STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner,	)	
vs.	)	Case No. 00-4747PL
LELAND M. HELLER, M.D., Respondent.	)	

RECOMMENDED ORDER

The parties having been provided proper notice, Administrative Law Judge John G. Van Laningham of the Division of Administrative Hearings convened a formal hearing of this matter in Okeechobee, Florida, on March 13, 2001. The hearing was adjourned on March 14, 2001.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues in this case relate to whether Respondent is guilty of charges that Petitioner has brought against him under Sections 458.331(1)(t), (q), and (m), Florida Statutes, based on allegations that in treating a young patient, Respondent failed to practice medicine with the requisite level of care; inappropriately prescribed excessive quantities of medications; and failed to keep medical records that justified his treatment decisions.

PRELIMINARY STATEMENT

On September 28, 2000, Petitioner Department of Health (the "Department") filed a three-count Administrative Complaint against Respondent Leland M. Heller, M.D. ("Dr. Heller"). In this charging document, the Department accused Dr. Heller of having committed several offenses which, if proved, would warrant the suspension or revocation of his medical license, the imposition of an administrative fine, other discipline such as probation, or some combination of these or other penalties.

The charges stemmed from Dr. Heller's treatment of a young child named J.B. during a 36-day period in the autumn of 1998. Succinctly stated, the Department alleged that in treating this boy Dr. Heller had failed to practice medicine with the level of care, skill, and treatment recognized by a reasonably prudent similar physician as being acceptable under similar conditions

and circumstances; prescribed legend drugs other than in the course of his professional practice; and failed to keep legible medical records that justified the course of his treatment of J.B. Dr. Heller disputed the factual allegations and demanded an administrative hearing, signing an Election of Rights form on October 9, 2000.

On November 27, 2000, the Department referred the matter to the Division of Administrative Hearings for further proceedings. Thereafter, in due course, a final hearing took place, as scheduled, on March 13 and 14, 2001.

At hearing, the Department called two witnesses: J.B.'s kindergarten teacher, Mrs. Glenda McBride; and, as its medical expert, Morteza Nadjafi, M.D. The Department also proffered four exhibits, each of which was received into evidence:
Dr. Heller's licensure file (Petitioner's Exhibit 1);
Dr. Heller's license certification (Petitioner's Exhibit 2);
Dr. Nadjafi's curriculum vitae (Petitioner's Exhibit 3); and
Dr. Heller's medical records for J.B. (Petitioner's Exhibit 4).

Dr. Heller presented two expert witnesses through their videotaped depositions. Each of his four exhibits, all of which related to these depositions, was admitted into evidence. They are: the videotape and transcript of the deposition of Dr. Joseph Talley (Respondent's Exhibit 1); Dr. Talley's curriculum vitae (Respondent's Exhibit 2); the videotape and

transcript of Dr. David Rooney's deposition (Respondent's Exhibit 3); and Dr. Rooney's curriculum vitae (Respondent's Exhibit 4).

At the final hearing, Dr. Heller moved to strike the testimony of the Department's expert witness, Dr. Nadjafi, on the ground that, as a board-certified psychiatrist, he is not a "similar physician" to family practitioner Dr. Heller, and therefore is legally incompetent to offer an opinion against Dr. Heller regarding the applicable standard of care under Section 458.331(1)(t), Florida Statutes. The Administrative Law Judge denied this motion, reasoning that Dr. Nadjafi's specialty affected the weight rather than the admissibility of his testimony, but granted the parties leave to file post-hearing memorandums on the subject, in view of its significance. Each side timely submitted a memorandum, and these were carefully reviewed. Being fully advised, the undersigned is satisfied that Dr. Nadjafi possessed sufficient expertise in Dr. Heller's specialty so as to render an opinion on the prevailing standard of care, see Section 766.102(2)(c)2., Florida Statutes, and thus there exist no grounds for reconsidering the ruling made at hearing.

The Transcript of the final hearing was filed with the Division on April 24, 2001. The parties timely filed proposed

recommended orders that were considered thoughtfully in the preparation of this Recommended Order.

FINDINGS OF FACT

The evidence presented at final hearing established the facts that follow.

1. Dr. Heller is a Florida-licensed physician who holds license number ME 0036675. A family practitioner in the small, rural community of Okeechobee, Florida, Dr. Heller is board-certified by the American Board of Family Practice.

I. Dr. Heller's Treatment of J.B.

2. On Monday, August 31, 1998, a mother brought her son J.B., then age five, to Dr. Heller's office. This visit was the first of six to Dr. Heller that J.B. and his mother would make over the next six weeks; five of those visits would take place in the 17 days from August 31 to September 16, 1998. This case is about Dr. Heller's treatment of J.B.

A. First Week

3. In taking J.B.'s medical history on August 31, 1998, Dr. Heller learned that from before the age of two the boy had presented behavioral problems and been difficult to control. When he was three years old, J.B. had been treated at a psychiatric hospital. Now J.B. was having difficulty paying attention in school, experiencing mood swings, and becoming easily irritated; he had been violent at home, too.

4. Dr. Heller discussed with J.B.'s mother the medications J.B. was currently taking, as well as the medications that J.B. had tried in the past, to determine whether those medications had been effective in controlling J.B.'s behavior. Dr. Heller learned that J.B. was currently taking ten milligrams of Adderall in the morning.[1] He noted that although the Adderall was not particularly effective, J.B.'s behavior worsened when the Adderall wore off. Additionally, J.B.'s mother had stopped giving her son his afternoon dose of Adderall because the medicine apparently suppressed his appetite, and he would not eat when taking it. J.B.'s mother also informed Dr. Heller that J.B. had taken Risperdal in the past, and this drug had helped a great deal.[2] She believed he had taken 0.5 milligrams of Risperdal twice a day. J.B. had never taken Prozac.[3]

5. During the visit, Dr. Heller talked with J.B. and observed his behavior. Pertinent parts of this discussion and evaluation are included in the doctor's notes. Dr. Heller recorded that J.B. was thin and extremely hyperactive. The child would not sit still for any length of time. J.B. also had difficulty speaking clearly, and his mother confirmed that he had speech and language delays. Dr. Heller wrote that J.B.'s reaction to any criticism was to want to hit someone.

6. After interviewing J.B.'s mother and examining J.B., Dr. Heller diagnosed J.B. preliminarily with several behavioral

and mental health problems, namely, attention-deficit hyperactivity disorder ("ADHD"), problems with violence, depression, rejection sensitivity, and possible dysthymia. He believed that J.B. might be bipolar and had concerns about the patient's low weight, which appeared to have been caused by Adderall. He thought that the boy might have some combination of hearing, speech, and language problems as well.

7. To control J.B.'s violent behavior, Dr. Heller started J.B. on 0.5 milligrams of Risperdal, twice a day, the same dose his mother recalled he had taken previously. Although Risperdal is often used as an anti-psychotic agent, it is also helpful in controlling violent behavior.

8. Dr. Heller continued J.B. on the same amount of Adderall that the boy was already taking, to improve his attention in class; prescribed Prozac for J.B., ten milligrams daily for five days to be followed by ten milligrams daily for five more days, to treat the child's depression and mood swings; and instructed J.B.'s mother to bring the boy back after eight days for another examination.

9. On Wednesday, September 2, 1998, J.B. developed a mild dystonic reaction for which he was treated with Benadryl at a local hospital's emergency room and sent home. An unwanted but tolerable side effect of certain drugs, a dystonic reaction is an involuntary, potentially dangerous, sometimes painful

contraction of the muscles, usually affecting the upper neck but occasionally striking other parts of the body. Risperdal most likely had caused J.B.'s reaction.

10. Based on the symptoms commonly associated with dystonic reactions——not to mention that J.B. was taken to the emergency room——the event must have frightened the boy and his family. There is no evidence, however, that J.B. was either in pain or in danger from this distressing side effect. When Dr. Heller was informed that day of his patient's condition and emergency treatment therefor, he scheduled an office visit with the child for the next day.

11. On September 3, 1998, J.B.'s mother brought J.B. to Dr. Heller's office as recommended to discuss the dystonic reaction. Despite Risperdal's side effect, the drug was working well, J.B.'s mother reported, and the patient "look[ed] much better" to Dr. Heller. He also noted that the "[c]hild like[d] taking Prozac, [which was] helping him a lot." Dr. Heller decided to continue the boy on these medicines plus the Adderall at the same dosages, and to add Cogentin, 0.5 milligrams twice a day, to control the dystonic reactions.[4]

12. Later that afternoon, J.B. returned to Dr. Heller's office complaining of weakness and nosebleeds. In response, Dr. Heller reduced J.B.'s morning dose of Risperdal to 0.25 milligrams and prescribed neosynephrine for the nose bleeds.

B. Second Week

13. Informed by telephone a few days later, on Sunday, September 6, 1998, that J.B.'s nosebleeds had re-occurred, Dr. Heller again advised using neosynephrine and applying pressure——neither of which had yet been tried.

14. Dr. Heller saw J.B. in his office the following Wednesday, September 9, 1998. He observed that the child seemed better behaved and had shown some improvement on Risperdal. During this visit, J.B.'s mother suggested that her son try Ritalin instead of Adderall, telling Dr. Heller that J.B. had done better with Ritalin in the past. Acting on this information, Dr. Heller prescribed slow-release Ritalin, 20 milligrams twice a day, in the place of Adderall. Because J.B. had not suffered another dystonic reaction——evidently the Cogentin was doing its job——Dr. Heller continued J.B. on Cogentin at 0.5 milligrams, twice a day, and instructed the boy to resume taking the originally-prescribed amount of Risperdal: 0.5 milligrams twice a day. He also directed that J.B.'s Prozac be increased to 20 milligrams daily. Dr. Heller asked J.B.'s mother to bring him back to the office in two weeks.

C. Third Week

15. Five days later, on Monday, September 14, 1998, Dr. Heller saw J.B. again. His mother reported that J.B. was doing much better in school——apparently the Ritalin was

helping——but he remained angry with and "hateful" to her at home. J.B. himself told Dr. Heller that his mother "irritate[d]" him. Armed with this data, Dr. Heller increased J.B.'s evening dose of Risperdal from 0.5 milligrams to 1.5 milligrams, continuing him on 0.5 milligrams of the drug in the morning. Dr. Heller also increased J.B.'s morning dose of Ritalin from 20 milligrams to 40 milligrams, while keeping the second dose constant at 20 milligrams. He continued J.B. on the same dosages of Prozac and Cogentin. Finally, Dr. Heller recommended family counseling and requested to see the boy again in two days.

16. When Dr. Heller next examined J.B. on Wednesday, September 16, 1998, the patient's mother reported that J.B. was doing better in school on the higher morning dose of Ritalin but was still having problems at home. Dr. Heller observed that the boy was poorly behaved but under control. He decided to stay the course and continue J.B. on the present combination of medicines, at existing dosages, with instructions to return after one month.

D. Fourth and Fifth Weeks

17. J.B. was not brought to Dr. Heller's office during the weeks of September 20 and September 27, 1998.

E. Sixth Week

18. Dr. Heller saw J.B. again on Monday, October 5, 1998. At this time, J.B. was reportedly doing well in school but not at home, where, according to his mother, J.B. expressed "[l]ots of anger towards [his] father"——to the point that she feared the father's visit at Christmas. J.B. had stopped taking his evening dose of Risperdal. The boy was still having some nosebleeds, and he had a rapid heartbeat. His psychological and behavioral problems continued, although his violent behavior was under control.

19. J.B.'s mother gave Dr. Heller a note from Mrs. Glenda McBride, J.B.'s teacher, in which Mrs. McBride had conveyed her concerns about J.B.'s failure to eat at school and his depressive behavior. To stimulate J.B.'s appetite, Dr. Heller prescribed Sinequan——which is an antidepressant that, as a side effect, can increase the user's appetite——at a dose of 25 milligrams, twice a day. He asked to see J.B. in three weeks.

20. As it happened, however, the October 5, 1998, visit was J.B.'s last to Dr. Heller's office. Around that time, the Florida Department of Children and Families ("DCF") became involved, apparently at the instance of J.B.'s older brother, a prison inmate who had accused their mother of overmedicating the boy. The record is empty of substantial competent evidence concerning DCF's investigation, findings, or interventions, if

any. What is clear, however, is that J.B.'s physician-patient relationship with Dr. Heller abruptly ended.

21. At hearing, J.B.'s kindergarten teacher recounted an out-of-court statement by the boy's mother informing her that J.B. had been taken off all medications except Ritalin effective October 6, 1998. After that date, according to Mrs. McBride, the child improved visibly in the classroom, where she had the opportunity to observe him until the end of January 1999, when J.B. moved away. The trier accepts Mrs. McBride's testimony as far as it goes——which is not as far as the Department would take it.

22. Specifically, neither Mrs. McBride's testimony nor any other evidence clearly and convincingly establishes that Dr. Heller's treatment of J.B. either failed, was deleterious, or would not have brought about an improvement in J.B.'s condition similar to that witnessed by Mrs. McBride if J.B. had remained in Dr. Heller's care beyond October 5, 1998. For one thing, Mrs. McBride's second-hand testimony regarding the purported change in J.B.'s mix of medicines as of October 6, 1998, is not, by itself, clear and convincing evidence of that fact; and, there was no persuasive direct evidence——e.g. the testimony of J.B.'s next treating physician——to corroborate her account or to explain what subsequent care and treatment, if any, were rendered. For another, there are any number of

reasons unrelated to medical care that could have caused or contributed to J.B.'s improvement which are not excluded by or inconsistent with the evidence in the record.[5] In sum, the trier expressly does not find, and affirmatively rejects any inference, that DCF "rescued" J.B. from Dr. Heller.

II. The Charges

23. In Count One of its Administrative Complaint, the Department accused Dr. Heller of failing to practice medicine with the requisite degree of care and skill, in violation of Section 458.331(1)(t), Florida Statutes, in four specific respects: (a) inappropriately prescribing excessive doses of medicine to J.B.; (b) failing to take a baseline electrocardiogram ("EKG") for J.B.; (c) failing to consult a family therapist or counselor for J.B.; and (d) failing to note in J.B.'s medical records information regarding the mental status examination of J.B. or any observations of his behavior in the office. At hearing, however, the Department withdrew the allegation that Dr. Heller had negligently failed to order an EKG. Further, the Department's own expert testified that Dr. Heller's alleged failure to consult with a family therapist was not a breach of the standard of care; needless to say, Dr. Heller's experts agreed. Thus, the alleged negligent acts described in (a) and (d) above are the ones that remain in dispute.[6]

24. In Count Two, the Department charged Dr. Heller with prescribing legend drugs other than in the course of his professional practice, in violation of Section 458.331(1)(q), Florida Statutes, based on the following allegations:

> a. On or about August 31 and September 9, 1998, [Dr. Heller] ordered an automatic 10 mg. increase in Patient J.B.'s Prosac [sic] prescription without allowing an appropriate amount of time for the medicine to take effect
>
> b. On or about September 14, 1998, [Dr. Heller] increased Patient J.B.'s morning dose of Ritalin from 20 mg. to 40 mg. in one jump;
>
> c. From on or about August 31, 1998 to on or about September 14, 1998, [Dr. Heller] increased Patient J.B.'s dose of Risperdal to a total of 2 mg. a day despite the fact that Patient J.B. suffered an earlier dystonic reaction;
>
> d. On or about October 5, 1998, [Dr. Heller] prescribed Sinnequan [sic] to Patient J.B. in an effort to increase his appetite despite the fact that Patient J.B. was already suffering from the side effects of his other medications;
>
> e. From on or about August 31, 1998 to on or about October 8, 1998, [Dr. Heller] prescribed excessive doses of multiple medications without regard for the interactions and side effects of the high doses on Patient J.B.

At hearing, the Department withdrew the allegation, set forth in (a) above, regarding the purportedly excessive increase in J.B.'s Prozac.

25. The Department alleged in Count Three of its Administrative Complaint that Dr. Heller had violated Section 458.331(1)(m), Florida Statutes, by failing to keep medical records that justified the following alleged misconduct: (a) his prescribing of excessive doses and multiple medications to J.B.; (b) his failure to take a baseline EKG for J.B.; (c) his failure to consult a family therapist; and (d) his failure to note in J.B.'s medical records information regarding the mental status examination of J.B. or any observations of the patient's behavior in the office. For the reasons set forth in paragraph 23 above, the records dispute has boiled down to the alleged deficiencies described in the foregoing clauses (a) and (d).

III. The Standard of Care

26. At hearing, the Department agreed that the standard of care against which Dr. Heller's conduct must be measured is that level of care, skill, and treatment which is recognized by a reasonably prudent family practitioner as being acceptable under similar conditions and circumstances. The Department disavowed any intent to hold Dr. Heller to the standard of care governing psychiatrists.

27. In its proposed recommended order, however, the Department has asserted that Dr. Heller provided psychiatric treatment to J.B., and that, consequently, a board-certified

child psychiatrist should be considered a "similar health care provider." This contention is somewhat, if not entirely, inconsistent with the stipulation at hearing regarding the applicable standard of care; at the very least, it muddies the water.

28. The greater weight of the evidence shows that mental illnesses and behavioral problems such as J.B.'s are conditions that reasonably fall within the discipline of family practice, and that specialists such as Dr. Heller may appropriately diagnose and treat the mentally ill without thereby engaging in the specialized practice of psychiatry.[7] As a matter of fact, therefore, the relevant standard of care in this case is that applicable to small-town family practitioners.

29. The evidence regarding the appropriate standard of care is in conflict. The Department's expert, Dr. Morteza Nadjafi, is a board-certified child psychiatrist who practices in the large city of Orlando, Florida. Based primarily on the medical records that Dr. Heller prepared and without having discussed the case with Dr. Heller himself, Dr. Nadjafi found much to criticize in Dr. Heller's treatment of J.B. Broadly speaking, it is Dr. Nadjafi's opinion that, in caring for——and in documenting his treatment of——J.B., Dr. Heller repeatedly fell short of the minimal standard of care for any physician, irrespective of specialty.

30. On the other hand, Dr. Heller's experts opined that Respondent treated J.B. with the requisite level of care expected of a reasonably prudent family practitioner. They were: Dr. Joseph Talley, author of a textbook entitled Family Practitioner's Guide to the Treatment of Depressive Illnesses that was favorably reviewed in the New England Journal of Medicine, a board-certified family practitioner who regularly treats mentally ill patients in the small North Carolina town where he works; and Dr. David Rooney, a board-certified psychiatrist who presently specializes in treating adults and geriatric patients, whose background includes a one-year, post-graduate internship in family practice that was followed by about a year's employment as a family practitioner in a rural community in Iowa.

31. As the trier of fact and arbiter of credibility, the Administrative Law Judge must resolve the evidential conflict regarding the acceptable degree of care and Dr. Heller's failure or success in practicing with it. Accordingly, the trier has carefully considered the substance and foundations of the several experts' opinions as well as their respective demeanors, testimonial inconsistencies, and possible biases, ultimately determining the appropriate weight to be given each witness's testimony. On balance, all factors considered, the trier believes that Dr. Heller's witnesses painted a more accurate

picture of the relevant standard of care.[8] Of the three experts, Dr. Talley's testimony was the most persuasive because his specialty, community, and practice are the most similar to Dr. Heller's.

IV. Ultimate Factual Determinations

32. In treating J.B., Dr. Heller did not fail to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. To the contrary, Dr. Heller's care and treatment of a difficult patient more likely than not exceeded the relevant standard of care and probably reflected above-average skill for a family practitioner in a small town where there is (according to the Department's expert) no local psychiatrist.

33. The Department failed to adduce clear and convincing evidence that Dr. Heller prescribed drugs to J.B. inappropriately or in excessive or inappropriate quantities, either negligently in violation of the applicable standard of care or (it follows from the foregoing) in amounts that no reasonable physician could justify as medically appropriate. If the Department had proved the latter clearly and convincingly, then the trier would have been allowed to presume that the doctor had prescribed drugs outside the course of his medical practice in violation of Section 458.331(1)(q), Florida

Statutes. As it is, however, the greater weight of the evidence shows that Dr. Heller prescribed drugs for J.B. in appropriate quantities, for medically justifiable purposes. Further, the evidence is overwhelming——indeed, is clear and convincing——that Dr. Heller's treatment of J.B. took place in the course of his professional practice.

34. Dr. Heller's medical records pertaining to J.B. were legible; they properly identified the responsible physician (Dr. Heller) by name and professional title; and, as a preponderance of evidence demonstrates, they justified the course of treatment that Dr. Heller rendered to J.B. Dr. Heller not only exercised reasonable care under the circumstances in preparing these records, but also he obeyed the statutory directives regarding record-keeping set forth in Section 458.331(1)(m), Florida Statutes. The Department's evidence to the contrary is not clear and convincing.

CONCLUSIONS OF LAW

35. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

36. Section 458.331(1), Florida Statutes, sets forth the acts that constitute grounds for which doctors may be disciplined. Among the described offenses are the following:

(m) 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.

* * *

(q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

* * *

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited

> to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $25,000 each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. 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.

Section 458.331(1), Florida Statutes.

37. If the Board of Medicine finds a physician guilty of any of the statutorily proscribed acts, including those mentioned above, it may enter an order imposing one or more of the following penalties:

> (a) Refusal to certify, or certification with restrictions, to the department an application for licensure, certification, or registration.
> (b) Revocation or suspension of a license.
> (c) Restriction of practice.
> (d) Imposition of an administrative fine not to exceed $10,000 for each count or separate offense.
> (e) Issuance of a reprimand.
> (f) Placement of the physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, to attend continuing education courses, to submit to

> reexamination, or to work under the supervision of another physician.
> (g) Issuance of a letter of concern.
> (h) Corrective action.
> (i) Refund of fees billed to and collected from the patient.
> (j) Imposition of an administrative fine in accordance with s. 381.0261 for violations regarding patient rights.

Section 458.331(2), Florida Statutes.

38. A proceeding to suspend, revoke, or impose other discipline upon a professional license is penal in nature. State ex rel. Vining v. Florida Real Estate Commission, 281 So. 2d 487, 491 (Fla. 1973). Accordingly, to impose discipline, the Department must prove the charges against Dr. Heller by clear and convincing evidence. Department of Banking and Finance, Div. of Securities and Investor Protection v. Osborne Stern & Co., 670 So. 2d 932, 935-36 (Fla. 1996)(citing Ferris v. Turlington, 510 So. 2d 292, 294-95 (Fla. 1987)); Nair v. Department of Business & Professional Regulation, 654 So. 2d 205, 207 (Fla. 1st DCA 1995).

39. In Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983), the Court of Appeal, Fourth District, canvassed the cases to develop a "workable definition of clear and convincing evidence" and found that of necessity such a definition would need to contain "both qualitative and quantitative standards." The court held that

> clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking 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.

Id. The Florida Supreme Court later adopted the fourth district's description of the clear and convincing evidence standard of proof. Inquiry Concerning a Judge No. 93-62, 645 So. 2d 398, 404 (Fla. 1994). The First District Court of Appeal also has followed the Slomowitz test, adding the interpretive comment that "[a]lthough this standard of proof may be met where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous." Westinghouse Electric Corp., Inc. v. Shuler Brothers, Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991), rev. denied, 599 So. 2d 1279 (1992)(citation omitted).

40. Whether Dr. Heller failed to practice medicine with reasonable skill and safety and committed the other wrongful acts of which he stands accused are questions of fact for the trier to resolve——not issues of law. See Hoover v. Agency for Health Care Administration, 676 So. 2d 1380, 1384 (Fla. 3d DCA 1996). As set forth in the preceding Findings of Fact, the trier has determined as matter of ultimate fact that the

Department failed to establish, by the requisite level of proof, that Dr. Heller is guilty as charged.

41. There is one legal issue that merits further discussion. Based on the same alleged over-prescribing of drugs to J.B., the Department accused Dr. Heller of professional negligence in violation of Section 458.331(1)(t), Florida Statutes, and also of prescribing legend drugs "other than in the course of [his] professional practice," in violation of Section 458.331(1)(q). Given the identity of the conduct underlying both charges, it is important to point out that Section 458.331(1)(q) does not target "mere" negligence but rather proscribes a different form of misconduct.

42. The wrongdoing that Section 458.331(1)(q) seeks to prevent, it bears repeating, is "prescribing . . . a legend drug . . . other than in the course of the physician's professional practice." (Emphasis added). The underlined language is the gravamen of the offense.[9] To establish guilt, the Department must prove that the accused doctor was not practicing medicine when he prescribed the drugs in question but instead was engaged in an illicit (and probably oftentimes criminal) activity, e.g. selling narcotics to a "patient" who was not really sick but wanted the drugs for recreational purposes. No other subpart of Section 458.331(1), it may be seen, generally proscribes this type of physician misbehavior.[10]

43. To help the Department prove this offense, the legislature has provided a presumption, which arises when the Department demonstrates that the accused doctor prescribed drugs "inappropriately or in excessive or inappropriate quantities[.]" Section 458.331(1)(q), Florida Statutes. In that event, it may be "legally presumed" that the doctor was not acting in the course of his or her professional practice, "without regard to his or her intent." Id.

44. From the plain language of Section 458.331(1)(q), considered as a whole, it is clear that the terms "inappropriate" and "excessive," taken in context, do not refer to simple breaches of ordinary and reasonable care. Such negligence is the province of Section 458.331(1)(t).

45. Supporting this interpretation is the common sense observation that there is no logical connection between an ill-advised prescription resulting from negligence and the conclusion that the negligent physician was operating outside the course of his medical practice. It is an undeniable and commonly-known fact of the human condition that all doctors make a mistake now and again, and some doctors' mistakes unfortunately cause harm, for which the law provides redress. But reasonable people do not ordinarily conclude that a negligent doctor must have made his mistake other than in the course of his medical practice. To the contrary, the natural

and normal assumption when contemplating medical malpractice is that the wrong occurred while the doctor was practicing medicine. (Conversely, it is counterintuitive to conceive of a doctor's dispensing drugs outside the course of his medical practice as a form of professional negligence; this is a wrongful act, to be sure, deserving of censure and sanction without question, but not one commonly thought of as malpractice.)

46. Further, if the terms "inappropriate" and "excessive" were construed to embrace all prescription practices that fall short of that which reasonable care requires under the circumstances, then the presumption of guilt effectively would re-define and become the offense, and Sections 458.331(1)(q) and 458.331(1)(t) would be practically indistinguishable. Because the legislature presumably did not intend that Section 458.331(1)(q) be subsumed by Section 458.331(1)(t)——which would make the former redundant——it follows that the presumption of guilt should not arise from proof of mere negligence.

47. The Department has proposed a novel solution to the redundancy problem. It contends that whether a prescription is inappropriate or excessive should be determined based on a universal standard of care——the same for all doctors, regardless of specialty.[11] This would, of course, distinguish Section 458.331(1)(q) from Section 458.331(1)(t), but in a potentially

anomalous way. A doctor could be deemed to have exercised reasonable care in compliance with Section 458.331(1)(t) but be found in violation of the "universal" standard under Section 458.331(1)(q) and punished for prescribing outside the course of his medical practice! That cannot have been the legislature's intent.

48. To have relevant meaning in reference to the offense of prescribing drugs outside the scope of a medical practice, then, the words "inappropriate" and "excessive" should be understood to connote prescription practices that are an abuse of professional discretion, that is, so far beyond the pale that no reasonable physician could justify them. Put another way, if reasonable physicians can disagree about whether the prescription in question was inappropriate or excessive, then the presumption is not warranted, and the Department must prove a charge under Section 458.331(1)(q) with other evidence that the doctor was acting outside the course of his professional practice.[12]

49. Here, the Department failed to prove, clearly and convincingly, either a "universal" standard of care respecting the prescriptions at issue (assuming for argument's sake that such is relevant, as the Department urges) or that Dr. Heller's treatment decisions were an untenable abuse of professional judgment. Further, at any rate, as set forth above, the trier

has determined based on the totality of the evidence that Dr. Heller in fact treated J.B. in the course of his professional practice.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, the Department having failed to prove the charges brought against Dr. Heller by clear and convincing evidence, it is RECOMMENDED that the Board of Medicine enter a final order dismissing the Administrative Complaint.

DONE AND ENTERED this 12th day of June, 2001, in Tallahassee, Leon County, Florida.

JOHN G. VAN LANINGHAM
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 12th day of June, 2001.

ENDNOTES

[1]/ Adderall is a stimulant used to treat attention deficit disorder and hyperactivity. It is a legend drug as defined by Section 465.003(7), Florida Statutes. This medicine's side effects include facial tics and a decrease in appetite.

[2]/ Risperdal is a legend drug as defined by Section 465.003(7), Florida Statutes. Risperdal contains risperdone and is an anti-psychotic medication that is used for aggressive behavior, hallucinations, delusions, and schizophrenia. The side effects of Risperdal are akathisia (a severe state of restlessness and agitation), dystonic reaction (a form of muscle contraction), and Parkinsonism (a level of stiffness where one has a "mask" face and cannot smile or show expression).

[3]/ Prozac is a legend drug as defined by Section 465.003(7), Florida Statutes. Prozac is classified as a serotonin uptake inhibitor and is used for treatment of depression, anxiety, panic attacks, obsessive-compulsive disorder, and behavior disturbances. The side effects of Prozac are sleepiness, sedation, dry mouth, decrease in appetite, nausea, potential vomiting, and tremors.

[4]/ Cogentin is a legend drug as defined by Section 465.003(7), Florida Statutes, that is given to counteract a number of side effects collectively referred to as "extrapyramidal" symptoms, one of which is dystonic reaction. Side effects of this medicine are increased temperature and dry mouth.

[5]/ For example, if DCF removed J.B. from his mother's custody and placed him with another family member or in foster care, or provided some other assistance to J.B.'s mother that improved the family's home life, this might have accounted for the child's improvement at school. The record does not tell the whole story, and hence the evidence is inconclusive.

[6]/ The alleged negligent act described in clause (d) is repeated in Count Three of the Administrative Complaint as a basis for the records charge brought under Section 458.331(1)(m), Florida Statutes. See paragraph 25, infra. Interestingly, the Department argues in its proposed recommended order, as it did at hearing, that violations of Section 458.331(1)(m) are not to be determined with reference to the standard of reasonable care that obtains in the application of Section 458.331(1)(t) because "the standard of care for medical records is the same for all physicians." If this were true, then a particular doctor, preparing a medical record with all the skill and care that Section 458.331(1)(t) requires, could nevertheless violate the (presumably) stricter standard imposed by Section 458.331(1)(m).

This apparent anomaly is readily resolved. The Department is partially correct: the standard of care applicable under

Section 458.331(t) is irrelevant to Section 458.331(m). Where the Department has erred is in urging that a "standard of care" analysis is necessary in the application of Section 458.331(m). The record-keeping offense plainly is not a "standard of care" violation but rather a failure to follow a fairly specific statutory mandate. Indeed, expert testimony should not be needed in most instances to establish the violation, except to explain medical terms of art.

All that being said, the Department's decision to charge Dr. Heller with malpractice under Section 458.331(1)(t) based in part on purported record-keeping deficiencies was a questionable strategy but of little moment here, since the Department failed to prove that Dr. Heller negligently prepared his medical records.

[7]/ Moreover, the Department did not charge Dr. Heller with "performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform," in violation of Section 458.331(1)(v), Florida Statutes.

[8]/ As an aside, it should be noted that Dr. Heller did not have the burden to establish the applicable standard of care, although he did so by the greater weight of the evidence. Rather, because the Department must prove its case by clear and convincing evidence, Dr. Heller needed only to raise in the mind of the fact-finder, by evidence or argument, such doubt about the weight of the Department's proof as to produce a hesitance concerning the truth of the allegations sought to be established. In other words, to determine that the Department's proof was less than clear and convincing would not have required the trier to find, as it has, that Dr. Heller's experts, more likely than not, articulated the correct standard of care. Indeed, the Department's heavy burden is such that, in a given case, the trier could find that the Department has proved the relevant standard of care by a preponderance of the evidence and yet determine that the Department has failed to establish the doctor's alleged negligence. This point is made here solely to emphasize that in this case the trier is more than merely hesitant about the truth of the Department's allegations——which would have been sufficient to recommend disposition in favor of Dr. Heller——but instead deems Dr. Heller's version of the truth likely to be correct.

[9]/ The Department's rule establishing disciplinary guidelines, which informs licensees of the ranges of penalties that will routinely be imposed for the various statutory violations, summarizes the act prohibited by Section 458.331(q), Florida Statutes, as "[i]nappropriate or excessive prescribing." See Rule 64B8-8.001(2), Florida Administrative Code. This is not the offense, however, as the plain language of the statute makes clear. In this instance, the following caveat, stated in the rule, must be taken seriously: "The verbal identification of offenses are descriptive only; the full language of each statutory provision cited must be consulted in order to determine the conduct included." Rule 64B8-8.001(2), Florida Administrative Code.

[10]/ Several subparts aim to curtail the prescription of specific drugs. See Sections 458.331(1)(bb), (cc), (ee), and (ff), Florida Statutes.

[11]/ The Department's argument here is similar to its contention regarding the standard of care it urges should govern record-keeping violations. See note 6, supra.

[12]/ Because the presumption is not the offense, and since the presumption appears to be rebuttable (for the statute does not expressly make it conclusive), a doctor who has issued an indefensible prescription might still be able to disprove the presumed fact by demonstrating that his egregious error nevertheless occurred during the course and within the scope of his professional practice.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.