STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF OPTOMETRY,	)	
Petitioner,	)	
vs.	)	Case No. 00-3895PL
MICHAEL R. DUENAS, O.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Notice was given and on November 6, 2000, a final hearing was held in this case and conducted pursuant to Sections 120.569 and 120.57(1), Florida Statutes. The final hearing was held at the Recreation Center, 131 Oak Street, Chattahoochee, Florida. The hearing was conducted by Charles A. Stampelos, Administrative Law Judge.

APPEARANCES

For Petitioner: Deborah B. Loucks, Esquire
Agency for Health Care Administration
Post Office Box 14229
Mail Stop 39
Tallahassee, Florida 32317-4229

For Respondent: Stewart E. Parsons, Esquire
101 North Madison Street
Quincy, Florida 32351

STATEMENT OF THE ISSUES [1]

1. Whether the standard of care for the practice of optometry required that patient, J.P., be dilated by Respondent at the January 1998 appointment.

2. Whether the standard of care for the practice of optometry required Respondent to note in patient J.P.'s patient record the reason for not dilating J.P. at the January 1998 appointment.

PRELIMINARY STATEMENT

On July 14, 2000, the Department of Health, Board of Optometry (Petitioner) alleged that Michael R. Duenas, O.D., (Respondent) is subject to discipline pursuant to Section 463.016(1)(h), Florida Statutes, through violation of Florida Administrative Code Rule 64B13-3.007(2)(f), by failing to perform and record an internal examination, including the failure to perform a dilated fundus examination as required by Florida Administrative Code Rule 64B13-3.010(10)(a), or failing to note justification for not dilating the patient in the patient's case record. Respondent disputed several allegations of material fact contained in the Amended Administrative Complaint and requested a hearing. The Department forwarded the request for hearing to the Division of Administrative Hearings, which scheduled the proceeding.

Prior to the final hearing, Respondent filed a Motion to Dismiss or Strike and Petitioner filed a Response. Ruling was deferred. The Motion is granted for the reasons stated herein. See Conclusion of Law 44.

The parties entered into a Pre-Hearing Stipulation offered into evidence as Joint Exhibit Number 1. At the hearing, Petitioner presented the testimony of J.P., the patient of Respondent, who is mentioned in the Amended Administrative Complaint. Kenneth Lawson, O.D., an expert witness, also testified. Respondent testified in his behalf and also offered the testimony of Walter Hathaway, O.D. and Adam Gordon, O.D., M.P.H., expert witnesses. The parties offered into evidence Florida Administrative Code Rules 64B13-3.007 and 64B13-3.010, which are applicable in this proceeding. See Joint Exhibit Number 2.

The Transcript of the hearing was filed on November 21, 2000. Both parties filed proposed recommended orders, which have been reviewed and utilized in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Petitioner is the state agency charged with regulating the practice of optometry in the State of Florida.

2. At all times material to this case, Respondent has been licensed as a certified optometrist in the State of Florida,

holding license number 1734. Respondent practices optometry in Chattahoochee, Florida.

3. Respondent received his Doctor of Optometry degree from the University of Alabama in Birmingham in 1982. He is licensed to practice optometry in Georgia and Florida, and in the latter since June of 1982. Respondent has been a certified optometrist in Florida since 1984-1985.

4. Respondent specializes in diseases of the retina which include, but are not limited to, diabetes and hypertension. Respondent is engaged in the private practice of optometry, but also practices hospital-based optometry as a physician-consultant with Florida State Hospital. He has lectured and published extensively in the area of optometry, including issues on public health and the importance of high blood pressure and diabetes.

5. Respondent sits on the Council on Optometric Education which is an 11-member board that accredits all of the optometry schools and residency programs in the United States and Canada.

6. As a certified optometrist, Respondent is competent to perform a dilated fundus examination.

Respondent's examination and treatment of J.P.

7. Respondent provided optometry services to patient, J.P., a registered nurse, for the first time on February 21, 1989. This was J.P.'s initial patient visit. Respondent performed a

dilated fundus examination on J.P. which indicated his peripheral retina was completely normal. J.P. did not report any history of high blood pressure/hypertension at that time.

8. On August 20, 1990, Respondent performed a full and general examination of J.P.'s eyes and all of the components of that examination were recorded in J.P.'s patient record. J.P. did not report any history of hypertension at that time. No dilation was performed nor was it required.

9. In late 1994, J.P. was working as a nurse at Florida State Hospital when a patient slapped him on the face. J.P. suffered a corneal abrasion. On December 13, 1994, Respondent examined J.P. Respondent diagnosed J.P.'s problem as "mild iritis," and medical treatment was afforded. Respondent performed a thorough examination of J.P.'s retina, including the peripheral examination with dilation. All aspects of the retina were within normal limits. There was no sign of any hypertensive changes at that time, nor any sign of any trauma related to the incident. J.P.'s injury resolved satisfactorily, and, J.P. had no further trouble whatsoever. J.P. was told to return in one week for a follow-up visit, but he did not. J.P. has not had any trouble with his eyes after the December incident and after being treated by Respondent in December of 1994.

10. J.P. has had borderline high blood pressure/hypertension since he was a teenager. He started taking

daily medication in 1990. J.P. advised Respondent of his hypertension and the nature of his medication on a form when he visited in 1994. J.P.'s hypertension was well-controlled with medication at the time of J.P.'s December 1994 visit through his next examination in January 1998. He suffers no symptoms from his high blood pressure/hypertension.

11. J.P. returned to Respondent in January 1998 to obtain a prescription for reading glasses. J.P.'s January 1998 visit with Respondent was not his initial presentation or visit.

12. J.P was questioned about his hypertension and J.P. told Respondent it was in good control. J.P. had been seeing Dr. Richardson, a local physician. Dr. Richardson refers patients with ocular complications of systemic diseases to Respondent for examination. Dr. Richardson, who was familiar with J.P.'s health, did not express any concern to Respondent regarding J.P.'s hypertension.

13. Because Respondent had not examined J.P. for over two (2) years, he performed a comprehensive examination and all of the minimal procedures for vision analysis including consideration of J.P.'s patient history and visual acuity's, which were done and recorded. He performed an external examination, with a slit lamp, which was done and recorded. Respondent also performed a pupillary examination, which was recorded as normal. Visual field and confrontation testing were

done and recorded. He also graded the blood vessel status for any abnormalities. He recorded the cup-to-disk ratio having performed an internal examination by direct ophthalmoscopy. There were no recorded arteriosclerotic changes, and no hypertensive retinopathy. He graded the ratio between the arteries and the veins, which was normal at two-thirds. An extra ocular muscle balance assessment was done. Respondent, using a direct ophthalmoscope, was able to view the majority of the retina and assess the blood vessel status for any signs of retinopathy, at which point there was no sign of retinopathy, which was consistent with the patient's history of having controlled hypertension. Tonometry was performed and the results for a glaucoma check recorded. Refraction was performed and results with acuity recorded.

14. J.P. had no physical limitation or medical condition, such as diabetes, which may have required this examination. J.P.'s blood pressure or hypertension was reported as being in good control, and the record does not reveal otherwise. While performing the vision analysis, Respondent had a good view of the retina because J.P. did not have cataracts or other media opacities in the lens or cornea or vitreous of the eye that could cause problems seeing the retina, which might require dilation. Respondent also weighed the risks of dilation. Respondent's

explanations for not performing the dilated fundus examination and for not noting same in J.P.'s patient chart are reasonable.

15. A treatment plan was devised for J.P. and J.P. was apprised of the findings of the examination. Respondent advised J.P. to return in one year. J.P. did not return. Respondent issued a prescription for glasses for J.P.

16. J.P. never encountered any unresolved medical problems nor encountered any medical problems with his eyes that resulted from the lack of a dilated fundus examination on his eyes in January 1998. This examination was not medically indicated.

Standard of Care for performing a dilated fundus examination and notation in the patient's record

17. A dilated fundus examination is performed to enable the optometrist to examine the anterior part of the eye, -- in particular, the peripheral part of the retina -- and to assess the condition of the lens, looking for cataracts, for example. Eyedrops are placed in the eye to enlarge or dilate the pupil. This helps the optometrist to view a larger area of the retina in greater detail than can be done without dilation of the pupil.

18. Florida Administrative Code Rule 64B13-3.007 provides for "minimum procedures for vision analysis" and specifically subsection (2)(f) provides: "An examination for vision analysis shall include the following minimum procedures, which shall be recorded on the patient's case record . . .[i]nternal examination

(direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities) . . . ."

19. Florida Administrative Code Rule 64B13-3.007(4), not referenced in the Amended Administrative Complaint, provides: "Except as otherwise provided in this rule, the minimum procedures set forth in paragraph (2) above shall be performed prior to providing optometric care during a patient's initial presentation, and thereafter at such appropriate intervals as shall be determined by the optometrist's sound professional judgment. Provided, however, that each optometric patient shall receive a complete vision analysis prior to the provision of further optometric care if the last complete vision analysis was performed more than two years before."

20. Florida Administrative Code Rule 64B13-3.010 provides the "standard of practice for licensed optometrists." Subsection(10)(a) provides: "To be in compliance with Rule 64B13-3.007(2)(f), certified optometrists shall perform a dilated fundus examination during the patient's initial presentation and thereafter whenever medically indicated. If in the certified optometrist's sound professional judgement, dilation should not or can not be performed because of the patient's age or physical limitations or conditions, the reason(s) shall be noted in the patient's medical record." There is no cited agency precedent interpreting subsection (10)(a).

21. The Board's expert, Kenneth Lawson, O.D., is a certified optometrist licensed to practice optometry in the State of Florida. He has been a consultant for the Board of Optometry for approximately three (3) years and has reviewed twenty-five (25) to thirty-five (35) cases involving complaints filed against optometrists.

22. According to Dr. Lawson, Florida Administrative Code Rule 64B13-3.010(10)(a) was enacted in 1995 because there had been an ambiguity with respect to the dilation standard of care. It is Dr. Lawson's opinion that this rule requires a certified optometrist to perform a dilated fundus examination on every initial patient and where medically indicated. He interprets the word "initial" to mean the first time the patient is seen by the optometrist and also when the patient has not been examined by an optometrist for a period of three (3) years. Dr. Lawson opines that every patient becomes an initial patient every three (3) years if not examined and dilated within the three-year period. He also believes dilation is required during every visit if there has been trauma to the eye or if the patient has had a history of ocular trauma or other factors such as hypertension, regardless of whether the hypertension is under good control during each visit. See Conclusion of Law 46.

23. As a rule, however, Dr. Lawson dilates every patient over sixty-five (65) years old every year and all patients under

sixty-five (65) every two years. These time periods can vary depending on the health of the patient. For example, Dr. Lawson stated that there is a low risk or probability that hypertension would lead to blindness or impairment of visual acuity if the hypertension is well-managed by medication and the patient is younger than sixty (60). Dr. Lawson conceded that the Board's rule does not require dilation every year, only every three years. Dr. Lawson also opines that there should be some documentation on the patient's chart indicating why dilation was not performed.

24. Dr. Lawson relied on the Physician's Current Procedural Terminology (CPT) textbook, volume IV, to support his position that an "initial" patient is one who has not received any services from the physician within a three-year period. Dr. Lawson believes that the words "initial" and "medically indicated," appearing in subsection (10)(a), are referenced by the three-year period. He concludes that it is the standard of care for dilation to be performed every three (3) years.

25. However, the CPT instructs physicians on how to bill for procedures and enables an optometrist to receive a higher rate of reimbursement rate for the visit; it is not a standard of care. The textbook or physician code book was not offered in evidence and is not a credible source. Dr. Lawson's explanation of the relevant standard of care is not persuasive.

26. Walter Hathaway, O.D. and Adam Gordon, O.D., M.P.H. testified on behalf of Respondent as expert witnesses.

27. Dr. Hathaway is a certified optometrist in the State of Florida and has practiced for thirty-four (34) years. He has served as an expert reviewer for the State of Florida, Board of Optometry, and has served as an expert witness twelve (12) times.

28. Dr. Hathaway opined that a dilation is required during the patient's initial evaluation or presentation and when medically indicated; for example, when the patient has a history of diabetes, flashes, or floaters, which indicates retinal detachment.

29. Dr. Hathaway opined that a dilated fundus examination is not required in all cases where a patient reports a history of hypertension if the hypertension is under control.

30. Dr. Hathaway was asked to consider a hypothetical set of facts based upon the facts of record regarding J.P.'s health and Respondent's examinations of J.P. Based on his professional judgment, Dr. Hathaway concluded that Respondent was not required to perform a dilated fundus examination on J.P. during the course of his examination on January 6, 1998.

31. Dr. Gordon is a licensed optometrist in the State of Alabama, has practiced for eighteen (18) years, and has been a Clinical Associate Professor at the University of Alabama-Birmingham School of Optometry for sixteen (16) years. He also

examines patients in a private group practice. Formerly, he served as a faculty member at Johns Hopkins University Hospital in Baltimore, Maryland.

32. Dr. Gordon was also asked to consider a hypothetical set of facts based upon the facts of record regarding J.P.'s health and Respondent's examinations of J.P. and stated, that in his professional judgment, a dilated fundus examination was not medically indicated for this patient on January 6, 1998. Likewise, Dr. Gordon stated that this examination is not required on all patients reporting a history of hypertension. Conversely, he would consider dilation if the patient reported his or her high blood pressure was out of control or if he or she stopped seeing a physician or had stopped taking medication for the condition, factors absent here.

33. It was not medically indicated for Respondent to automatically give J.P. a dilated fundus examination in January 1998, because J.P.'s hypertension was under control at that time. J.P. testified that his hypertension had been controlled with medication through and including his January 1998 visit with Respondent. Further, J.P. had no problems with his eyes after his 1994 visit with Respondent. A dilation examination may have been required if J.P.'s hypertension had been uncontrolled or if J.P. exhibited some other medical problem such as diabetes, or if

J.P. had stopped taking prescribed medication. These factors are not present here.

34. The weight of the evidence supports only one finding: there was no medical indication which would have required Respondent to perform a dilated fundus examination on J.P. during his January 1998 examination. The weight of the evidence supports Respondent's exercise of professional judgement in not performing a dilated fundus examination on J.P. during the January 1998 visit.

35. The weight of the evidence proves that the standard of care set forth in Florida Administrative Code Rule 64B13-3.010(10)(a) for performing a dilated fundus examination does not require this examination automatically every three (3) years. Rather, dilation should be performed during the "initial presentation," and when "medically indicated" based on the certified optometrist's exercise of sound professional judgment in light of the patient's medical history and current health.

36. Further, the weight of the evidence proves that the standard of care set forth in Subsection (10)(a) does not require a certified optometrist to note in a patient record the reason why a dilated fundus examination was not performed unless dilation was not performed based solely on the patient's age or physical limitations or conditions, all absent here. The latter criteria are the only ones stated in the rule, and the weight of

the evidence does not prove that additional criteria should be considered.

CONCLUSIONS OF LAW

37. The Division of Administrative Hearings has jurisdiction over the parties to and subject matter of this proceeding. Sections 120.57(1) and 120.569, Florida Statutes.

38. The Department of Health, Board of Optometry, is responsible for disciplinary proceedings against certified optometrists in Florida. Chapter 463, Florida Statutes.

39. The Department has the burden of proving the allegations against Respondent by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987). "Where the licensee is charged with a violation of standards of professional conduct and the specific acts or conduct required of the professional are explicitly set forth in the statute or a valid rule promulgated pursuant thereto, the burden on the agency is to show a deviation from the statutorily-required acts . . . ." McDonald v. Department of Professional Regulation, Board of Pilot Commissions, 582 So. 2d 660, 670 (Fla. 1st DCA 1991) (Zehmer, J., specially concurring) (citing Purvis v. Department of Professional Regulation, 461 So. 2d 134 (Fla. 1st DCA 1984)). Further, because Section 463.016(1)(h), Florida Statutes, and Florida Administrative Code Rules 64B13-3.007(2)(f) and 64B13-3.010(10)(a) authorize revocation or suspension of a professional

license, they are penal in nature and are strictly construed in favor of the licensed certified optometrist. See Breesmen v. Department of Professional Regulation, Board of Medicine, 567 So. 2d 469, 471 (Fla. 1st DCA 1990). "This being true the statute [and here the rules] must be strictly construed and no conduct is to be regarded as included within it that is not reasonably proscribed by it. Furthermore, if there are any ambiguities included such must be construed in favor of the applicant or licensee." Lester v. Department of Professional and Occupational Regulations, State Board of Medical Examiners, 348 So.2d 923, 925 (Fla. 1st DCA 1977). As in Lester, Chapter 463 and the rules at issue here have been enacted in the interest of the public welfare and are generally to be liberally construed so as to advance that purpose. However, this "laudable question or purpose" does not justify a construction that would deny to Respondent the right to know in advance from a reading of the language what conduct is proscribed by the Legislature, and here, by the Board of Optometry. Id.

40. An agency interpretation of statutes and rules it administers is entitled to great deference. Childers v. Department of Environmental Protection, 696 So. 2d 962, 964 (Fla. 1st DCA 1997); see also Amisub (North Ridge General Hospital, Inc.,) d/b/a North Ridge Medical Center v. Department of Health and Rehabilitative Services, 577 So. 2d 648, 649 (Fla. 1st DCA

1991). However, this general statement of construction cannot prevail over a principle of law as firmly established in disciplinary proceedings of a penal nature, i.e., that the optometry practice act must be strictly construed in favor of the licensed certified optometrist.

41. Petitioner alleges that Respondent violated Section 463.016(1)(h), Florida Statutes, and Florida Administrative Code Rules 64B13-3.007(2)(f) and 64B13-3.010(10)(a), because he was required to perform a dilated fundus examination on J.P. during the January 1998 examination or failed to note any justification for not performing the examination in J.P.'s patient record.

42. During his January 1998, examination of J.P., Respondent performed all of the minimum procedures for vision analysis required in Florida Administrative Code Rule 64B13-3.007(2). Florida Administrative Code Rule 64B13-3.010(10)(a) establishes a specific standard of care dictating when and under what circumstances a certified optometrist is required to perform a dilated fundus examination, as opposed to other procedures. Thus, the two-year provision in Florida Administrative Code Rule 64B13-3.007(4) does not apply.

43. Florida Administrative Code Rules 64B13-3.007(2)(f) and 64B13-3.010(10)(a) set forth the standard of care applied in this case and only required Respondent to perform a dilated fundus examination during J.P.'s initial visit or presentation in 1998

and, thereafter, only whenever medically indicated. The weight of the evidence proves that given the good condition of J.P.'s health in January of 1998, as explained to and understood by Respondent, a dilated fundus examination was not "medically indicated" nor was this his "initial presentation."

44. Further, the clear meaning of the second sentence of Subsection (10)(a) required Respondent to note in J.P.'s medical record his reason(s) for not performing the dilated fundus examination only if the examination was not performed because of J.P.'s age or physical limitations or conditions. These situations are absent here. Thus, Subsection (10)(a) did not require Respondent to note in J.P.'s record why he did not perform a dilated fundus examination on J.P. in January of 1998.

45. One additional point merits discussion. The court noted in Breesmen that "[b]asic due process requires that a professional or business license not be suspended or revoked without adequate notice to the licensee of the standard of conduct to which he or she must adhere. The opinions of the expert witnesses offered by the parties cannot make certain, after-the-fact, those standards of conduct that are not clearly set forth in the statute or a rule." Breesmen, 567 So. 2d at 471.

46. The Board may choose within its statutory authority to amend its rules to require certified optometrists to perform the

dilated fundus examination more frequently and under different circumstances. For example, if appropriate and if considered and adopted pursuant to the requirements of Chapter 120, Florida Statutes, the Board may choose to adopt Dr. Lawson's position. However, Dr. Lawson's opinions are not reasonably derived from the statute and rules at issue. As noted herein, the weight of the evidence does not support his position nor the bases for his position in this case. To the extent Dr. Lawson's testimony is offered to support a non-rule policy, it is rejected. See Section 120.57(1)(e), Florida Statutes. It would not be appropriate for the Board to create and apply a new standard of care after-the-fact as a basis for discipline in this case. See Section 120.54(1)(f), Florida Statutes ("An agency may not adopt retroactive rules, including retroactive rules intended to clarify existing law, unless that power is expressly authorized by statute.")

47. Petitioner did not prove its case against Respondent by clear and convincing evidence. The Amended Administrative Complaint should be dismissed.

RECOMMENDATION

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

RECOMMENDED that the Amended Administrative Complaint filed against Respondent be dismissed with prejudice.

DONE AND ENTERED this 6th day of December, 2000, in Tallahassee, Leon County, Florida.

CHARLES A. STAMPELOS
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
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 6th day of December, 2000.

ENDNOTE

1/ The parties stipulated to these issues of fact remaining to be litigated which have been rephrased slightly. Joint Exhibit Number 1.

COPIES FURNISHED:

Stewart E. Parsons, Esquire
101 North Madison Street
Quincy, Florida 32351

Deborah B. Loucks, Esquire
Agency for Health Care Administration
Post Office Box 14229
Mail Stop 39
Tallahassee, Florida 32317-4229

Dr. Robert G. Brooks, Secretary
Department of Health
4052 Bald Cypress Way, Bin A00
Tallahassee, Florida 32399-1701

Joe Baker, Jr., Executive Director
Board of Optometry, Department of Health
4052 Bald Cypress Way
Tallahassee, Florida 32399-1701

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.