STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF CHIROPRACTIC, Petitioner, vs. DOUGLAS N. GRAHAM, D.C., Respondent.	)	Case No. 97-5960

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its duly designated Administrative Law Judge, William J. Kendrick, held a formal hearing in the above-styled case on June 2, 1998, in Marathon, Florida.

APPEARANCES

For Petitioner: Thomas Wright, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317

For Respondent: E. Renee Alsobrook, Esquire
Alsobrook & Dove, P.A.
Post Office Box 10426
Tallahassee, Florida 32302-2426

STATEMENT OF THE ISSUE

At issue in this proceeding is whether Respondent committed the offenses set forth in the Administrative Complaint and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaint dated May 30, 1996, the Agency

for Health Care Administration charged Respondent, a licensed chiropractic physician, with perceived violations of Section 460.413, Florida Statutes, in his care of two patients (referred to in the complaint as B. D. and K. E.). The complaint alleged, as follows:

FACTS PERTAINING TO PATIENT B.D.

4. At all times material hereto, Respondent provided patient B.D. with chiropractic and nutritional care.

5. On or about November 7, 1993, Respondent conducted an initial examination of patient B.D.

6. Respondent's initial examination of patient B.D. was not complete or adequate for evaluating the patient.

7. On or about November 7, 1993, Respondent's treatment plan for B.D. included light massage, muscle release, adjustments, and fasting.

8. From on or about November 7, 1993, to on or about November 16, 1993, Respondent's fasting regime for patient B.D. consisted of a water-only diet.

9. Respondent's records for B.D. state that on November 16, 1993, patient B.D. broke the fast when he consumed diluted fruit juice.

10. Respondent's records for B.D. state that on November 23, 1993, patient B.D. was allowed solid food.

11. Respondent's records indicate that patient B.D. suffered extreme weight loss and that his overall condition was deteriorating.

12. On or about December 7, 1993, Respondent telephoned 911, to have patient B.D. transported to the emergency room of Fisherman's Hospital.

13. Patient B.D.'s records failed to indicate the medical necessity or justification of the treatment rendered to the patient.

COUNT I

14. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13), as if fully stated herein.

15. Based on the foregoing, Respondent has violated Section 460.413(1)(m), Florida Statutes, by failing to keep written chiropractic records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, test results, x-rays, diagnosis of a disease, condition, or injury.

COUNT II

16. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13), as if fully stated herein.

17. Based on the foregoing, the Respondent has violated Section 460.413(1)(r), Florida Statutes, by gross or repeated malpractice or the failure to practice chiropractic at a level of care, skill, and treatment which is recognized by a reasonably prudent chiropractic physician as being acceptable under similar conditions and circumstances.

COUNT III

18. Petitioner realleges and incorporates paragraphs one (1) through thirteen (13), as if fully stated herein.

19. Based on the foregoing, the Respondent has violated Section 460.413(1)(v), Florida Statutes, through violation of Rule 59N-17.0065, Florida Administrative Code, by failing to maintain adequate patient records.

FACTS PERTAINING TO PATIENT K.E.

20. At all times material hereto, Respondent provided patient K.E. with chiropractic treatment and nutritional care.

21. On or about December 7, 1992, patient K.E. completed a case history form.

22. Respondent's records for patient K.E. do not indicate that an examination or evaluation was performed.

23. Respondent placed patient K.E. on a two (2) week fast, consisting of water intake only.

24. Sometime in or around January 1993, Respondent placed patient K.E. on a diet regime consisting of raw fruit and vegetables.

25. Patient K.E. suffered extreme weight loss and her overall condition deteriorated.

26. Respondent's records for K.E. do not indicate the medical necessity or justification of the treatment rendered to the patient.

COUNT IV

27. Petitioner realleges and incorporates paragraphs one (1) through three (3) and paragraphs twenty (20) through twenty-six (26), as if fully stated herein.

28. Based on the foregoing, Respondent has violated Section 460.413(1)(m), Florida Statutes, by failing to keep written chiropractic records justifying the course of treatment of the patient, including, but no limited to, patient histories, examination results, test results, x-rays, diagnosis of a disease, condition or injury.

COUNT V

29. Petitioner realleges and incorporates paragraphs one (1) through three (3) and paragraphs twenty (20) through twenty-six (26), as if fully stated herein.

30. Based on the foregoing, the Respondent has violated Section 460.413(1)(r), Florida Statutes, by gross or repeated malpractice or the failure to practice chiropractic at a level of care, skill, and treatment which is recognized by a reasonably prudent chiropractic physician as being acceptable under similar conditions and circumstances.

COUNT VI

> 31. Petitioner realleges and incorporates paragraphs one (1) through three (3) and paragraphs twenty (20) through twenty-six (26), as if fully stated herein.
> 32. Based on the foregoing, the Respondent has violated Section 460.413(1)(v), Florida Statutes, through violation of Rule 59N-17.0065, Florida Administrative Code, by failing to maintain adequate patient records.

For such violations, the agency proposed that one or more of the following penalties be imposed:

> [R]evocation or suspension of the Respondent's license, imposition of an administrative fine not to exceed $1,000 for each count, issuance of a reprimand, placement of the chiropractic physician on probation for a period of time and subject to such conditions as the Board may specify, including requiring the chiropractic physician to submit to treatment, to attend continuing education courses, to submit to reexamination, or to work under the supervision of another chiropractic physician.

Respondent disputed the factual allegations contained in the complaint and, under cover letter of December 19, 1997, the agency referred the matter to the Division of Administrative Hearings for the assignment of an administrative law judge to conduct a formal hearing pursuant to Sections 120.569, 120.57(1), and 120.60(5), Florida Statutes. Consistent with the provisions of Chapter 96-403, Sections 8 and 24, Laws of Florida, the Department of Health was substituted as the agency in interest in these proceedings.

At hearing, Petitioner called as witnesses: the patient K. E. (now known by her maiden name K. M.); Thomas F. Daniels, an agency investigator; Robert Butler, Jr., D.C., accepted as an expert in chiropractic care; and the Respondent. Petitioner's Exhibits 1 through 13 and 15 were received into evidence, subject to the limitations noted on the record.[1] Respondent testified on his own behalf, but offered no additional proof.

The hearing transcript was filed July 6, 1998, and the parties were initially accorded until July 17, 1998, to file proposed recommended orders;[2] however, at Respondent's request (and with Petitioner's agreement) the time to file proposed recommended orders was extended to August 4, 1998. Consequently, the parties waived the requirement that a recommended order be rendered within 30 days after the transcript has been filed. Rule 28-106.216(2), Florida Administrative Code. The parties elected to file such proposals and they have been duly considered.

FINDINGS OF FACT

Respondent's licensure and practice

1. Respondent, Douglas N. Graham, is now, and was at all times material hereto, licensed as a chiropractic physician by the State of Florida, having been issued license number CH 0005483.

2. At all times pertinent, Respondent operated two businesses associated with the practice of chiropractic. The first business, a typical chiropractic practice, was operated under the name Action Chiropractic, and was located in a small office building at 8095 Overseas Highway, Marathon, Florida. The second business, known as Club Hygiene, promoted a hygienic (nutritionally sound) lifestyle based on the consumption of uncooked fruit and vegetables, nuts and seeds. As part of the regime at Club Hygiene, fasting (to detoxify the body) was also promoted as an avenue to better health.

3. Club Hygiene was located in Respondent's two-story home at 105 Bruce Court, Marathon, Florida. The ground floor, where the patients (or guests, as they were referred to at Club Hygiene) resided, consisted of three bedrooms, one bathroom, a small recreation room or area, and a porch for dining. Each bedroom contained two beds, allowing a maximum capacity of six guests. On the second level was Respondent's residence, which he shared with up to three "interns,"[3] who cared for the guests.

4. The instant case primarily involves concerns voiced by Petitioner regarding the care of two patients (K. E. and B. D.) at Club Hygiene in 1993. Regarding those concerns, Petitioner questioned whether Respondent's record keeping met minimum standards and whether Respondent's treatment met the prevailing standard of care.

The K. E. affair

5. On December 7, 1992, K. E. presented as a walk-in at Respondent's chiropractic clinic, Action Chiropractic, for a free consultation to address whether she could benefit from chiropractic care. At the time, K. E., a female, was 25 years of age (date of birth March 7, 1967), 5'6" tall, and weighed 105 pounds.

6. On presentation, K. E. filled out a case history sheet which detailed her present and past symptoms, as follows: occasional dizziness and headache; occasional pain between shoulders; frequent constipation and difficult digestion, with occasional pain over stomach; occasional colds, ear noises, and sore throat; occasional skin eruptions (rash); occasional frequent urination; and, occasional cramps or backache and vaginal discharge, with frequent irregular menstrual cycle. History further revealed an injury to a "muscle in back" over 5 years previous. Personal habits reflected a light appetite, as well as light use of alcohol and drugs. Exercise and sleep habits were noted as moderate. When asked to describe her major complaints and symptoms, K. E. responded, "They said I had scoliosis when I was young. I'm curious if it still is there." The date symptoms were first noticed was stated to be "middle school."

7. K. E.'s visit with Respondent lasted about twenty minutes, and included a brief spinal check, as well as a discussion regarding diet and nutrition. Respondent apparently

told K. E. she would benefit from chiropractic care; however, neither the patient record nor the proof at hearing reveal the results of his examination, diagnosis, prognosis, or any treatment plan.

8. Due to a lack of funds, K. E. declined further chiropractic care. At the time, or shortly thereafter, Respondent offered K. E. the opportunity to become an "intern" at Club Hygiene. The Internship Agreement entered into by Respondent and K. E. on January 18, 1993, provided as follows:

> The internship will last for a period of . . . 6 months . . . beginning on MONDAY, JANUARY 18TH , 1993 and ending on SUNDAY, JULY 18th , 1993.
>
> The company will provide the Intern with room, board, and the opportunity for hands-on, first-hand experience in the day-to-day operation of a hygienic retreat, supervision of fasting patients, and hygienic living.
>
> The Intern will provide the Company with their full-time efforts in the operation of the retreat in the manner determined by the company and in fitting with all reasonable rules and guidelines to be enforced by the company . . . .

As an inducement to complete the internship, interns were apparently rewarded with a supervised fast at the end of their term.

9. When K. E. joined the staff of Club Hygiene in January 1993, she was one of three interns who cared for the patients (guests). Also on staff, and working under Respondent's supervision, was Tim Trader (referred to as Dr. Trader in these proceedings), a unlicensed naturopathic physician.[4]

10. As an intern, K. E. changed the guests' linen, cleaned the guest bathroom, assisted with food preparation and, on a rotating basis with the other interns, dined with the guests. Each morning, K. E. also took the guests' blood pressure, and noted their vital signs.

11. When K. E. began work at the club she was suffering health problems and, more particularly, stomach trouble (difficult digestion and pain) and constipation. To assist her, Respondent recommended various diets, and K. E., at Respondent's recommendation, moved from eating predominantly cooked foods to raw natural foods; however, her stomach troubles persisted, and by April 1993 her weight had dropped to about 92 pounds.

12. In April 1993, on the advise of Dr. Trader and with the concurrence of Respondent, K. E. started a fast, water only, as a means to address her health problems. There is, however, no evidence that K. E. was physically examined prior to fasting, although at some point Respondent apparently suggested that "she had severe problems, including but not limited to, malabsorption syndrome, leaky gut syndrome, potential hiatal hernia and resultant malnutrition." Moreover, apart from the meager patient

record of K. E.'s office visit in December 1992, there is no patient record or other documentation (evidencing patient history, symtomatology, examination, diagnosis, prognosis, and treatment) to justify the care (diet and fasting) offered K. E.[5]

13. K. E. fasted for two weeks and by the end of the fast her weight was approximately 87 pounds. During the fast, Respondent was frequently out-of-town; however, K. E. was supervised by Dr. Trader, who assured her vital signs were regularly taken.[6]

14. Following the fast, K. E.'s health continued to deteriorate, and her weight dropped to approximately 77 pounds. She became concerned and sought to consult with Frank Sabatino, D.C., another "hygienic physician." Ultimately K. E. was seen by Dr. Sabatino, and also a medical doctor; however, their findings are not of record. Moreover, there was no proof offered at hearing regarding the nature of K. E.'s disorder, whether (given the nature of the disorder) a fast was or was not appropriate, whether the fast caused or contributed to any injury, or what subsequent care (if any) K. E. required. As of the date of hearing, to a lay observer, her appearance evidenced good health.

15. To address whether Respondent's treatment met the prevailing standard of care, Petitioner offered the opinions of two chiropractic physicians, Bruce I. Browne, D.C., and Robert S. Butler, Jr., D.C.[7] It was Dr. Browne's opinion that the care Respondent offered K. E., including the supervision (albeit not

personal) provided for her fasting, met the prevailing standard of care, but that Respondent failed to maintain patient records that justified the course of treatment. Dr. Butler agreed the patient records were inadequate, but was also of the opinion that Respondent's care failed to meet the prevailing standard of care because he authorized a fast without first performing a complete examination to resolve whether K. E.'s condition was appropriate for a fast, or stated otherwise, whether she was physically capable of withstanding the stress of a fast. Respondent admitted, at hearing, that he had not done any examination that would permit him to appropriately treat K. E.

16. Given the proof, it must be concluded that Respondent failed to maintain patient records regarding K. E. that justified her course of treatment. It must also be concluded that by approving a fast without an adequate examination, Respondent's care of K. E. fell below the prevailing standard.

The B. D. affair

17. In or about early November 1993, B. D., a male, and resident of the State of Washington, telephoned Respondent to arrange a visit. At the time, according to Respondent, B. D. had been hospitalized for two or three weeks and "wanted out."[8] Respondent agreed.[9]

18. B. D. arrived at Club Hygiene on November 7, 1993. At the time, he was 37 years of age (date of birth June 5, 1956), 5' 9 1/2" tall, weighted 115 pounds, and was in extremely poor

health. He was also HIV positive, and had developed acquired immune deficiency syndrome (AIDS).[10]

19. On presentation, as reflected by his case history, B. D. expressed to Respondent the fear or thought that he was dying, and related the following major complaints and symptoms: anal infection, frequent diarrhea, weight loss, inability to assimilate food, fatigue, and loss of energy. At the time, B. D. had been fasting for 1 1/2 days.

20. Examination confirmed the presence of an anal infection (thought to be fungal in origin) oozing clear fluid, and further noted, inter alia, an irritated nose and throat (slight redness), and that the upper cervical and lower lumbar were tender and fixated. Heart was noted to be clear and strong, and the lungs were noted to be clear in all four quadrants. The only recommendation reflected by the patient records relates to the observation concerning the upper cervical and lower lumbar, and reads as follows: "Daily light massage, muscle release, and gentle specific adjustments. P[atien]t concerned about overall health. Monitor closely."

21. B. D. continued his fast (water only) until November 16, 1993 (when he consumed diluted apple and celery juice), and Respondent monitored his progress on a daily basis. (Petitioner's Exhibit 5). The progress notes reflect a weight loss from 115 pounds to 102 1/2 pounds during the course of the fast, but no untoward occurrence.

22. B. D. apparently continued on a juice diet until November 23, 1993, when he was reintroduced to solid food. By that date, B. D.'s weight was noted to have dropped to 100 pounds.

23. On November 24, 1993, B. D.'s blood pressure was noted as 88/62 and his pulse/respiration as 74/20. He was also noted to be fatigued and he rested all day. Between November 24, 1993, and November 28, 1993, the only entry appears to be for November 26, 1993, when B. D.'s blood pressure is noted to be 100/70s.

24. By November 28, 1993, B. D.'s blood pressure was noted to have fallen to 66/50 and his pulse/respiration was noted as 80/20. No entry appears for blood pressure or pulse/respiration on November 29; however, there was an entry that B. D. was "experiencing problem breathing." A morning entry on November 30, 1993, noted "Ronci in all 4 Quads.-very slight. Breathing extremely labored." Blood pressure was noted as 62/42 and pulse/respiration as 80/28.

25. Respondent's progress notes contain no entries for December 1, 1993. On December 2, 1993, the notes reflect "Breathing labored still." Pulse/respiration was recorded as 80/32; however, no blood pressure reading was noted. There are no entries for December 3, 1993.

26. On December 4, 1993, blood pressure was recorded as 62/44 and pulse/respiration as 92/32. B. D. was noted to be very

fatigued. No entries appear on December 5, 1993, and on December 6, 1993, at 5:00 p.m., B. D.'s blood pressure is noted as 62/52 and pulse/respiration as 100/weak. B. D. is again noted as very fatigued, and his weight is recorded as 95 1/4 pounds. No entries appear for December 7, 1993.

27. At 11:08 p.m., December 7, 1993, Monroe County Emergency Services were summoned to Club Hygiene by a 911 telephone call, and they arrived at 11:15 p.m. The EMT's (emergency medical technician's) report reflects that for past medical history they were advised that B. D. was HIV positive, and for chief complaint they were advised "Breathing diff[iculty] - Family states onset 1 w[ee]k, getting progressively worse." At 11:20 p.m., blood pressure was noted as 109/53 and pulse/respiration was noted as 113/40. B. D. was transported to Fishermens Hospital and he was admitted through the emergency room at 11:36 p.m.

28. B. D. remained at Fishermens Hospital until December 20, 1993, when he was transferred to Lower Florida Keys Health System for further studies and treatment. The discharge summary from Fishermens Hospital reveals his course as follows:

> This is 37 year old male who presents to the Emergency Room with dyspnea, weakness for the past several days, states he has been visiting from the state of Washington with his mother and became ill while in the area. His past medical history is negative for previous hospitalization accept (sic) for surgery for right inguinal hernia he states he was found to be HIV positive seven years ago but has been in good health until

recently. Family history is negative for TB, diabetes, cancer, and cardiac disease, he has no known allergies, he is single, he has been a heavy abuser of alcohol in the past until four years ago. In the past he worked as an investment consultant with Japan, he does not smoke, he uses no drugs except an occasional marijuana. He states he knows no known risks for AIDS and does not know how he contacted it.[11]

Review of systems denies any illness prior to be the past few weeks, prior to this admission, he states he is confused regarding his past medical history and does'nt (sic) know how he became HIV positive.

Physical examination revealed emaciated 37 year old male who is on a non rebreather oxygen mask. His skin is warm and dry, pupils are equal and regular and react normally to light in accomidation (sic). Teeth are negative. Tembranic membrane is normal. Neck is subtle there is no cervical adenopathy, thyroid is smooth without enlargement, he has rales in both lungs over the entire parietal with respirations of 36 per minute, no wheezing is heard, his pulse is 92, regular sinus rhythm, there are no murmurs. Abdomen is soft without masses. Heart tenderness, there was no peripheral edema. Penial pulses are present. He is alert, although he is slightly confused regarding his recent medical history. Reflexes were equal, there is no vocal motor weakness.

* * *

Chest x-ray at the time of admission showed pulmonary edema, possibly non-cardiac follow up chest x-ray showed evidence of diffuse infiltrates involving the right lung and also the left lower lobe consistent with pneumocystis carinii pneumonia with evidence of bilateral pulmonary edema. Follow up chest x-ray showed increased . . . desity in the right lung infiltrate and progression of infiltrates to the left mid and lower lung fields with air bronchograms and air

> alveolgrams Indicating alveolar infiltrates. EKG abnormal record to the extreme right axis deviation, poor R wave progression, sinus tachycardia.
>
> Patient was seen in consultation by Dr. Halterman in the event that his respiratory status required intubation, however he never did require this.
>
> * * *
>
> He was treated in ICU, he developed a pneumothorax, spontaneous pneumothorax and was seen by Dr. Mankowitz for insertion of a chest tube, because of failure to show improvement arrangements were made for transfer to Key West for further studies and treatment and possible Phentolamine, Phetamadine.
>
> His condition upon transfer is poor.
>
> Prognosis is poor.
>
> FINAL DIAGNOSIS: Respiratory failure, secondary to diffused alveolar infiltrates, probable pneumocystis carinii pneumonia.
>
> Spontaneous pneumothorax, adult immune deficiency syndrome.

29. B. D. was admitted to Lower Florida Keys Health System, Key West, Florida, at 2:50 p.m., December 20, 1993. Thereafter, his condition deteriorated, and at 9:17 p.m., December 26, 1993, he was pronounced dead. The death summary notes an admitting and final diagnosis as follows:

> ADMITTING DIAGNOSIS: Pneumonia
> FINAL DIAGNOSIS: Pneumonia, HIV infection, respiratory failure, respiratory complications, emphysema, cachexia

Cause of death, as stated on the Certificate of Death, was

cardiopulmonary failure, as a consequence of pneumonia, due to acquired immune deficiency syndrome (AIDS).

30. To address whether Respondent's care for B. D. met the prevailing standard of care, as well as whether his records conformed to the minimum requirements of law, Petitioner again called upon Doctors Browne and Butler.

31. With regard to the adequacy of Respondent's patient records, Doctors Browne and Butler concur, and observe that with regard to B. D., the patient records failed to conform with the minimum requirements of law (they failed to include a diagnosis or a treatment plan) and, therefore, failed to justify the course of treatment. Given the record, the opinions of Doctors Browne and Butler regarding the inadequacy of Respondent's records, as they relate to B. D., are credited.

32. With regard to whether Respondent's treatment met the prevailing standard of care, Doctors Browne and Butler offer somewhat differing opinions. Dr. Browne was of the opinion that Respondent's treatment met the prevailing standard until November 30, 1993, when B. D.'s breathing was noted to be extremely labored. At that time, according to Dr. Browne, prevailing practice required Respondent, as a chiropractor, to cease treating B. D. and to advise him to seek relief from another practitioner who possessed the requisite skill, knowledge, and facilities to treat his ailment properly. In Dr. Butler's opinion, Respondent should have called for a chest

x-ray, and his failure to do so failed to meet the prevailing standard of care.[12]

33. Respondent explained his reaction to B. D.'s congestion and labored breathing, as follows:

> Q. What did you do, you noted he was congested?
> A. I suggested he go to a hospital.
> Q. And his response?
> A. He did not want to go to a hospital. He wanted to wait it out, and I said you can wait at my house. But if you go down hill, you have to go to a hospital.
> Q. Is that what happened?
> A. Yeah. He started to become ever so slightly synodic (sic), meaning that he was breathing but he wasn't getting lots. His fingertips were starting to turn blue.
>
> * * *
>
> Q. Did you discuss with him at this time a need to get additional care?
> A. I discussed it with him many times, because this was not, this was not in my league. It was not in my scope. It was not - I did not have access to the tools even if I knew how to treat a man at this point. Those are my concerns for Brian. And, finally, I said, Brian, look, you have to trust my judgment, you go to the hospital whether you want to or not.

Q. Who called for the ambulance?
A. I have no idea.

* * *

Q. Did you consider the need for an x-ray when you saw Brian's breathing become labored?
A. No.
Q. Did you make any suggestions to him at the time you noted his breathing had become labored?
A. When it became labored?
Q. Yes, sir.
A. Not that I'm aware of saying anything to him. No. I don't believe so.

(Transcript, pages 174, 175, and 177).

34. Having considered the proof, Dr. Browne's opinion is accepted as most compelling and provides the most complete description of the breadth of Respondent's obligations, as well as the scope of his breach. On the other hand, Dr. Butler's opinion (that the circumstances required a referral for chest x-ray) has not been rejected; however, Respondent's failure to refer for x-ray (when he realized B. D.'s condition was beyond his knowledge or the methods of treatment available to him) is viewed as a failing subsumed within his breach of the prevailing standard which required that Respondent cease treating B. D. and refer him to another physician who possessed the requisite skill, knowledge, and facilities to treat his ailment properly.[13]

CONCLUSIONS OF LAW

35. The Division of Administrative Hearings has jurisdiction over the parties to, and the subject matter of,

these proceedings. Sections 120.569, 120.57(1), and 120.60(5), Florida Statutes.

36. Where, as here, an agency proposes to take punitive action against a licensee, it must establish grounds for disciplinary action by clear and convincing evidence. Section 120.57(1)(h), Florida Statutes (1997), and Department of Banking and Finance v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996). That standard requires that "the evidence must be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established." Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

37. Pertinent to this case, Section 460.413, Florida Statutes (1993),[14] provides that the following acts shall constitute grounds for which the Board of Chiropractic (Board) may take disciplinary action against a licensee:

> (m) Failing to keep written chiropractic records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, test results, X rays, and diagnosis of a disease, condition, or injury. X rays need not be retained for more than 4 years.
>
> * * *

> (r) Gross or repeated malpractice or the failure to practice chiropractic at a level of care, skill, and treatment which is recognized by a reasonably prudent chiropractic physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the standards for malpractice in s. 766.102 in interpreting this provision. . . .[15]
>
> * * *
>
> (v) Violating any provision of this chapter, any rule of the board or department, or a lawful order of the board or department previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the department.

38. For the perceived violation of subsection 460.413(1)(v), the agency contends Respondent failed to comply with the minimum recordkeeping standards established by Rule 59N-17.0065, Florida Administrative Code (now codified at 64B2-17.0065, Florida Administrative Code); however, the minimum standards now imposed are substantially greater than those that were imposed by rule when the events which gave rise to the charges in this case occurred. At that time the rule, then codified at 61F2-17.005, Florida Administrative Code, established the following minimal recordkeeping standards:

> (1) These standards apply to all licensed chiropractic physicians and certified chiropractic assistants. These standards also apply to those examinations advertised at a reduced fee, or free (no charge) services.
> (2) Adequate patient records shall be legibly maintained. Initial and follow-up services (daily records) shall consist of documentation to justify care. If abbreviations or symbols are used in the

> daily recordkeeping, a key must be provided.
> (3) All patient records shall include patient history, symptomatology, examination, diagnosis, prognosis, and treatment.
> (4) Provided the Board takes disciplinary action against a chiropractic physician for any reason, these minimal clinical standards will apply. It is understood that these procedures are the accepted standard(s) under this chapter.

These are the standards by which Respondent's recordkeeping should be judged; however, these requirements are little more than a restatement of the requirements of Subsection 460.413(1)(m), Florida Statutes. Consequently, any violation of subsections 460.413(1)(m) and (v) should be considered one violation and not a separate violation for penalty purposes.

39. Applying the foregoing provisions of law to the facts, as found, compels the conclusion that, with regard to his treatment of B. D., Respondent violated the provisions of subsections 460.413(1)(m), (r), and (v), as alleged in Counts I, II, and III, respectively, of the Administrative Complaint, and that, with regard to his treatment of K. E., Respondent violated the provisions of subsections 460.413(1)(m), (r), and (v), as alleged in Counts IV, V, and VI, respectively, of the Administrative Complaint.[16]

40. Having reached the foregoing conclusions, it remains to resolve the appropriate penalty that should be imposed. Pertinent to this issue, Section 460.413(2), Florida Statutes (1993), authorizes the Board to impose one or more of the following penalties when it finds a licensee guilty of any of the

foregoing offenses:

> (a) Refusal to certify to the department an application for licensure.
> (b) Revocation or suspension of a license.
> (c) Restriction of practice.
> (d) Imposition of an administrative fine not to exceed $1,000 for each count or separate offense.
> (e) Issuance of a reprimand.
> (f) Placement of the chiropractic physician on probation for a period of time and subject to such conditions as the board may specify, including requiring the chiropractic physician to submit to treatment, to attend continuing education courses, to submit to reexamination, or to work under the supervision of another chiropractic physician.

Also pertinent to this case, Rule 64B2-16.003(1), Florida Administrative Code, provides the guidelines for the disposition of disciplinary cases. The guidelines for violations of subsections 460.413(1)(m), (r), and (v) are as follows:

> (u) 460.413(1)(m): from a minimum of one (1) year of probation, up to a maximum of suspension of license for three (3) months, followed by six (6) months of probation;
>
> * * *
>
> (z) 460.413(1)(r): gross or repeated -- from a minimum of suspension of license for three (3) months, followed by six (6) months of probation, up to a maximum of revocation or denial of license; other -- from a minimum of an administrative fine of $1,000 and six (6) months of probation, up to a maximum of suspension of license for one (1) year, followed by two (2) years of probation;
>
> * * *
>
> (dd) 460.413(1)(v): from a minimum of reprimand, up to a maximum of revocation or denial of license. . . .

Finally, Rule 64B2-16.003(2), Florida Administrative Code, sets forth the aggravating and mitigating circumstances which may be considered in determining the appropriate penalty.

41. Applying the foregoing standards to the facts of this case, with regard to B. D., compels the conclusion that an appropriate penalty for Respondent's violation of subsection 460.413(1)(r), given that Respondent's care was found to have failed to meet the prevailing standard of care, as opposed to gross or repeated malpractice, would be a suspension of licensure for one (1) year, followed by two (2) years of probation. For the violations of subsections 460.413(1)(m) and (v), as they related to B. D., an appropriate penalty would be a one (1) year term of probation, to be served concurrently with the term imposed for the subsection 460.413(1)(r) violation.

42. With regard to K. E., an appropriate penalty for Respondent's violation of subsection 460.413(1)(r), given that Respondent's care was found to have failed to meet the prevailing standard, as opposed to gross or repeated malpractice, would be an administrative fine of $1,000 and six (6) months of probation, to be served concurrently with the term imposed for the violation regarding B. D. For the violations of subsections 460.413(m) and (v), as they relate to K. E., an appropriate penalty would be a one (1) year term of probation to be served concurrently with the term imposed for the violation relating to B. D.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a Final Order be entered which finds the Respondent committed the offenses alleged in Counts I through VI of the Administrative Complaint, and which imposes, as a penalty for such violations, a suspension of licensure for a term of one (1) year, followed by a two (2) year term of probation (subject to such terms as the Board may reasonably impose), and an administrative fine of $1,000.

DONE AND ENTERED this 5th day of August, 1998, in Tallahassee, Leon County, Florida.

WILLIAM J. KENDRICK
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847

Filed with the Clerk of the
Division of Administrative Hearings
this 5th day of August, 1998.

ENDNOTES

1/ Petitioner withdrew its proposed Exhibit 14, and it is not of record. Petitioner's Exhibit 15 was the deposition of Bruce I. Browne, D.C., which, with the parties' agreement, was taken post-hearing and, when filed, received in evidence as Petitioner's Exhibit 15.

2/ The parties were accorded ten days after the filing of the transcript or the deposition of Dr. Browne (as discussed in Endnote 1), which ever was later, to file proposed recommended orders. Dr. Browne's deposition was filed July 7, 1998, and, it being the later document filed, the ten day period began to run on that date.

3/ The status of "interns" is discussed infra.

4/ See Chapter 462, Florida Statutes.

5/ At hearing, Respondent averred that K. E. was his maid, not his patient, and presumably, consistent with his view of her status, that is why he never did an examination (that was adequate for chiropractic treatment) and why he did not prepare or maintain patient records. However, while she may not have been a patient when she first joined the staff at Club Hygiene, her status changed overtime when Respondent began to consult with her regarding her ill health; offered dietary counsel to address her ill health; and K. E. entrusted herself to his care and supervision. Consequently, a patient-physician relationship did ultimately exist between K. E. and Respondent.

6/ Blood testing was not ordered either before or during the fast; however, there was no showing at hearing that it was necessary.

7/ According to Petitioner, Respondent's care of K. E. failed to meet the prevailing standard of care because he "fail[ed] to make appropriate examinations and properly supervise and monitor her fast." (Petitioner's Proposed Recommended Order, page 8). At least with regard to the supervision provided for K. E.'s fast, Respondent's treatment did not fall below the prevailing standard.

8/ B. D. had been on a "health diet" for 7 years. (Petitioner's Exhibit 7, Emergency Department Nursing Record, Fishermens Hospital). Adoption of such a diet coincided with B. D.'s discovery that he was HIV positive.

9/ Respondent testified that he initially treated B. D. in or around 1988, and approximately every 15 or 18 months thereafter. On this occasion, however, Respondent denies that he treated B. D. or, stated otherwise, that a patient-physician relationship existed (and, therefore, he owed no duty of care to B. D.). Rather, Respondent avers that B. D.'s visit was personal.

Given the proof, Respondent's averment that, apart from a patient-physician relationship, a familiar or personal relationship existed between him, B. D., and B. D.'s family, is accepted; however, that does not detract from the conclusion that he treated

B. D. and that a patient-physician relationship existed during this visit. Indeed, it is apparent that B. D. came to Club Hygiene to fast under Respondent's supervision and that Respondent accepted that trust and responsibility.

10/ Respondent testified, at hearing, that he was unaware that B. D. was HIV positive or that he had developed AIDS. Considering the proof, Respondent's testimony in this regard is rejected as inherently improbable and unworthy of belief.

11/ The history B. D. provided, as reflected by this paragraph, is suspect and, most likely, false in significant respects. First, his occupation was noted as investment consultant (or student) on admission, yet Respondent knew him to be a professional musician. Second, he denies past hospitalizations or poor health until recently, yet immediately before his arrival at Club Hygiene, he was hospitalized for 2 to 3 weeks, and he was in extremely poor health on arrival at Club Hygiene.

Also suspect, and most likely untrue, are certain statements B. D. (and his mother) made on his emergency room admission. Then, as reflected by the admission note, the EMTs stated that B. D. was being prescribed vitamins (treated) by a chiropractor (Respondent) but "they" (B. D. and his mother) denied this. B. D. also denied any medical problems, and stated Respondent was just a friend and was not treating him. Considering the record, B. D.'s statements that Respondent was not treating him are rejected as not credible, and most likely uttered to protect Respondent from criticism for having cared for him at that time.

12/ Dr. Butler was also of the opinion that Respondent's care failed to meet the prevailing standard in one other particular. In this regard, Dr. Butler observed that, given the presence of infection, the prevailing standard of care required a complete blood count (CBC) to identify its cause or nature before approving a fast. Here, B. D.'s patient history, which revealed what Respondent perceived to be a fungal infection, was available to both Dr. Browne and Dr. Butler, and they have reached opposing conclusions regarding its significance to Respondent's care. Given the record, or lack of further explanation, there is no apparent reason to prefer Dr. Butler's opinion over Dr. Browne's. Consequently, it must be concluded that Dr. Butler's opinion that Respondent's care failed to meet the prevailing standard regarding this aspect of B. D.'s care is not accepted as persuasive.

13/ Here, as early as November 28, 1993, if not before, B. D.'s blood pressure was depressed, and his respiration labored. By November 30, 1993, B. D.'s condition had deteriorated, with congestion noted in all four quadrants, and extremely labored breathing. B. D.'s respiratory distress progressively

deteriorated; however it was not until approximately 11:00 p.m., December 7, 1993, an elapsed time of almost 10 days from the onset of depressed respiration, when Respondent insisted B. D. "trust [his] judgment" and go to the hospital. (Transcript, page 175). According to Respondent, in the interim "we just kind of watched him. There was not a lot any of us could do at this point." (Transcript, page 176). Such being the case, it was Respondent's obligation to cease caring for B. D. and refer him to a facility that could address his needs; however, there is no compelling proof that Respondent advised B. D. that his condition was beyond his knowledge or the methods available for him to treat, the gravity of his circumstances, or the need to seek immediate care by a medical physician. By failing to do so, Respondent's care fell below the prevailing standard; however, whether earlier referral would have affected the progress of B. D.'s disorder is, based on this record, at best speculative.

14/ Section 460.413(1), Florida Statutes (1997), is substantially the same as the 1993 version except with regard to subsection 460.413(1)(m) which in the 1997 version places additional obligations on the chiropractic physician. That subsection provides, as follows:

> (m) Failing to keep legibly written chiropractic records that identify clearly by name and credentials the licensed chiropractic physician rendering, ordering, supervising, or billing for each examination or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories, examination results, test results, X rays, and diagnosis of a disease, condition, or injury. X rays need not be retained for more than 4 years.

Here, the law as it existed at the time of the events in question has been applied.

15/ Section 766.102, Florida Statutes (1993), provides, in pertinent part, as follows:

> (1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider . . ., the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider

> represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

16/ Respondent's contention that a physician-patient relationship did not exist between him and B. D. or K. E. has not been overlooked; however, as noted in the Findings of Fact Respondent's contention has been rejected. In so concluding, it is observed that the existence of a physician-patient relationship is a question of fact to be resolved by observing whether the patient entrusted himself to the care of the physician and whether the physician accepted the case. In resolving that issue, it is inconsequential that the services are performed gratuitously. See, e.g., 61 Am. Jur. 2d, Physicians, Surgeons, and other Healers, Sections 36, 44, 158 and 159.

Once the patient has been accepted, the physician incurs the consequent duty of due care and skill in treatment, to continue to provide for health care once the relationship has been established, and, when the patient's ailment is beyond his knowledge or the methods of treatment available to him are not of a character productive of reasonable success, to advise the patient of the need for other treatment and to refer him to an appropriate practitioner. See, e.g., 61 Am. Jur. 2d, Physicians, Surgeons, and other Healers, Sections 228 - 234.

In hand with the physician's duty of due care, the physician also incurs the duty of good faith and fair dealing. That duty is founded on the premise that the physician is learned, skilled, and experienced in those matters about which the patient is uninformed, but which are of the most vital interest to his well-being; therefore, the patient must of necessity place great reliance, faith, and confidence in the professional's word, advice, and acts. Moreover, a person in ill health is more subject to domination and undue influence. See, e.g., 61 Am. Jur. 2d, Physicians, Surgeons, and other Healers, Sections 166 - 168.

COPIES FURNISHED:

Thomas Wright, Esquire
Agency for Health Care Administration
Post Office Box 14229
Tallahassee, Florida 32317

E. Renee Alsobrook, Esquire
Alsobrook & Dove, P.A.
Post Office Box 10426
Tallahassee, Florida 32302-2426

Eric G. Walker, Director
Board of Chiropractic
Department of Health
1940 North Monroe Street
Tallahassee, Florida 32399-0792

Angela T. Hall, Agency Clerk
Department of Health
1317 Winewood Boulevard, Building 6
Tallahassee, Florida 32399-0700

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.