 when enforcing this paragraph.” Section 766.102(3), Florida Statutes, provides, “[t]he existence of a medical injury shall not create any inference or presumption of negligence against a health care provider, and the claimant must maintain the burden of proving that an injury was proximately caused by a breach of the prevailing professional standard of care by the health care provider.”

125. Respondent argues that in order to prove that he breached the requisite standard of care, Petitioner must first establish what the standard of care requires with respect to each of these alleged acts. Petitioner’s expert's (Dr. Diebel’s) opinion, Dr. Lopez argues, as to what he personally (as opposed to what reasonably prudent similar healthcare providers) would do in a particular case is insufficient to prove Respondent failed to meet the proper standard of care. Petitioner fell short of making the necessary showing, argues Respondent.

126. The gist of Respondent’s argument as to why Dr. Diebel’s expert testimony should be discounted, at least, or totally discredited, at most, is that his career was spent largely at a teaching hospital, Orlando Health, with

full trauma, medical/surgical, and other tertiary services, rather than, as is the case with Dr. Lopez here, a smaller community hospital such as Good Samaritan. This case concerns obstetrical services and the aftercare of mothers and newborns following delivery. This was not a case of a trauma patient being brought to a hospital ill equipped or even licensed to provide tertiary care to patients presented following an accident or major medical event. The patient in this matter was known by Respondent who had previous experience with her and her family, all without incident. The labor and delivery of the patients' baby was uneventful in terms of its duration, complexity, and the fact that no complications arose immediately after a healthy baby was delivered. Any hospital providing obstetrical services must be equipped to deal with a labor and delivery, the possibility of a cesarean section, complications with the placenta, blood pressure anomalies, and other routine pre-delivery and aftercare that is customarily provided to mothers and their newborn babies in a community hospital such as Good Samaritan, a regional hospital, or a major teaching hospital such as Orlando Health.

127. What happened in this tragic case is that, while the patient's bleeding seemed to be under control, in Respondent's opinion, following an internal examination and normal bleeding control methods employed by Dr. Lopez post-delivery, her condition deteriorated during the night, after Dr. Lopez had left the hospital ostensibly because he could not find clean scrubs and did not have a set of clean clothes with him in his car, a locker, or anywhere he could readily access them. Moreover, the supracervical hysterectomy performed by Respondent was not more appropriate than a TAH in this case. Further, the autopsy performed after the patient died during the early hours of the morning showed conclusively the patient developed or had come to the hospital with DIC. This blood condition led to her uncontrollable bleeding and, ultimately, her death, and, apparently, was not discovered in time to save her life, either because of a delay from the laboratory or due to medical negligence on Respondent's part.

128. Respondent should not have left his patient alone in the hospital for the night, even if his clothes were covered in blood and needed changing. It is hard to imagine that a hospital, even a community hospital, did not have a spare set of scrubs to fit Dr. Lopez. Even assuming this was entirely accurate, it does not excuse his leaving to change and not returning as soon as possible to the hospital where he may (or may not) have been able to save his patient. While she may have died regardless of his returning to the hospital, while she was still alive and her blood pressure and overall condition were deteriorating, leaving her with just an experienced and dedicated nurse along with an anesthesiologist in house and an intensivist who was available only via telemedicine fell below the standard of care for a physician with his level of experience, personal knowledge of the patient and her family, and the knowledge that the hospital was not fully staffed during the overnight shift.

129. Respondent even tries to bring into the discussion the fact that, during this time of the COVID-19 pandemic (which came to light in 2020, three years after the incident at issue), there is a shortage of personal protective equipment, and this might somehow correlate with his having to leave the hospital in 2017 to properly wash and change clothes. The plain fact of the matter is that Dr. Lopez did not go home, change, and return to continue to care for his patient. Even Respondent's own expert, Dr. Feld, a physician with 45 years of relevant experience, testified that he would not have left the hospital under these circumstances with a patient he knew and had cared for over many years.

130. Petitioner proved by clear and convincing evidence that Respondent violated section 458.331(1)(t), as outlined in the Complaint.

131. At all times material to Petitioner's Complaint, section 458.331(1)(t) subjected a licensee to discipline for committing medical malpractice as defined in section 456.50.

132. Pursuant to section 456.079, the Board of Medicine has adopted rule 64B8-8.001. The rule provides notice of the disciplinary penalties typically imposed for violations of section 458.331.

133. At all times material to Respondent's malpractice at issue in this case, the penalty authorized for a violation of section 458.331(1)(t), second offense, ranged from two years' probation to revocation or denial and an administrative fine from $5,000 to $10,000.

134. The rule also provides aggravating factors to consider should a penalty outside the disciplinary guidelines be recommended. The following aggravating factors apply in this case:

> • Exposure of the patient to injury or death. The evidence clearly demonstrates that O.C. expired because of Dr. Lopez's malpractice.
> • Disciplinary history of the licensee. Dr. Lopez was previously disciplined by the Board for standard of care violations in 2003 and 2014. The 2014 case involved allegations that were almost identical to the circumstances in this case and involved a patient death.

135. The remedial measures instituted by the Board of Medicine after the 2014 disciplinary case obviously did not affect the way in which Dr. Lopez practices.

136. The events giving rise to this matter demonstrated that Dr. Lopez delivered a healthy baby to a mother who had been a long-term patient of his. During the delivery, the mother suffered cervical lacerations and developed a postpartum hemorrhage. Dr. Lopez initially took appropriate steps to control the bleeding, repair the lacerations, and perform a hysterectomy (although performing a TAH would probably have stemmed the tide of the blood loss, while the supracervical procedure only paused it) on the mother. However, his leaving the hospital at a time when he believed everything to be under control and the time had come for him to go home, clean up, and go to sleep for the night was where his failure to complete his care for his patient led,

ultimately, to her untimely death. Had he returned to the hospital after cleaning up, he might have saved his patient. Perhaps, his patient still would not have survived, but we will never know that because Respondent left her to go home. He may have been tired after a long day. He may have, in good faith, believed that everything was going to be all right and was under control. The fact is, the experts agreed they would have stayed with the patient until they were certain she was in no further danger from her delivery, her postpartum bleeding, and her surgery.

137. Since August of 2017, Dr. Lopez has elected to no longer deliver babies or perform surgery. His obstetrical patients are now delivered by hospital-based obstetricians, and he refers all patients requiring surgery to other surgeons. He has voluntarily elected not to reactivate his hospital privileges at any hospital at this time.

138. In light of the guidelines and the applicable aggravating factors outlined above, but also in light of the mitigating factor that he self-imposed upon his practice, Respondent's license to practice medicine should be suspended for one year, and, following the suspension, he should be prohibited from delivering babies and performing surgery, as he has voluntarily chosen to do since 2017.

RECOMMENDATION

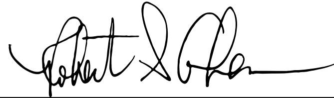
Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health, Board of Medicine, enter a final order:

i. Finding that Respondent, Berto Lopez, M.D., violated section 458.331(1)(t), Florida Statutes (2017), as charged in Petitioner's Amended Administrative Complaint;

ii. Suspending Respondent's license to practice medicine in the State of Florida and limiting his practice following his term of suspension as set forth in paragraph 138 above; and

iii. Imposing costs of investigation and prosecution.

DONE AND ENTERED this 3rd day of December, 2020, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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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.