

**STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS**

DEPARTMENT OF HEALTH,

PETITIONER,

v.

DOH Case No. 2006-24381

PIERRE J. RENELIQUE, M.D.,

RESPONDENT.

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK *[Signature]*
DATE 9/12/08

**Motion for Final Order for Hearing Not
Involving Disputed Issues Of Material Fact**

COMES NOW, Petitioner, Department of Health, by and through the undersigned counsel, and moves the Board of Medicine to conduct a hearing not involving disputed issues of material fact and to enter a Final Order in this cause. As grounds therefore, Petitioner states:

1. On February 23, 2007, Petitioner filed an Administrative Complaint against the Respondent alleging that the Respondent violated Sections 458.331(1)(t)(m)(w), Florida Statutes (2006)
2. On August 11, 2008, Petitioner filed an Amended Administrative Complaint against the Respondent alleging that the Respondent violated Sections 458.331(1)(t)(m), Florida Statutes (2006).

3. The Respondent, upon receiving the Administrative Complaint, and Amended Administrative Complaint disputed a number of material factual allegations in the Complaint and demanded a formal hearing. The case was referred to the Division of Administrative Hearings (DOAH) on September 5, 2008.

4. On September 5, 2008, Petitioner served Respondent through counsel via E-mail and Facsimile with Petitioner's First Request for Admissions. Petitioner's First Request was also sent to DOAH for filing and was posted the same day on the DOAH website.

5. As of November 10, 2008, Respondent has not responded to Petitioner's First Set of Admissions.

6. Because Respondent failed to answer the Department's request for admissions within thirty-five (35) days, pursuant to the Florida Rules of Civil Procedure the DOAH administrative law judge assigned to this case entered an order deeming all of the allegations in the Administrative Complaint admitted by Respondent. Accordingly, there are no longer disputed issues of material fact in this case.

7. Based on the foregoing and pursuant to Section 120.57(2)(a)2, Florida Statutes, this case is being forwarded to the Board of Medicine for a

119

hearing not involving disputed issues of material fact and entry of a final order.

8. The Respondent has been advised by a copy of this motion that the Board will consider the investigative report, as well as any oral or written communication from the Department on the issues of penalty in this matter.

WHEREFORE, the Petitioner requests that this Honorable Board, after consideration of the record, issue a Final Order relating to Respondent's license to practice medicine in the state of Florida.

Respectfully submitted,

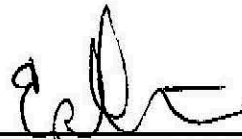


Ephraim D. Livingston
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265
Florida Bar #0121347



CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished via: ☒ ~~overnight~~ postage-paid U.S. Mail, ☐ Hand-Delivery, ☒ E-mail and/or ☐ Facsimile Transmission to counsel for Respondent, Joseph Harrison, Esq., [REDACTED] Boca Raton, Florida 33481 and [REDACTED] this 12 day of November, 2008.



Ephraim D. Livingston
Assistant General Counsel

**STATE OF FLORIDA
DEPARTMENT OF HEALTH**

DEPARTMENT OF HEALTH,

PETITIONER,

v.

CASE NO. 2006-24381

PIERRE JEAN-JACQUE RENELIQUE, M.D.,

RESPONDENT.

AMENDED ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Pierre Jean-Jacque Renelique, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 69962.

3. Respondent's address of record is [REDACTED]
Woodmere, New York 11598.

8-11-08

4. Respondent's last known address is [REDACTED]
North Miami Beach, Florida 33162.

5. Respondent is not board certified in any practice, but he practices in obstetrics and gynecology (OB/GYN) - abortion medicine.

FACTS SURROUNDING SW's PRE-OPERATIVE TREATMENT

6. On or about July 17, 2006, SW, an eighteen (18) year-old female, first presented to Miramar Women's Center for an elective termination of pregnancy. At that time, SW stated she did not know the date of her last menstrual period.

7. According to SW's statement to a Department investigator, on the same date, SW paid \$800 as down payment for the procedure and received two sonograms, which showed SW was twenty-three (23) weeks pregnant.

8. At the Miramar Women's Center, SW was informed she was to present to another clinic in North Miami to be further prepared and evaluated for the abortion. SW was told Respondent would be the treating physician, and SW signed forms consenting to treatment by Respondent - all prior to meeting Respondent.

9. SW's medical record contains the following documents from the July 17, 2006, visit to Miramar Women's Center: one sonogram image;

acknowledgment of receipt of post-op instructions; termination of pregnancy patient information sheet filled out by SW; an explanation of the dilation and curettage/vacuum aspiration abortion method; an informed consent form identifying Respondent as the physician; two forms regarding the use of cervical laminaria; and a notice of fees charged even if the abortion procedure was not performed combined with a notice that Respondent did not carry medical malpractice insurance.

10. On or about July 19, 2006, SW presented to the "North Miami Clinic" and met Respondent for the first time. This "North Miami Clinic" has not been identified by clinic name or address, even in SW's medical records.

11. According to SW, at the July 19 visit, Respondent gave SW some medication and instructed her to present to the "Hialeah Clinic" at 9:00 a.m. the next day. SW told a Department investigator that Respondent was not very informative at this visit.

12. According to Respondent's response to the Department investigation of this case ("Response"), on or about July 19, 2006, when SW presented to the "North Miami Clinic," he thoroughly examined SW and placed laminaria into the cervical canal. According to Respondent, he also prescribed Motrin, Cytotec, and Doxycycline.

13. Finally, Respondent claims he told SW to present to "A GYN Diagnostic Center" ("A GYN") in Hialeah on July 20, 2006, at about 9:00 am for observations, and that her procedure would begin at 2:00 pm.

14. Doxycycline is a synthetic broad-spectrum antibiotic derived from tetracycline. It is effective against a wide variety of bacteria, including those bacteria that cause many sexually transmitted diseases. Doxycycline is a legend drug that is not available without a prescription.

15. Motrin contains ibuprofen, a non-steroidal anti-inflammatory drug ("NSAID"). NSAID medicines are used to treat pain and redness, swelling, and heat (inflammation) from medical conditions such as different types of arthritis, menstrual cramps, and other types of short-term pain. Motrin and other NSAIDs can be given in both prescription and non-prescription strengths.

16. Cytotec contains misoprostol, which is a legend drug, available only by prescription. Misoprostol is chemically similar to prostaglandin, one of a number of hormone-like substances that participate in a wide range of body functions such as the contraction and relaxation of smooth muscle, the dilation and constriction of blood vessels, control of blood pressure, and modulation of inflammation. Misoprostol is most commonly used to reduce the risk of ulcers in patients taking certain medications. Misoprostol

can also induce or augment uterine contractions. In the abortion context, the uterine contractions dilate the cervix so that the uterine contents can be evacuated.

17. Cervical laminaria are osmotic dilators. When placed in the closed cervix, an osmotic dilator absorbs moisture from the tissues surrounding the cervix and swells, opening the cervix slowly, also called cervical dilation or ripening, with little discomfort. In the abortion context, the dilation of the cervix allows access to the uterus for evacuation of the uterine contents.

18. Cytotech and cervical laminaria are not used together because both are designed to ripen the cervix for the evacuation abortion procedure.

19. Despite the important events that occurred on that day, the only note of the July 19, 2006, visit included in SW's medical record is a nearly illegible, hand-written note on SW's patient information sheet. This note probably says, "Cx lam inserted 7/19/06." The note is not signed. There are no copies of prescriptions and no other note of any prescriptions being given on July 19, 2006. There is no record of any examination results.

FACTS SURROUNDING SW'S "PROCEDURE"

20. On or about July 20, 2006, pursuant to Respondent's instruction, SW presented to A GYN at about 9:30 am and was informed by a clinic staff member that no other staff was present. SW decided to wait in her personal car.

21. At approximately 10:30 am, SW went back into the clinic and was given two white pills by clinic staff. SW then returned to her car to wait.

22. At approximately 11:45 am, SW began to feel ill and was informed by clinic staff to go into the patient room, disrobe and lie down. A staff member contacted Respondent and was informed that he would be in around 12:00 noon.

23. At approximately 1:30, SW was still waiting for Respondent and was feeling worse by the minute. A staff member informed SW that Respondent should be in the clinic about 2:00 pm.

24. In his response to a law enforcement investigation of this incident, Respondent admitted that he was contacted by clinic staff multiple times on July 20, 2006.

25. On or about July 20, 2006, at approximately 2:00 pm, SW felt a large pain in her vaginal area and observed a "live baby" on the floor. A

staff member was with SW at that time. SW states she saw the baby moving about and the chest area slightly moving.

26. After SW delivered the baby, one of the owners of the clinic, Ms. Gonzalez, came into the room and cut the umbilical cord with scissors. Ms. Gonzalez then proceeded to place the baby and all of its remains in a plastic bag. She then closed the bag and placed it in a trashcan. Ms. Gonzalez holds no healthcare license of any kind.

27. Staff members did not call "911" or a neonatologist after SW delivered the baby.

28. SW received no medical aid after delivering the baby. SW heard staff members attempting to contact Dr. Relinque. Respondent arrived at the clinic at approximately 3:00 pm. He stated he had had to stop at another clinic to see another patient that was bleeding.

29. At Respondent's direction, an unlicensed staff member attempted to start an IV in SW, but was unsuccessful. Respondent then injected SW with medication and Ms. Gonzalez stated that this would make her sleep. Respondent stated he was "going to clean her up."

30. According to Respondent, he arrived at the clinic at approximately 2:20 pm on July 20, 2006. Respondent stated that SW was stable, and he initiated the abortion process. He stated that the fetal sac,

placenta, large clots and umbilical cord were removed together as a block. Respondent stated he thought the fetus was inside the sac.

31. Also according to Respondent, upon further examination, he could not find the fetus and performed a sonogram to determine if the fetus was still inside the womb. Respondent claims he was then informed by staff members that the fetus had already been delivered.

32. Respondent claims he asked staff members why he had not been informed that SW had delivered the fetus and claims he was told that the staff members had "panicked."

33. SW's medical records of the procedure differ from all other accounts of what occurred on July 20, 2006 at A GYN. There is a one-page document titled "Termination of Pregnancy" within SW's medical record. According to that medical record, Respondent performed an examination of SW prior to the procedure. The examination was normal, and SW's cervix was dilated 5-6 centimeters. The examination also reflects a uterine size of 22 weeks.

34. The Termination of Pregnancy form also indicates that "Risks, benefits and alternatives explained to the patient and consent is taken for: Suction D & E."

35. A suction D & E is a dilation and extraction abortion procedure wherein the cervix is dilated and the contents are extracted using suction.

36. The Termination of Pregnancy form also indicates that SW received 75 milligrams Demerol and 5 milligrams Versed by IV.

37. Demerol, which contains meperidine hydrochloride, is a Schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for the treatment of moderate to severe pain. Demerol has a high potential for abuse and has a currently accepted, but severely restricted, medical use in treatment in the United States. Abuse of Demerol may lead to severe physical and psychological dependence.

38. Versed is a benzodiazepine-type preoperative sedative, which is administered intramuscularly or intravenously. The potential known side effects for Versed include respiratory depression, respiratory arrest, hypoxic encephalopathy and even death.

39. The Termination of Pregnancy form goes on to indicate the "Procedure" was performed using 8 ccs of 2% lidocaine (local anesthetic) injected into the cervix. Following the local anesthetic, sharp curettage was used and SW lost an estimated 40 ccs of blood.

40. The Termination of Pregnancy form concludes that Respondent examined "fetal parts" and the "placenta," performed a post-operative

sonogram, found the uterus empty, and found the patient stable. SW was given Motrin for pain, follow up instructions, and a follow up appointment in two weeks. The Termination of Pregnancy form is signed, presumably by Respondent.

41. According to SW's medical records, on the recovery information sheet, SW arrived at A GYN clinic at 9:35 am and departed at 12:05 pm. However, at the bottom of the form, blood pressure and temperature information was recorded at 12:20 pm and 12:40 pm.

42. SW delivered the fetus at approximately 2:00 pm and Respondent arrived at the clinic at approximately 3:00 pm, therefore, SW's discharge time reflected in the medical records for SW is incorrect.

43. According to SW's medical records a dilation and extraction abortion was performed by Respondent. SW had already delivered the fetus, therefore, a D&E abortion was impossible.

44. Respondent failed to document SW's actual treatment in her medical record. In fact, Respondent prepared a false medical record when he knew what had actually happened.

45. Directly pursuant to Respondent's order, an unlicensed staff member attempted to start an IV on SW. The attempt was not successful.

At that time, Respondent administered Demerol, intramuscular, not intravenous as stated on the Termination of Pregnancy form.

46. As there were no licensed staff at A GYN clinic except Respondent, there was no one who could monitor SW during the D & E procedure, which used conscious sedation.

47. As there were no licensed staff at A GYN clinic except Respondent, there was no one who could monitor SW during her recovery period once Respondent left.

48. Respondent's statements of what time he arrived at A GYN clinic and SW's statement of what time she was discharged from A GYN clinic do not match the information placed in SW's medical record.

49. In his Response, Respondent stated that all along on July 20, 2006, SW was stable and had no remorse and prior to SW's discharge, instructions and a prescription were given. Respondent stated that SW was happy and seemed to be in a good mood. This is inconsistent with the fact that SW was in active labor when the clinic contacted Respondent and needed immediate medical attention.

POLICE INVOLVEMENT

50. On July 21, 2006, an anonymous caller dialed 911 and stated that a baby was born at the abortion clinic (A GYN) and killed on site.

51. On July 22, 2006, at about 7:00 a.m., police executed a search warrant at A GYN. The police seized SW's medical records and searched the facility. No fetal remains were discovered.

52. On July 28, 2006, another anonymous source told police that the fetal remains were on the roof of the clinic. Police responded and searched the roof but did not find any fetal remains.

53. On July 28, 2006, the anonymous source called police again and reported that the fetal remains had been returned to the clinic. Police obtained yet another search warrant and finally found the partially decomposed fetal remains in a cardboard box.

54. On or about July 29, 2006, the Miami-Dade County Medical Examiner Department ("Medical Examiner") performed an autopsy on SW's fetus. Analysis of the lungs of the fetus revealed that the lungs floated in water. This fact indicates that the fetus had filled its lungs with air prior to its death.

55. The Medical Examiner listed the cause of death of the fetus as "extreme prematurity."

COUNT ONE

56. Petitioner realleges and incorporates paragraphs one (1) through fifty-five (55) as if fully set forth herein.

57. Section 458.331(1)(t), Florida Statutes (2006), subjects a physician to discipline for:

t) Notwithstanding s. 456.072(2) but as specified in s. 456.50(2):

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.

2. Committing gross medical malpractice.

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

Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross medical malpractice," "repeated medical malpractice," or "medical malpractice," or any combination thereof, and any publication by the board must so specify.

58. Section 456.50(1)(g), Florida Statutes (2006), states:

"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. Only for the purpose of finding repeated medical malpractice pursuant to this section, any similar wrongful act, neglect, or default committed in another state or country which, if committed in this state, would have been considered medical malpractice as defined in this paragraph, shall be considered medical malpractice if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.

59. Dr. Renelique violated Section 458.331(1)(t), Florida Statutes (2006), by committing medical malpractice in one or more of the following ways:

- a) by utilizing Cytotech and cervical laminaria for a D & E procedure;
- b) by failing to ensure that licensed personnel were available at the clinic when he knew SW would present;
- c) by failing to secure the services of another physician to care for SW when she was in active labor and he was detained or failing to arrange for 911 to transfer SW to a hospital;
- d) by delegating authority to an unlicensed person to start an IV and administer medication to SW;
- e) by failing to ensure the proper disposal of the fetus and tissue;

f) by falsifying SW's medical records by indicating that dilation and extraction abortion was performed when Patient SW had already delivered the fetus.

60. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (2006), by committing medical malpractice in his care and treatment of S.W.

COUNT TWO

61. Petitioner realleges and incorporates paragraphs one (1) through fifty-five (55) as if fully set forth in this count.

62. Section 458.331(1)(m), Florida Statutes (2006), provides that 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 constitutes grounds for disciplinary action by the Board of Medicine.

63. Rule 64B8-9.003(3), Florida Administrative Code (2006), states:

The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

64. Respondent failed to keep medical records justifying his course of treatment of SW in violation of Section 458.331(1)(m), Florida Statutes, by failing to document one or more of the following:

- a. examination notes on the July 19, 2006 visit;
- b. medication and amount prescribed on the July 19, 2006 visit;
- c. who started SW's IV;
- d. who assisted the physician as SW underwent conscious sedation;
- e. who administered the Demerol 75mg;
- f. what actually happened on July 20, 2006;
- g. that a D and E procedure was never performed;
- h. that the fetus was delivered;

- i. recovery notes from July 20, 2006.

65. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2006), by 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.

COUNT THREE

66. Petitioner realleges and incorporates paragraphs one (1) through fifty-five (55) as if fully set forth in this count.

67. Section 458.331(1)(w), Florida Statutes (2006), sets forth grounds for disciplinary action by the Board of Medicine for delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

68. Respondent delegated professional responsibilities to a person when he knew or had reason to know that such person was not qualified by training, experience, or licensure to perform them in one or more of the following ways:

- a. allowing and/or ordering unlicensed personnel to start an IV;
- b. allowing and/or ordering unlicensed personnel to administer medications;
- c. allowing and/or ordering unlicensed personnel to recover SW from conscious sedation;
- d. delegating treatment of SW to unlicensed personnel when SW was in active labor.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 11th day of August, 2008.

Ana M. Viamonte Ros, M.D., M.P.H.,
State Surgeon General



Allison M. Dudley
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, FL 32399-3265
Florida Bar No. 159913

FILED

DEPARTMENT OF HEALTH
DEPUTY CLERK

CLERK: 

DATE 8-11-08

PCP: 2-23-07

PCP Members: El-Bahri & Winchester

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.