STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 01-1807PL
MAHESH ALLAM, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

On September 19, 2001, a formal administrative hearing was held in Lake Wales, Florida, before William F. Pfeiffer, a duly-appointed Administrative Law Judge, of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Ephraim D. Livingston, Esquire
Agency for Health Care Administration
Post Office Box 14229
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For Respondent: R. L. Caleen, Jr., Esquire
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STATEMENT OF THE ISSUE

Whether Respondent's license to practice medicine should be disciplined for the alleged violations as set forth in Petitioner's Administrative Complaint.

PRELIMINARY STATEMENT

By Administrative Complaint dated April 2, 2001, Petitioner, Department of Health, Board of Medicine, alleged that Respondent, Dr. Mahesh Allam, violated various provisions within Chapter 458, Florida Statutes, governing the practice of medicine in Florida. The Administrative Complaint sought an order imposing one or more penalties, including revocation or suspension of Respondent's medical license. The Complaint contained three counts relating to the medical care Respondent provided to patient W.B. on August 6, 1996.

In Count I of the Complaint, Petitioner alleged that Respondent failed to practice medicine with the level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar circumstances, as required by Subsection 458.331(1)(t), Florida Statutes. Specifically, Petitioner alleged that Respondent failed to see Patient W.B. for 11 hours despite the patients deteriorating condition; he failed to order appropriate tests to determine the cause of Patient W.B.'s deteriorating condition; he failed to order consultations for Patient W.B. with a cardiologist, pulmonologist or an intensivist; and he failed to order appropriate medications.

In Count II, Petitioner alleged that Respondent violated Subsection 458.331(1)(m), Florida Statutes, by failing to keep

written medical records justifying the course of treatment of Patient W.B. Specifically, Petitioner alleged that Respondent failed to document the reason for not ordering consultations, medications and/or the reason for not seeing Patient W.B. for 11 hours despite his deteriorating condition.

In Count III of the Complaint, Petitioner alleged that Respondent violated Subsection 458.331(1)(q), Florida Statutes, by inappropriately prescribing medications for Patient W.B. without seeing him and determining the cause of fever and delirium.

Respondent disputed the allegations in the Complaint and requested a formal hearing before an Administrative Law Judge of the Division of Administrative Hearings. On May 8, 2001, Petitioner forwarded the Complaint to the Division of Administrative Hearings. The case was initially set for August 1-3, 2001; however, a joint motion for continuance was granted and the hearing was reset for September 19-21, 2001.

On September 7, 2001, Respondent moved for a protective order concerning the depositions of Jack Giddings, M.D., and William Schmidt, M.D. The motion was denied.

At the final hearing on September 19, 2001, Petitioner presented the testimony of Vanessa McIntosh, a registered nurse; Stephen J. Nelson, a pathologist and medical examiner; and the depositions of William Schmidt, M.D., and Jack Giddings, M.D.,

in lieu of live testimony. Petitioner offered eight exhibits, including Patient W.B.'s complete medical records from the Lake Wales Medical Center, all of which were received into evidence.

Petitioner also offered a graphic representation of Patient W.B.'s vital signs and telephone calls between Respondent and the registered nurses attending to Patient W.B. at the Lake Wales Medical Center. This graphic was received in evidence, without objection, with the graphic representation prepared by Respondent as Respondent's Exhibit No. 2.

At the final hearing, Respondent testified on his own behalf and presented the expert testimony of Willard E. Manry, M.D., and Vincente S. Verzosa, M.D. Respondent offered four exhibits into evidence, all of which were admitted.

By stipulation, the parties agreed to file their proposed recommended orders within 30 days of receipt of the transcript of hearing. Their Proposed Recommended Orders were timely filed and have been carefully considered in the rendition of this Recommended Order.

FINDINGS OF FACT

Based on the testimony and documentary evidence presented at final hearing, and the entire record of this proceeding, the following findings of fact are determined.

Petitioner: Department of Health

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

Respondent: Dr. Mahesh Allam

2. Respondent, Dr. Mahesh Gandi Allam, is and has been at all times material to the allegations in the Administrative Complaint a licensed physician in the State of Florida, having been issued License No. ME 64990 on September 7, 1993.

3. Respondent earned his medical degree at the medical school of the University of the West Indies located at the University of London. He was employed for one year as the Medical Director at the University Hospital of West Indies in Kingston, Jamaica, followed by a three-year internal medicine residency at Howard University Hospital in Washington, D.C. Thereafter, he completed a two-year program fellowship at the same hospital.

4. After completing his formal education and training, Respondent began practicing medicine as a sole practitioner in Polk County, Florida, in 1993. On August 6, 1996, when he provided care and treatment to Patient W.B., Respondent was a sole practitioner. Currently, Respondent works with a group of four doctors employed by a professional corporation and

practices medicine in Lake Wales, Haines City and Winter Haven, Florida.

5. Respondent has had staff privileges and has treated Intensive Care Unit (ICU) patients at various hospitals including Heart of Florida, Lake Wales, and Winter Haven Hospitals since 1993.

6. Respondent has provided specialist consultations to area physicians on internal medicine and pulmonary medicine. He is board-certified in Internal Medicine.

Chronology of Events at Lake Wales Medical Center on August 6, 1996

7. According to Lake Wales Medical Center records, Patient W.B., a 42-year-old male, presented himself to the emergency room on August 6, 1996, at 6:45 a.m., with complaints of chills, fever, and an inability to take deep breaths. He indicated that his flu-like symptoms had begun four days earlier causing aching on both sides of his spine and cramping in his leg. He had experienced some diarrhea, no vomiting, no coughing, generalized muscle pain, leg pain, and was drinking fluids well.

8. He provided a medical history to the emergency room personnel of a past appendectomy and stated that he smoked two and one-half packs of cigarettes a day, drank two beers a day and had a family history of hypertension. The initial physical exam by emergency room staff at 6:55 a.m. revealed the

following: blood pressure of 100/56, pulse of 112-114/minute, respiration rate of 28-32/minute, temperature of 97.7 degrees, oxygen saturation of 99 percent, tachycardia (increase in heart rate above normal), tympany over the left lower lung fields and left upper quadrant, muscle tenderness bilaterally and good distal perfusion. A chest X-ray and an electrocardiogram (EKG) were ordered, and blood and urine samples were collected for laboratory analysis.

9. After a review of the lab results and other clinical data, the attending emergency room physician formed initial impressions consisting of dehydration, pancreatitis, R/O prerenal (renal failure), R/O Hepatitis, R/O UTI and thrombocy topenia.

10. At approximately 8:00 a.m., Respondent was called to the emergency room to attend to Patient W.B. Respondent had no previous knowledge of Patient W.B., but was selected from a hospital physician roster by the Emergency Room physician.

11. Respondent arrived at the Emergency Room at approximately 8:30 a.m., examined Patient W.B., reviewed his lab tests and advised the Emergency Room physician to admit him to the ICU.

12. Shortly thereafter, Respondent returned to the ICU, reassessed Patient W.B. and performed a thorough physical examination and evaluation. Respondent recorded Patient W.B.'s

chief complaint, current illness, past medical history, medications ingested, allergies, family history, and social history. Under social history, Respondent noted that Patient W.B. had a history of drinking one six-pack of beer each day but had stopped since the onset of the symptoms. Respondent indicated that Patient W.B. looked slightly ill with acute cardiopulmonary distress.

13. Respondent recorded the following vital signs: temperature 97.7 degrees, pulse 124, respiratory rate 32, blood pressure 109/51. Patient W.B's chest trachea was central, with "good air entry bilaterally with no wheezes or rhonci audible." His heart sounds were normal and jugular venous pressure was not elevated. Under "peripheries," Respondent noted that there was no edema, with good pulses. The abdomen was soft and non-tender, with minimum epigastric and periumbilical tenderness and no guarding or rebound. His bowel sounds were normal. Under "neurological," Respondent noted that "Patient is slightly weak but alert and oriented to time, place and person," with no obvious cranial nerve, motor or sensory deficits.

14. Respondent, in his evaluation, identified his patient's significant lab results including: WBG 6.9; hemoglobin 14.4; platelets 73,000; and bands 13 percent. Chemistry lab results showed a BUN of 56, creatinine of 3.3, bicarbonate of 19, total bilirubin of 2.7, creatinine kinase of

1810, GGT of 139, AST 136, and amylase of 235. The urinalysis was positive for blood and nitrates with a trace of leukocytes and bacteria.

15. The Radiographic Report indicated that the chest X-ray and abdomen, supine and upright, were normal or unremarkable.

16. It was later determined that the lab results collected earlier at 7:10 a.m. showed no growth in the patient's urine culture, and no growth in his blood cultures after 48 hours. The sputum from the lung showed 3+ growth of normal oropharyngeal flora after 48 hours. The hepatitis profile for A, B and C were non-reactive.

17. Respondent's history and physical examination of Patient W.B., and his evaluation of the lab results produced four initial impressions with four diagnoses:

1. Urinary tract infection with possible urosepsis;
2. Dehydration with prerenal azotemia;
3. Rhabdomyolysis; and
4. Pancreatitis.

18. Respondent's first diagnosis, urosepsis, was based on the patient's urinary tract infection which may lead to an infection in the blood. The second diagnosis was based on evidence that the patient was severely dehydrated, causing renal failure, i.e. prerenal azotemia. The third diagnosis, rhabdomyolysis, is indicative of massive muscle skeletal breakdown which leads to elevated creatine kinase as found in

Patient's lab that morning. The fourth diagnosis, Pancreatitis, relates to inflammation of the pancreas, as evidenced by Patient's abnormal amylase level and possible abnormal liver enzymes.

19. Respondent initiated the following plan of treatment to address the tentative diagnoses:

> 1. Patient will be admitted to Intensive Care Unit;
> 2. He will be started on aggressive hydration with IV fluids;
> 3. Clear liquids only to control Pancreatitis;
> 4. Septic screen followed by antibiotics for urinary tract infection. Patient most likely has a benign prostatic hypertrophy which will be investigated once patient's acute medical condition has resolved. Further therapy will be dictated on patient's clinical response.

Respondent's initial plan of care required the ICU registered nurses to monitor Patient W.B.'s vital signs, including temperature, pulse, respiratory, blood pressure and oxygen saturation rates, and stabilize him according to his orders.

Initial Orders by Respondent

20. At approximately 8:40 a.m., Respondent provided detailed orders to the nurses which included the following:

> 1. intravenous fluid hydration at 200 cc per hour for three liters, to correct the hydration;
> 2. monitor intake and output (I & O);
> 3. collect two sets of blood and send for cultures to identify any abnormalities in the blood system and liver;

4. obtain urine sample for culture and sensitivity;
5. obtain (by respiratory therapy) sputum for culture and sensitivity and gram stain;
6. obtain stool sample for gram stain, culture and sensitivity to look for infectious sites;
7. obtain abdominal x-ray, flat plate and upright, to ensure no complicating factors in abdomen which may lead to Pancreatitis;
8. test for serum lipase which is an enzyme elevated in Pancreatitis;
9. provide oral diet of clear fluids as tolerated, because a patient with Pancreatitis may not tolerate solid food; and
10. obtain a PT, PTT, hepatitis profile.

21. At approximately 10:00 a.m., Respondent ordered Bactrim, an antibiotic, to combat any sepsis. He ordered clear liquids and continuous IV fluids.

22. At approximately 11:00 a.m., Patient W.B. complained of shortness of breath. The ICU nurses and Respondent examined his lungs with a stethoscope which were unremarkable. Patient W.B's oxygen saturation was normal at 98 percent and his temperature was within normal range at 100 degrees.

Respondent Returns to Office Practice

23. At approximately 11:10 a.m., Respondent departed the hospital and headed for his office practice which was approximately 25-30 minutes from the Lake Wales Medical Center. He intended to manage Patient W.B. by phone until he returned to the ICU later that evening for his re-evaluation. Respondent testified that he normally re-evaluated all of his hospital

patients at the end of the day and completed his rounds at approximately 9:00 p.m. each night.

24. Phone management of patients at Lakes Wales Medical Center, a small-town hospital, was a common and necessary practice. While the hospital's ICU did not have a physician present at all times, Respondent testified that it was not practical for a doctor to remain in the ICU all day and all night. Petitioner's expert, Dr. Jack Giddings, agreed and stated, "The alternative to that would be for the physician to live in the hospital. How can you possibly object to it?"

25. The Lake Wales Medical Center contained six ICU patient beds, with one nurse to every two patients. Vanessa McIntosh, a registered nurse, attended to Patient W.B. during the 7:00 a.m. to 3:00 p.m. shift, while Nurse S. Long attended to him during the 3:00 p.m. to 11:00 p.m. shift.

26. Attending nurses in the ICU carefully monitor and record each patient's condition in their Nurse's Progress Notes. They regularly record patient vital signs including temperature, blood pressure, respirations, oxygen saturation and pulse. In addition, communications with the attending physician, including phone orders, and nurse actions are recorded.

Clinical Course of Patient W.B.

27. Through 10:00 a.m., while Respondent was present at the hospital, Patient W.B.'s vital signs were reasonably

consistent. His heart rate was 114/minute, his respirations were 24/minute, his blood pressure was 90/66 and his oxygen saturation rate was 93 percent.

28. Over the next several hours, Patient W.B.'s mental and physical status deteriorated. He became extremely anxious and agitated, required additional sedation and restraint, and his vital signs increasingly fluctuated in the abnormal range.

29. At approximately 12:55 p.m., Patient W.B.'s heart rate had risen to 143/minute, his respirations had nearly doubled to 39/minute, his blood pressure had increased to 108/96, and his oxygen saturation was at or slightly above 90 percent. In addition, the patient became increasingly anxious and was hyperventilating.

30. At approximately 1:00 p.m., Nurse McIntosh, the attending registered ICU nurse, was concerned and paged the Respondent at his office practice. Nurse McIntosh testified that the ICU nurses had a policy of contacting the attending physician to convey concerns about their patient, alert a change in their patient's condition, receive medication directives, provide patient status reports and lab results and to ask questions. She indicated that if the attending physician was needed immediately, the doctor was paged using the code "stat."

31. By 1:15 p.m., the Respondent had not returned her page so Nurse McIntosh, again, paged Respondent to alert him of

Patient W.B's change in status. At 1:30 p.m., Nurse McIntosh paged the Respondent for the third time. Patient W.B.'s vital signs were increasingly abnormal; he remained extremely anxious and was hyperventilating. Nurse McIntosh did not, however, page Respondent "stat" because she believed that Patient W.B.'s condition was not "seriously deteriorating."

32. At approximately 1:35 p.m., Respondent returned Nurse McIntosh's third page, received his patient's change in status over the telephone, and ordered sedatives ("Ativan" 2 mg IV push, and "Librium" 10 mg) to settle him. Respondent also ordered the lab to immediately draw arterial blood gases (ABGs) to determine his metabolic condition, e.g., whether there was a severe metabolic acidosis, metabolic alkalosis, or other abnormalities in his pH, and whether he was receiving adequate oxygen and the extent of oxygen saturation.

33. Respondent indicated that the results were important to determine whether Patient W.B. required intubation and a ventilator, and whether he required bicarbonate supplementation to correct the metabolic acidosis.

34. At approximately 1:40 p.m., ABGs were drawn and at 2:00 p.m., the results were relayed to Respondent. Patient W.B.'s oxygen saturation rate was borderline normal and his pH was in the normal range. Although he had difficulty breathing, he was maintaining his own oxygenation without the need for

immediate intubation and a ventilator. Respondent believed that Patient W.B. was tending toward mild metabolic acidosis and that his condition was common with renal failure and rhabdomyolysis.

35. Respondent indicated that, thereafter, he developed a working diagnosis of delirium tremens (DTs), a sudden, severe deterioration of a patient's neurological function, causing the patient to become disoriented, confused and agitated. Potentially lethal, DT's occurs in a small percentage of patients who are undergoing alcohol withdrawal. Although the symptoms are often delayed until days after the withdrawal, they include fever, excessive sweating, tachycardia, hypertension or hypotension, hallucinations, agitation, confusion, fluctuating mental status, seizures, and combativeness.

36. Proper treatment for a patient afflicted with DT's includes supportive sedation, sufficient fluids, adequate oxygenation, maintenance of respiratory status, and close monitoring.

37. While Patient W.B. did not exhibit all of the symptoms of DTs, the overwhelming weight of the testimonial evidence suggested that the diagnosis was not unreasonable nor inconsistent with the patient's lab results, vital signs, and behavior. In fact, Petitioner's expert Dr. Schmidt, when asked at hearing to describe the symptoms of a patient suffering from DTs, responded:

> Those that this patient showed, including agitation, perhaps delirium, loose associations in terms of conversations, rapid heart beat, rapid respirations, more and more agitations, combativeness.

38. In addition, Respondent's expert, Dr. William E. Manry, who is Board-certified in Family Practice and has practiced in Lake Wales for over 50 years, reviewed Patient W.B.'s medical chart and opined:

> I think the evidence is substantive that it just about had to be that. Part of the answer is based on the fact that he admitted, I think, a six-pack of beer a day. Now if an alcoholic admits to a six-pack of beer a day, the actual total is somewhere around three times as much.

39. Dr. Vincente S. Verzosa, a Board-certified Internist who has practiced medicine in the Lake Wales area for 30 years, agreed. "From the time the patient was admitted, he gradually deteriorated, or he developed delirium -- delirium tremens -- most probably. I think it had something to do with his demise later that day."

40. Following the nurse's 2:00 p.m. patient status update, Respondent ordered an additional sedative for Patient W.B. to control his heightened agitation. Respondent also instructed the nurses to page him if physical restraints were needed to control the patient.

41. At 3:00 p.m., Nurse Long, R.N., began her shift and tended to Patient W.B.

42. At 3:30 p.m., she recorded that his vital signs had improved since the earlier episode, his oxygen saturation was 94 percent, and his respiration rate was 36/minute. She noted that Patient W.B., again complained that it was difficult for him to breathe.

43. Patient W.B.'s vital signs recorded between 3:45 p.m., 4:00 p.m., and 4:35 p.m. reflected a mild increase in heart rate (134 to 139), respirations steady at 36, oxygen saturation steady at 93 percent, and fluctuating blood pressure.

44. At approximately 5:05 p.m., Patient W.B.'s condition again deteriorated and Nurse Long paged the Respondent. She recorded that Patient W.B.'s oxygen saturation rate was varying between 85-96 percent, his respirations were labored and he needed respiratory treatment. His respirations had increased to 44 per minute, his heart rate escalated to 150 per minute, and he was hyperventilating.

45. At approximately 5:40 p.m., Respondent called Nurse Long and she alerted him of Patient W.B.'s status. Respondent ordered a restraint vest, Valium, 10 mg IVP, and maintenance of oxygen saturation at or above 90 percent.

46. Shortly thereafter, at approximately 5:45 p.m., Patient W.B.'s status worsened and Nurse Long again paged Respondent. She recorded in her notes that the Valium had been given for his restlessness, he had twice climbed out of bed,

pulled at his IV lines, and twice removed his EKG leads and blood pressure cuff. Moreover, the orderly was called twice to place the Patient back into bed and install the restraint. According to Nurse Long, Patient W.B. was "getting combative."

47. At approximately 6:30 p.m., Patient W.B. remained agitated and combative. Although Respondent had not returned Nurse Long's 5:45 p.m. page, she called Respiratory Services, located within the hospital, to assist and increase his oxygen saturation rate. However, when personnel attempted to place an oxygen mask on him, the patient resisted.

48. At approximately 6:35 p.m., Patient W.B.'s pulse had climbed to 163 per minute, his respirations increased to 48 and his oxygen saturation rate was critically low at 73 percent.

49. At approximately 6:55 p.m., Respondent was again paged, twice. Hospital staff placed an external re-breather on Patient W.B. and provided him with 100 percent oxygen.

50. At approximately 7:25 p.m., Respondent contacted Nurse Long and was advised of Patient W.B.'s severely deteriorating condition. Respondent ordered 20 mg Valium IV to combat his extreme agitation. Shortly thereafter, Respondent departed his office for the hospital in preparation for possible intubation.

51. At approximately 7:55 p.m., Patient W.B. stopped breathing and the "code" was called. The emergency room

physician and other health care personnel immediately assisted and attempted to intubate the patient.

52. At approximately 8:10 p.m., Respondent arrived on the scene and assisted the health care professionals.

53. At approximately 8:30 p.m., on August 6, 1996, Patient W.B. expired.

Autopsy

54. On August 9, 1996, the Medical Examiner performed an autopsy on Patient W.B. The examiner stated in his Autopsy Report that Patient W.B. had "a number of bacteria in his system at the time of his death," and determined that bacterial sepsis was the cause of his death.

55. However, as the Medical Examiner indicated in his Autopsy Report, the death of Patient W.B. "is somewhat problematic." In fact, much of the expert testimonial evidence questioned the accuracy of the examiner's determination that bacterial sepsis was the cause of Patient W.B.'s death. Specifically, they opined that his determination was inconsistent with the fact that Patient W.B.'s blood cultures, collected shortly before his death, showed no bacterial growth five days after his demise. Respondent suggests that it is likely that Patient W.B. suffered a respiratory arrest at that time, not a cardiac arrest, and that he was, in fact, undergoing a seizure which led to his cardiac arrest.

Alleged Violations

Count I: Deviations From The General Standard of Care

(a) Failure to Physically Reevaluate the Patient Earlier

56. Petitioner's experts, Drs. Schmidt and Giddings, testified that in their opinion the acceptable standard of care, under the circumstances, required Respondent to physically reevaluate Patient W.B. sooner. Their opinions are credible and persuasive. Subsequent to 11:55 a.m., Patient W.B.'s vital signs fluctuated significantly in the abnormal range. In fact, on at least eight separate occasions in approximately six hours, an ICU nurse paged Respondent to alert him of his patient's deteriorating status, yet Respondent chose to manage him solely by telephone.

57. While Respondent's working diagnosis of delirium tremens was not shown to be unreasonable or inappropriate, nor was Respondent ever paged "stat" by the ICU nurses, the evidence is clear and convincing that a reasonably prudent physician would have physically reassessed his ICU patient's dramatically fluctuating condition earlier than 8:10 p.m. Considering Patient W.B.'s increasingly erratic vital signs and abnormal behavior, the severity of his condition, the potential and recognized lethality of Respondent's working diagnosis, the repeated pages he received, and the credible and persuasive expert testimonial evidence, Respondent failed to practice

medicine with the level of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

58. It is concluded that Petitioner proved Count I of the Administrative Complaint, by clear and convincing evidence. The acceptable standard of care required Respondent to physically reevaluate Patient W.B. earlier than 8:10 p.m., approximately 20 minutes before his death.

(b) Failure to Obtain Consultations With Specialists

59. Both Dr. Schmidt, who practices in Miami, and Dr. Giddings, who practices in Jacksonville, admitted that they were unfamiliar with the medical specialists available in Polk County and the surrounding area.

60. Respondent expressed his feeling that there was no indication of a need to obtain a consultation from a cardiologist or other specialist because the Patient did not exhibit any signs of a cardiac condition. It is concluded that Petitioner failed to establish by clear and convincing evidence that the acceptable standard of care required Respondent to seek a consultation when such specialists were either not available in the area or not indicated by his patient's condition.

(c) Failure to Order Follow-up Tests

61. Dr. Schmidt testified that, in his opinion, Dr. Allam fell below the acceptable standard of care by not ordering

follow-up tests for potassium and platelets, and not ordering a brain CT and an abdominal ultrasound or CT scan which "might have provided useful information."

62. Respondent and Drs. Manry and Verzosa gave detailed opinions in opposition to Dr. Schmidt's and their opinions are credible and persuasive on this issue.

63. It is concluded that Petitioner failed to establish by clear and convincing evidence that the acceptable standard of care required Respondent, on that day, to order the follow-up tests suggested by Dr. Schmidt.

Count II: Failure to Keep Appropriate Medical Records

64. It is concluded that Petitioner failed to establish by clear and convincing evidence that Respondent failed to document and keep appropriate medical records justifying the patient's course of treatment.

Count III: Failure to Appropriately Prescribe Medications

65. It is concluded that Petitioner failed to establish by clear and convincing evidence that Respondent failed to appropriately prescribe medications to Patient W.B.

CONCLUSIONS OF LAW

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

67. Pursuant to Section 458.331(2), Florida Statutes, Petitioner, Department of Health, Board of Medicine, may revoke, suspend or otherwise discipline a physician's license for violations of Section 458.331(1) including:

> (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 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. . . .

68. License disciplinary proceedings are penal in nature. See State ex rel. Vining v. Florida Real Estate Commission, 281 So. 2d 487 (Fla. 1973). In this disciplinary proceeding, Petitioner seeks to impose penalties which include revocation or suspension of a physician's license, and must prove the truth of the allegations by clear and convincing evidence. Section 458.331(3), Florida Statutes (2001); see also Ferris v. Turlington, 510 So. 2d 292 (Fla. 1st DCA 1987); Department of Banking and Finance v. Osborne Stern, 670 So. 2d 932 (Fla. 1996).

69. Based on the foregoing findings of fact, Petitioner failed to establish by clear and convincing evidence that Respondent violated Subsections 458.331(1)(m) or (q), Florida Statutes (2001), as alleged in the Administrative Complaint.

70. However, based on the foregoing Findings of Fact, with respect to Count I, the alleged violation of Subsection 458.331(1)(t), Petitioner established, with extensive, credible, clear and convincing evidence, the general standard of care, skill and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar circumstances. Petitioner further established, by clear and convincing evidence that Respondent deviated from that level of care.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner enter a final order finding that: (1) Respondent DID NOT violate Subsections 458.331(1)(m)and(q), Florida Statutes, as alleged in the Administrative Complaint; and (2) Respondent DID violate Subsection 458.331(1)(t), Florida Statutes, as alleged in the Administrative Complaint and imposing the following sanctions:

a. an administrative fine of $5,000;

b. the performance of ten hours in continuing medical education in care of critical patients; and

c. issuance of a letter of concern.

DONE AND ENTERED this 20th day of February, 2002, in Tallahassee, Leon County, Florida.

WILLIAM R. PFEIFFER
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 20th day of February, 2002.

COPIES FURNISHED:

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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.