STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 21-1137PL

EDMOND O. ALAKA, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

On October 19, 2021, Administrative Law Judge Lisa Shearer Nelson of the Florida Division of Administrative Hearings (DOAH) conducted a duly-noticed hearing by Zoom technology pursuant to sections 120.569 and 120.57(1), Florida Statutes (2021).

APPEARANCES

For Petitioner: Hunter M. Pattison, Esquire
Michael Jovane Williams, Esquire
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Prosecution Services Unit
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For Respondent: Edmond Olatunde Alaka, M.D., pro se
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STATEMENT OF THE ISSUES

The issues to be determined in this proceeding are whether Respondent violated section 458.331(1)(t)1., Florida Statutes (2012), and if so, what penalties should be imposed.

PRELIMINARY STATEMENT

On June 22, 2018, Petitioner, Department of Health (DOH or the Department), filed a one-count Administrative Complaint in DOH Case No. 2015-30041, alleging that Respondent violated the applicable standard of care with respect to the care of patient R.G., whom he treated in 2013. On July 25, 2018, Respondent signed an Election of Rights form disputing the allegations in the Administrative Complaint and requesting a hearing pursuant to section 120.57(1)(1). On March 25, 2021, the case was referred to DOAH for assignment of an administrative law judge and docketed as DOAH Case No. 21-1137PL.

The case was originally scheduled for hearing to take place on June 22 and 23, 2021. On June 7, 2021, the parties filed a Joint Motion for Continuance citing the need to conduct more discovery, which was granted. Shortly thereafter, Respondent's counsel moved to withdraw and requested that Respondent be given time to secure other counsel. On June 16, 2021, an Order was issued granting counsel's motion to withdraw and directing the parties to file a Joint Status Report on June 30, 2021, providing dates for hearing and advising whether Respondent intended to secure counsel. A timely filed Status Report indicated that Respondent was seeking new counsel, but ultimately Respondent determined to proceed pro se. The case was rescheduled for October 19 and 20, 2021, and the hearing commenced and was completed on October 19. The parties filed a Joint Pre-Hearing Statement which contains several stipulated facts that the parties agree do not require evidence at hearing. Where relevant, those facts have been included in the Findings of Fact below.

At hearing, Joint Exhibits 1 through 4 and Petitioner's Exhibits 1 through 4 were admitted into evidence. Dr. David Libert, M.D., testified on behalf of the Department, and Dr. Alaka testified on his own behalf.

The one-volume Transcript of the hearing was filed with DOAH on November 18, 2021. Dr. Alaka filed a letter which is construed as his Proposed Recommended Order on November 18, 2021, and Petitioner filed its Proposed Recommended Order on November 29, 2021, both of which have been considered in the preparation of this Recommended Order. Any references to Florida Statutes are to the 2012 codification, as that is the version in effect at the time of the conduct alleged. *McCloskey v. Dep't of Fin. Servs.,* 115 So. 3d 441 (Fla. 5th DCA 2003).

FINDINGS OF FACT

Based upon the Stipulation of the parties and the evaluation of the evidence presented at hearing, the following facts are found:

1. At all times material to the allegations in the Administrative Complaint, Respondent was a licensed medical doctor within the State of Florida and held license number ME 109501. Respondent's address of record is 216 Elm Drive, Chattahoochee, Florida 32324. The Department presented no evidence of prior discipline against his license.

2. In 2013, Respondent was under contract to furnish health care services to inmates at Suwannee Correctional Institution (SCI).

3. This case involves the care and treatment for hypertension that Respondent provided to R.G. while R.G. was an inmate at SCI in June and July 2013.

4. David Libert, M.D., who testified on behalf of the Department, is a Board-certified family practice physician who has been licensed in Florida since 1983. Dr. Libert sees patients in a clinical setting approximately three days a week but has never practiced in a correctional institution setting.

5. Dr. Libert testified that a "perfect" blood pressure reading is 120/80. A reading that is under 140/90 is considered acceptable, but blood pressure that is consistently above 140/90 indicates hypertension.

6. Malignant hypertension, or hypertensive emergency, is an acute elevation of blood pressure that is associated with end organ damage. End organ damage is the affect that the high blood pressure has on certain parts of the body, such as the brain, heart, and kidneys. The traditional benchmark reading that signals malignant hypertension is 180/120, which Dr. Libert testified is an arbitrary number but represents the "old" definition of the condition. According to Dr. Libert, newer studies define malignant hypertension as an acute rise on the height in blood pressure associated with end organ damage, even if the blood pressure reading does not go as high as the 180/120 measure recognized in older literature. The record is not clear when the change in definition took place, and if that change reflects the standard of practice in June 2013. Dr. Libert did not describe what constitutes an acute rise in blood pressure, either in terms of the length of time by which it is measured, or how much of a change in blood pressure constitutes an acute rise.

7. The systolic reading is the top number in a blood pressure reading and represents the maximum pressure that is exerted on the arteries with the contraction of the heart. The diastolic reading represents the pressure after the heart has relaxed from its beat and is the lower number in a blood pressure reading. While 180/140 is the traditional reading identified as a signal for malignant hypertension in "older" literature, there was no testimony as to whether systolic and diastolic readings are equally important, or whether one is more important than the other when determining that a patient's blood pressure is too high. In other words, no testimony was presented to answer the question of whether, for example a blood pressure reading of 185/96 or 170/133 would be considered a symptom of malignant hypertension. While there is no question both readings would indicate hypertension, the evidence did not indicate whether it is enough to have one of the two pressure readings above the 180/120 level to signal the possibility of malignant hypertension.

8. The Department of Corrections has protocols for treatment of different systems of the body. The form for the Hypertension Protocol, which is included several times within R.G.'s medical records from Suwannee, includes several categories of information to be addressed by treating personnel, such as Subjective (which includes the patient's chief complaint and current symptoms); Objective (which requires notation of vital signs, such as temperature, pulse, respiration, blood pressure, oxygen saturation and weight); Findings Requiring Immediate Clinician Notification; Plan; and Education.

9. Under the heading "Findings Requiring Immediate Clinician Notification," there are several factors that a health care provider (typically in this setting, a nurse) would check before the need to contact a physician arises. Those factors are blood pressure greater than 160/100 (see PLAN first); oxygen saturation less than 93 percent; heart rate less than 60 or greater than 110; wheezing (chest congestion); blurred vision; pedal edema extending to above the knees; severe headache OR headache not relieved after two hours of OTC pain med; or other.

10. The PLAN portion of the protocol provides the following treatment alternatives:

> For mild to moderate headache give:
> Acetaminophen 325mg two tablets every 4-6 hours as needed for pain, OR
> Ibuprofen 200mg two tablets every 6 hours as needed for pain
> Put patient in a quiet environment; recheck blood pressure in 15 minutes x2. Notify clinician if BP remains greater than 160/100.
> 1st blood pressure recheck: __/___, at _____.
> 2nd blood pressure recheck: __/___, at _____.
> Bed rest lay-in x24 hours
> Blood pressure recheck in 24 hours
> Return to clinic for BP check
> Pass
> Other

11. Respondent was responsible for patient R.G.'s medical care at SCI and had access to all of R.G.'s medical records from SCI's medical clinic.

12. R.G. was a 61-year-old male inmate who presented to the clinic at SCI for treatment.

13. On or about June 7, 2013, R.G. presented to SCI's clinic with a blood pressure reading of 164/96, and complaining of a headache. R.G. was given 10 mg Lisinopril to reduce his blood pressure, a pass for three days of bedrest, and a follow-up appointment for June 10, 2013. The medical record entitled Hypertension Protocol does not contain Respondent's name and he did not see R.G. that day. However, from the Physician's Order Sheet, it appears that he was consulted and approved the administration of Lisinopril, and prescribed 10 mg of Lisinopril daily for three months.

14. On June 9, 2013, R.G. presented at the clinic complaining about his blood pressure. The medical record notes that he had a headache. His blood pressure reading was 151/90, and the section entitled Findings Requiring Immediate Clinician Notification did not have any symptoms checked. The medical record does not indicate that Respondent saw R.G. on June 9, 2013, and he was not consulted about his care. The PLAN section of the Hypertension Protocol says "No treatment required."

15. On June 10, 2013, it appears that R.G. may have been seen at the clinic more than once. The initial entry in his medical records for that date, which does not have a time recorded, indicates that his blood pressure was 158/98. The second entry, recorded at approximately 2:00 p.m., indicates that R.G. presented to the clinic with a blood pressure reading of 173/98. Respondent ordered a one-time dose of .2 mg Clonidine, and 10 mg of Lisinopril and directed that his blood pressure be taken again in an hour. Respondent tried to find the underlying cause for the rise in R.G.'s blood pressure by sending him for blood work, and a thyroid and cardiovascular evaluation by the cardiac clinic. Respondent also directed that his blood pressure be checked twice weekly for an indecipherable number of weeks.

When R.G.'s blood pressure was rechecked at approximately 4:00 p.m., it was 158/89. Respondent again ordered administration of 10 mg Lisinopril, increased his prescription for Lisinopril to 20 mg for three months, and ordered 600 mg of Ibuprofen to treat R.G.'s headache.

16. R.G. next presented to the clinic on June 11, 2013, at 10:00 a.m. At that time, his blood pressure was noted as 152/94. There is no indication in the medical record that Respondent saw R.G. during that visit, and there is no documentation in the Physician's Order Sheet to indicate that Respondent ordered any prescriptions for him.

17. On June 18, 2013, R.G. went to the clinic complaining of a headache and vomiting. He listed his pain level at 6 out of 10. At his initial presentation at noon, his blood pressure was 197/105 in the left arm, and 186/86 in the right.

18. Under the PLAN heading, the medical record indicates R.G. was given 200mg Ibuprofen for his headache, and 0.2 mg of Conidine for blood pressure. His blood pressure was rechecked at 1:00 p.m. and had lowered to 139/84.

19. The medical record for June 18, 2013, does not indicate that Dr. Alaka saw R.G. or that he was consulted about him. The Department of Corrections Physician Order Sheet for R.G. has an entry dated June 18, 2013, but part of the record is indecipherable, and there is no doctor Signature/stamp completed for the entry. In addition, the portion of the entry that is readable refers to a Dr. Gonzalez, as opposed to Dr. Alaka.

20. On June 20, 2013, R.G. returned to the clinic, this time complaining that he was stumbling and had a headache. A protocol sheet for Neurological Changes/Deficits was used in the medical records as opposed to the Hypertension Protocol. At this visit, his blood pressure was 120/62. There is no indication on the medical record for this date that Dr. Alaka saw R.G.

21. R.G. returned to the clinic on June 25, 2013, at 5:39 p.m. The medical record indicates that he had a slight headache, a small amount of pitting/extremity swelling, fatigue, and had vomited that morning. His blood

pressure was 165/94 in the left arm and 175/91 in the right. Pedal edema was noted to stop at the mid to upper shins, and the records indicate that R.G. had slept only three hours or less in the previous 24-hour period.

22. R.G. was given acetaminophen for his headache, and his blood pressure was rechecked at 5:59 p.m. and 6:15 p.m.. His blood pressure at the first recheck was 165/94, and at the second recheck was 164/93. The Hypertension Protocol indicates that R.G. was administered 10 mg of Lisinopril, was instructed to comply with all prescribed medications, and not to sit with his legs crossed. The Physician's Order Sheet indicates that per Respondent's discussion with the nurse who saw R.G.,[1] the prescription for 20 mg of Lisinopril was discontinued and replaced with a prescription for the same drug at 10 mg daily for three months.

23. There was speculation throughout the hearing that R.G. did not always take his medications as prescribed, and there are notations in the medical records that R.G. sometimes refused recommended medical treatments, such as a referral for a urologist and a cardiac workup. There was no clear and convincing evidence that R.G. was also failing to take his blood pressure medications as required, although it is certainly a possibility.

24. There is no indication in the medical records that R.G. went to the clinic for treatment after June 25, 2013.[2] On July 2, 2013, R.G. was found unresponsive on the floor. He was transferred to ShandsLiveOak Regional Medical Center, and from there, transferred to Jacksonville Memorial on

[1] The Administrative Complaint alleges that R.G. was seen by an ARNP during this visit. The signature of the health care provider indicates that he or she was an SRN, not an ARNP. The ARNP who reviewed the records and made what was referred to as an incidental entry (one where the record is reviewed but the patient is not seen) the following day is a different provider.

[2] There is an entry for June 28, 2013, entitled Pre-Special Housing Health Assessment. Dr. Alaka testified he did not know what that meant. It appears from the record that the purpose of the assessment was to extend R.G.'s low bunk pass. At that time, his blood pressure was recorded as 158/92. It is not clear who conducted the assessment.

July 3, 2013. R.G. died on July 5, 2013. The Medical Examiner's Report lists R.G.'s cause of death as hypertension.

25. Dr. Libert reviewed the medical records related to R.G.'s treatment. He opined that Respondent did not meet the applicable standard of care in his care and treatment of R.G. because he did not arrange for transportation to the hospital on June 18, 2013. He also opined that Respondent should have transferred R.G. on later dates prior to the transfer that occurred on July 2, 2013. He further opined that Respondent failed to recognize the signs and symptoms of malignant hypertension and failed to diagnose it. Dr. Libert also testified that Respondent failed to order basic blood tests that should have been ordered for a patient with hypertension. However, as noted above, Respondent did order blood work on June 10, 2013.

26. There is no indication in the medical records that Dr. Alaka saw R.G. on June 18, 2013. With respect to the June 25 visit, Dr. Alaka would have received a phone call from staff, but did not see R.G. in person.

27. Dr. Alaka has no independent recollection of seeing R.G., and had to rely solely on his review of the medical records for his account of what happened. The treatment of this patient occurred over eight years prior to the hearing in this case. Dr. Alaka did not believe that treatment in a prison setting is the same as the treatment rendered in a typical outpatient setting, and testified that in an outpatient setting, physician groups are free to set their own protocols. In a correctional setting, physicians were required to follow the protocols established by the Department of Corrections. Dr. Alaka testified that following the protocols was a condition of employment.

28. Dr. Alaka testified that he did not create or maintain the medical records for patients at the facility, but would have access to the records when treating a patient. It is not clear, however, whether he had access to the records when he was not at the facility but received a telephone call regarding the treatment of a patient.

29. Based upon the medical records in evidence, Dr. Alaka saw R.G. on June 10; was consulted about R.G. on June 7 and June 25; and was neither present nor consulted regarding R.G. on June 9, June 11, June 18, and June 20, 2013.

30. The only time that the medical records indicate R.G.'s blood pressure may have been above the standard of 180/120 for malignant hypertension was June 18, 2013, and when rechecked, the pressure went down to 139/84. As noted above, the medical records do not indicate that Dr. Alaka either saw R.G. or was consulted about his care on that day.

31. On June 25, 2013, R.G.'s blood pressure, while still considered high, was well below the standard identified for consideration of malignant hypertension.

32. Dr. Alaka also testified that one must always consider the possibility of malignant hypertension when taking a patient's blood pressure, but did not believe R.G.'s blood pressure reached that level. He tried to prevent it through the use of medication but did not believe that you needed to transfer a patient because of swelling, vomiting, or headache combined with high blood pressure, because those symptoms can occur with a variety of conditions. In his view, there should be concrete blood pressure readings, with indications of organ disturbance or stress. Organ damage would be substantiated through blood work and treated with medication while waiting for results. If the blood pressure is sustained, then he would call his supervisor and report the blood pressure; that it is not coming down; what medications were given; and request a transfer. He testified he did not request a transfer in this case because the blood pressure came down with treatment. In addition, Dr. Alaka noted that blood pressure readings can vary within the same hour, depending on who took the reading, the size of the cuff used, operator error, etc.

33. Dr. Alaka also testified, credibly, that transfers to facilities outside the prison setting required approval by the regional medical director, and that

was a condition for working at SCI. The Department did not provide any evidence to rebut the statement that Respondent did not have the authority to order transfer out of the facility, or that following the protocols reflected in the medical records was not required for employment at the facility.

34. Dr. Alaka's view of what blood pressure reading would have triggered a diagnosis of malignant hypertension is higher than Dr. Libert's. Based on the evidence presented, Dr. Libert's definition appears to be more reasonable. However, based on the totality of the evidence presented, the Department did not present clear and convincing evidence to show that Respondent's care and treatment of R.G. violated the prevailing standard of care as alleged in the Administrative Complaint.

CONCLUSIONS OF LAW

35. DOAH has jurisdiction of the subject matter and the parties to this action pursuant to sections 120.569 and 120.57(1), Florida Statutes (2021).

36. This is a proceeding whereby the Department seeks to discipline Respondent's license to practice medicine. The Department has the burden to prove the allegations in the Administrative Complaint by clear and convincing evidence. *Dep't of Banking & Fin. v. Osborne Stern and Co.*, 670 So. 2d 932 (Fla. 1996); *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

when the evidence is in conflict, but seems to preclude evidence that is ambiguous. *Westinghouse Elec. Corp. v. Shuler Bros.,* 590 So. 2d 986, 988 (Fla. 1st DCA 1991).

37. Moreover, in disciplinary proceedings, the statutes and rules must be strictly construed in favor of the respondent. *Elmariah v. Dep't of Prof. Regul.*, 574 So. 2d 164 (Fla. 1st DCA 1990); *Taylor v. Dep't of Prof. Regul.*, 534 So. 2d 782, 784 (Fla. 1st DCA 1988), and words used by the Legislature cannot be interpreted to broaden their application. *Beckett v. Dep't of Fin. Servs.*, 982 So. 2d 94, 99-100 (Fla. 1st DCA 2008); *Dyer v. Dep't of Ins. & Treas.*, 585 So. 2d 1009, 1013 (Fla. 1st DCA 1991). Not only are the statutes and rules strictly construed, but the conduct alleged needs to be personal to Respondent. *Beshore v. Dep't of Fin. Servs.*, 928 So. 411, 413 (Fla. 1st DCA 2006); *Pic N' Save Cent. Florida, Inc. v. Dep't of Bus. Regul.*, 601 So. 2d 245, 254 (Fla. 1st DCA 1992)(in the absence of evidence that licensee's employees acted in a persistent and practiced manner in making illegal sales of alcohol, there is no factual basis for drawing an inference that the licensee has acted negligently or with a lack of due diligence in the supervising and training of its employees in order to subject the licensee to discipline).

38. Finally, Respondent can only be found guilty of violations that are actually alleged in the Administrative Complaint. *Trevisani v. Dep't of Health*, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005); *see also Christian v. Dep't of Health*, 161 So. 3d 416, 417 (Fla. 2d DCA 2014); *Ghani v. Dep't of Health*, 714 So. 2d 1113, 1114-15 (Fla. 1st DCA 1998).

39. In this case, the Administrative Complaint alleges the following:

> 13. At all times relevant to this Complaint, the prevailing professional standard of care dictated that a physician assessing and/or treating a patient with R.G.'s symptoms should:
> a) diagnose the potential cause of causes of the patient's signs and symptoms;

b) consider the possibility of malignant hypertension and/or a hypertensive emergency, and/or
c) transfer the patient to the emergency department based on the combination of high blood pressure and associated symptoms such as swelling, vomiting, and headaches.

14. Respondent failed to meet the prevailing professional standard of care in his treatment of Patient R.G. in one or more of the following ways:
a) By failing to diagnose the potential cause or causes of the patient's sign and symptoms;
b) By failing to consider the possibility of malignant hypertension and/or a hypertensive emergency; and/or
c) By failing to transfer the patient to the emergency department due to his condition at that time.

15. Section 458.331(1)(t)1., Florida Statutes (2012-2013), subject a licensee to discipline for committing medical malpractice as defined in Section 456.50(1)(g), Florida Statutes. Section 456.50(1)(g), Florida Statutes (2012) states that medical malpractice means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. Section 766.102, Florida Statutes (2012), provides that the prevailing standard of care for a given healthcare 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.

16. From on or about June 18, 2013, through on or about June 25, 2013, Respondent fell below the prevailing standard of care in his treatment of Patient R.G. in one or more of the following ways:
a) by failing to diagnose potential cause or causes of Patient R.G.'s signs and symptoms;

> b) by failing to consider the possibility of malignant hypertension and/or a hypertensive emergency; and/or
> c) by failing to transfer Patient R.G. to the emergency room due to his condition at that time.
>
> 17. Based on the foregoing, Respondent committed medical malpractice in violation of Section 458.331(1)(t)1., Florida Statutes (2012), by failing to meet the standard of care in his treatment and diagnosis of Patient R.G.

40. Respondent did not see R.G. on June 18, 2013, and was not consulted regarding his care on that date. He cannot be disciplined for the evaluation of the patient by other staff. *Beshore. supra; Pic N'Save*, *supra*.

41. While the Administrative Complaint alleges that from June 18 through June 24, 2018 [sic] R.G. presented to the clinic four times with complaints of headache, nausea, vomiting, and stumbling, Respondent was consulted with respect to only one of those visits. For that visit, June 25, Respondent was consulted by telephone, and it appears that R.G. was not compliant with the instructions given on that date.

42. The Administrative Complaint charges Respondent with violating the applicable standard of care, which as noted above, is the "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." Dr. Libert testified that the standard of care provided in a prison setting is the same as that provided in a private clinical setting but acknowledged that he has never practiced in a prison setting. While the standard of care may indeed be the same, the evidence presented was not sufficient to establish that it is. This is a disciplinary proceeding. Therefore, a finding that, in light of all relevant surrounding circumstances, the care given by a private practitioner is the same or similar to a physician providing care in a correctional institution setting must be based upon evidence more substantial than a conclusory statement. For example, Dr. Libert was not

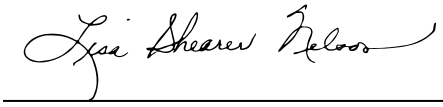
asked whether the protocols used by the health care providers working within the Department of Corrections were consistent with the applicable standard of practice. Moreover, he did not testify whether transfer to a hospital setting for patients in a private clinic involve the same concerns that are present with transfer of an inmate, or what measures should be in place or what measures a physician must follow to address those concerns.

43. In addition, the evidence was simply not clear and convincing that Respondent erred in not ordering the transfer of patient R.G. for malignant hypertension. The blood pressure readings, while high, did not reach the 180/120 mark identified by Dr. Libert as the signal for malignant hypertension in the older literature. He did not identify when the change in standards took place, and did not identify under the more recent standard what constitutes an acute rise in blood pressure. Given the high burden of proof in disciplinary proceedings and the number of questions left unanswered regarding the expected standard of care, the Department simply did not meet its burden of proof regarding the care and treatment of R.G.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Administrative Complaint against Respondent be dismissed.

DONE AND ENTERED this 20th day of December, 2021, in Tallahassee, Leon County, Florida.



LISA SHEARER NELSON
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Filed with the Clerk of the
Division of Administrative Hearings
this 20th day of December, 2021.

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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.