STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 02-0080PL
ANTHONY GLENN ROGERS, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on May 7, 2002, at West Palm Beach, Florida, before Administrative Law Judge Michael M. Parrish of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Kim M. Kluck, Esquire
Agency for Health Care Administration
Office of General Counsel
Post Office Box 14229
Tallahassee, Florida 32308

For Respondent: C. William Berger, Esquire
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STATEMENT OF THE ISSUES

This is a license discipline case in which the Petitioner seeks to take disciplinary action against the Respondent on the basis of charges set forth in a three-count Administrative

Complaint. The Administrative Complaint charges the Respondent with violations of subsections (m), (q), and (t) of Section 458.331(1) Florida Statutes.

PRELIMINARY STATEMENT

At the final hearing on May 7, 2002, the Petitioner presented the testimony of one expert witness (Dr. Chaitoff) and also offered three Petitioner's exhibits and one joint exhibit, all of which were received in evidence. At the final hearing, the Respondent testified on his own behalf and also presented the testimony of two additional witnesses (the subject patient and the patient's mother). The Respondent also offered five Respondent's exhibits, all of which were received in evidence. Following the final hearing on May 7, 2002, the Respondent also submitted the deposition testimony of an expert witness (Dr. Brookoff).

At the conclusion of the hearing, the parties were allowed 10 days from the filing of the transcript of the deposition of Dr. Brookoff within which to file proposed recommended orders. The deposition transcript was filed with the Division of Administrative Hearings on July 26, 2002. Thereafter, all parties filed timely proposed recommended orders containing proposed findings of fact and conclusions of law. The parties' proposals have been carefully considered during the preparation of this Recommended Order.[1]

FINDINGS OF FACT

1. At all times material to this case, the Respondent, Anthony Glenn Rogers, M.D., has been licensed, and continues to be licensed, to practice medicine in the State of Florida. His license number is ME 0062034. Dr. Rogers is a pain management specialist. Dr. Rogers is certified by the American Board of Anesthesia and the American Academy of Pain Management.

2. On October 20, 1998, Patient N. A. presented to the Respondent with complaints of chronic back pain following two motor vehicle accidents and three back surgeries. At that time Patient N. A. was an adult female approximately 32 years of age. Immediately prior to her presentation to the Respondent she had been treated for a period of approximately five months by Dr. Robert E. Lentz who, at that time, also specialized in pain management in the same geographic community as the Respondent.[2]

3. In May of 1998, Dr. Lentz's initial treatment plan for the Patient N. A. was as follows:

> There is no surgical procedure indicated nor is there any blocks indicated for this patient at this time. Medications will be the patient's mainstay of therapy. Therefore at this time we will renew her prescriptions with the following changes we will try to reduce the amount of Dilaudid for breakthrough pain by increasing her MS Contin from 60 mg. q.d. to 60 mg. b.i.d and the Dilaudid remaining for breakthrough pain. The patient will phone in a few days to update her progress on the new medication regimen.

4. When the Patient N. A. first presented to the Respondent, she was taking the following medications in an effort to relieve her chronic back pain: MS Contin, Dilaudid, Effexor, and Klonopin.

5. Prior to her treatment by Dr. Lentz and by the Respondent, the Patient N. A. had been treated for many years by physicians in the state where she previously resided. That treatment had included three back surgeries and numerous other invasive procedures for the purpose of trying to relieve her chronic back pain. Some of those prior invasive procedures had produced life threatening consequences. None of the prior invasive procedures had produced any beneficial effects. By the time the Patient N. A. presented to the Respondent, she was strongly opposed to any further surgical or other invasive procedures. Her opposition was based on her prior experiences which indicated that such procedures could be risky, could be painful, and in the past had not provided her with any benefit.

6. The Respondent's records of Patient N. A.'s first visit to his office indicate that he performed a physical examination of the patient, but the records do not document a complete physical examination. The documentation issue aside, the Respondent's initial physical examination of Patient N. A. was sufficient and appropriate under the circumstances. The history

memorialized in the Respondent's records of his initial consultation with Patient N. A. was sufficient and appropriate.

7. In the care and treatment of a patient who presents with the history, signs, and symptoms, presented by the Patient N. A. on her initial presentation, the level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances requires that the initial physical examination of the patient include a neurological or reflex assessment and a range of motion examination. The Respondent's medical records of the initial presentation of the Patient N. A. do not include a notation that the Respondent conducted a neurological or reflex assessment or a range of motion examination on that occasion, even though the Respondent performed such assessments and examinations during the patient's initial visit.

8. The Respondent initially diagnosed Patient N. A.'s condition as "chronic lower back pain, failed back syndrome." This was a sufficient diagnosis, especially in view of the patient's long history of treatment for the same condition.[3]

9. The Respondent's initial plan of treatment for Patient N. A. was to obtain the patient's old medical records, discuss epidural adhesionolysis, and to follow up in one week. He prescribed Oxycontin, 80 mg. (three tablets, three times a day) and Dilaudid, 4 mg., for breakthrough pain.

10. During the course of the next eighteen months,[4] the Patient N. A. continued to see the Respondent for care and treatment of her "chronic low back pain, failed back syndrome." During that period of time, she saw the Respondent an average of about twice a month. During that period of time the Respondent continued to prescribe Oxycontin and Dilaudid for her. He also prescribed other medicines from time to time in his efforts to relieve her chronic pain.

11. At all times material to this case, the Patient N. A. was enrolled in a Humana HMO. The Respondent was not a participating provider with that HMO. The Respondent was not the "primary physician" for the Patient N. A. in her HMO plan. At the time the Patient N. A. first went to see the Respondent, she was experiencing some difficulties in her relationship with her HMO and for a period of several months she did not have a "primary physician." Shortly after he began the care and treatment of the Patient N. A., the Respondent felt that it would be beneficial to the care and treatment of the patient for her to have an MRI examination. Because the Patient N. A. did not have a "primary physician" at that time, the Respondent contacted the HMO in an effort to persuade them to authorize an MRI examination for the Patient N. A. The Respondent's efforts in this regard were unsuccessful because the HMO did not want to discuss any substantive issues with him since he was not one of

their participating physicians. Eventually, the Respondent was able to have the Patient N. A. admitted to a hospital via the emergency room and during the course of that admission was able to arrange for the patient to receive an MRI examination.

12. On January 22, 1999, the Respondent increased Patient N.A.'s prescription of Oxycontin, 80 mg., to four tablets, three times a day. The Respondent also continued to prescribe Dilaudid for the patient to take for breakthrough pain. The Respondent did not document a physical examination on that date.

13. On April 13, 1999, the Respondent increased Patient N. A.'s prescription of Oxycontin, 80 mg., to five tablets, three times a day. The Respondent's medical records for that date did not document a physical examination on that date.

14. On June 11, 1999, the Respondent doubled Patient N. A.'s prescription of Oxycontin, 80 mg., from five tablets, three times a day, to ten tablets three times a day. The Respondent's medical records for that date did not document a physical examination on that date.

15. On June 28, 1999, the Respondent increased Patient N. A.'s prescription of Oxycontin, 80 mg., to eleven tablets, three times a day. The Respondent's medical records for that date did not document a physical examination on that date.

16. On August 2, 1999, the Respondent increased Patient N. A.'s prescription of Oxycontin, 80 mg., from eleven tablets,

three times a day, to thirteen tablets, three times a day. The Respondent's medical records for that date did not document a physical examination on that date.

17. On September 2, 1999, Patient N. A. presented to the Respondent with complaints of continued pain and headaches. The Respondent increased her prescription of Oxycontin, 80 mg., from thirteen tablets, three times a day, to twenty tablets, three times a day, and he also gave her prescriptions for Oxyfast liquid and Fioricet for her headaches. The Respondent's medical records for that date did not document a physical examination on that date.

18. Other dates on which the Respondent increased Patient N. A.'s prescriptions without adequately documenting a physical examination were November 23, 1998, and April 26, 1999. Also, on December 30, 1999, at which time the Patient N. A. presented with a complaint of a new injury to her lower back and left leg, the Respondent's medical records do not adequately document a physical examination on that date.

19. The level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances requires, at a minimum, that under the circumstances described in paragraphs 12 through 18, above, the physician must conduct at least a focussed physical examination of the patient and must

include in the patient's medical records a description of the types of physical examinations conducted and the results of such examinations.

20. In order to achieve the level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in the care and treatment of a patient such as the Patient N. A., the physician should conduct at least a focused physical examination of the patient before increasing the patient's pain medications. Such a physical examination should also be conducted where there is a significant change in the patient's condition. This type of focused physical examination could include such matters as observation of the patient, palpation, range of motion tests for the back and legs, reflex tests, strength tests, sensation tests, and observation of the patient's gait.

21. The Respondent is still providing care and treatment for the Patient N. A. The patient seems to be satisfied with the care she is receiving from the Respondent and also seems to be very appreciative of the efforts the Respondent has made on her behalf. She is also appreciative of the fact that the Respondent has provided some of his services to her without seeking compensation for his services.

22. In the course of his professional career, the Respondent has not had a patient who presented a case as complicated as that presented by the Patient N. A. Cases of this level of complexity are very rare; so rare that in an entire career of a physician specializing in pain management it is unlikely that the physician would see more than two or three such cases.

23. During the course of his care and treatment of the Patient N. A., the Respondent discussed with her just about every procedure that was available to attempt to relieve her chronic back pain. The Patient N. A. was opposed to any form of invasive procedure and hoped to be able to achieve relief from her pain through the use of medicines.

24. During the course of his care and treatment of the Patient A. N., the Respondent never felt there were any secondary gain issues or diversion issues.

25. During the course of his care and treatment of the Patient N. A., the Respondent knew that she was also seeing a psychiatrist at the same time and that she was receiving prescriptions from the psychiatrist. On a number of occasions the Respondent and the Patient N. A. discussed her psychiatric care, and on one or two occasions the Respondent spoke directly to her treating psychiatrist.

26. During the course of his care and treatment of the Patient N. A., the Respondent recommended that the patient be seen by an orthopedic surgeon. However, he could not refer her to an orthopedic surgeon because he was not a Humana HMO provider and the Humana HMO did not honor or recognize his referrals.

CONCLUSIONS OF LAW

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

28. At all times material to this case, Section 458.331(1), Florida Statutes, included the following material provisions on which the Board of Medicine could take disciplinary action against a licensed physician:

> (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.
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> * * *
>
> (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.

29. Where the revocation or suspension of the physician's license is sought, proof greater than a mere preponderance of the evidence must be submitted before the Board of Medicine (Board) may take punitive action against a licensed physician. Clear and convincing evidence of the physician's guilt is required. Section 458.331(3), Florida Statutes. <u>See also</u> <u>Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Company</u>, 670 So. 2d 932, 935 (Fla. 1996); <u>Ferris v. Turlington</u>, 510 So. 2d 292 (Fla. 1987); <u>McKinney v. Castor</u>, 667 So. 2d 387, 388 (Fla. 1st DCA 1995); <u>Tenbroeck v. Castor</u>, 640 So. 2d 164, 167 (Fla. 1st DCA 1994); <u>Nair v. Department of Business and Professional</u>

Regulation, 654 So. 2d 205, 207 (Fla. 1st DCA 1995); Pic N' Save v. Department of Business Regulation, 601 So. 2d 245 (Fla. 1st DCA 1992); Munch v. Department of Professional Regulation, 592 So. 2d 1136 (Fla. 1st DCA 1992); Newberry v. Florida Department of Law Enforcement, 585 So. 2d 500 (Fla. 3d DCA 1991); Pascale v. Department of Insurance, 525 So. 2d 922 (Fla. 3d DCA 1988); Section 458.331(3), Florida Statutes; Section 120.57(1)(h), Florida Statutes ("Findings of fact shall be based on a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute.").

30. "'[C]lear 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 in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.'" In re Davey, 645 So. 2d 398, 404 (Fla. 1994), quoting, with approval, from Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

31. When the Board seeks to take punitive action against a physician, such action may be based only upon those offenses specifically alleged in the administrative complaint. See

Cottrill v. Department of Insurance, 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996); Chrysler v. Department of Professional Regulation, 627 So. 2d 31 (Fla. 1st DCA 1993); Klein v. Department of Business and Professional Regulation, 625 So. 2d 1237, 1238-39 (Fla. 2d DCA 1993); Arpayoglou v. Department of Professional Regulation, 603 So. 2d 8 (Fla. 1st DCA 1992); Willner v. Department of Professional Regulation, Board of Medicine, 563 So. 2d 805, 806 (Fla. 1st DCA 1992); Celaya v. Department of Professional Regulation, Board of Medicine, 560 So. 2d 383, 384 (Fla. 3d DCA 1990); Kinney v. Department of State, 501 So. 2d 129, 133 (Fla. 5th DCA 1987); Sternberg v. Department of Professional Regulation, 465 So. 2d 1324, 1325 (Fla. 1st DCA 1985); Hunter v. Department of Professional Regulation, 458 So. 2d 842, 844 (Fla. 2d DCA 1984).

32. Furthermore, in determining whether Section 458.331(1), Florida Statutes, has been violated in the manner charged in the administrative complaint, one "must bear in mind that it is, in effect, a penal statute. . . . This being true the statute 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 . . . licensee." Lester v. Department of Professional and Occupational Regulations, 348 So. 2d 923, 925 (Fla. 1st DCA 1977).

33. Count One of the Administrative Complaint alleges that the Respondent violated Section 458.331(1)(t), Florida Statutes, in that:

> . . .while Patient N.A. was under his care, Respondent did one or more of the following:
> (a) Failed to document a complete history of Patient N.A.'s complaints;
> (b) Failed to properly diagnose Patient N.A.'s condition;
> (c) Failed to conduct a physical examination before increasing Patient N.A.'s narcotic prescriptions;
> (d) Failed to refer Patient N.A. to any specialists for evaluation; and/or
> (e) Failed to order any diagnostic tests or studies for Patient N.A.

34. There is no clear and convincing evidence to establish the facts upon which the violation charged in Count One of the Administrative Complaint is predicated. There is no clear and convincing evidence that the Respondent failed to document a complete history of Patient N. A.'s complaints. Rather, the greater weight of the evidence is to the effect that the patient history documented by the Respondent was "sufficient and appropriate." There is no clear and convincing evidence that the Respondent failed to properly diagnose Patient N. A.'s condition. Rather, the greater weight of the evidence is to the effect that the Respondent's diagnosis was a "sufficient diagnosis." There is no clear and convincing evidence that the Respondent failed to conduct a physical examination before increasing Patient N. A. is narcotic prescriptions.[5] There is no

clear and convincing evidence that the Respondent failed to refer the Patient N. A. to any specialists. Quite to the contrary, the Respondent discussed with the patient her visits to her psychiatrist and also urged the patient on numerous occasions to be seen by an orthopedic surgeon. There is no clear and convincing evidence that it would have been useful for the Patient N. A. to be evaluated by any other specialists. Finally, there is no clear and convincing evidence that the Respondent failed to order any diagnostic tests or studies for Patient N. A. To the contrary, early in his treatment of the Patient N. A. the Respondent concluded that an MRI examination might be useful and, when the patient's HMO would not agree to pay for an MRI, the Respondent spent time and effort to find another way for the patient to receive an MRI examination.

35. As noted in the foregoing paragraph, there is a lack of clear and convincing evidence to establish the factual predicates upon which the violation alleged in Count One is based. Accordingly, Count One of the Administrative Complaint should be dismissed.

36. Count Two of the Administrative Complaint alleges that the Respondent violated Section 458.331(1)(m), Florida Statutes, in that:

> . . . Respondent failed to adequately document one or more of the following:
> (a) A complete history of Patient N.A.'s complaints;
> (b) An appropriate diagnosis of Patient N.A.'s condition;
> (c) Any physical examinations before increasing Patient N.A.'s narcotic prescriptions;
> (d) Referrals to any specialists for further evaluation of Patient N.A.'s condition; and/or
> (e) The results of any diagnostic tests or studies.

37. There is competent substantial evidence to establish a small number of the facts upon which the violation charged in Count Two of the Administrative Complaint is predicated. However, there is no clear and convincing evidence to establish the majority of the facts upon which the violation charged in Count Two of the Administrative Complaint is predicated.

38. There is no clear and convincing evidence that the Respondent failed to adequately document a complete history of Patient N. A.'s complaints. To the contrary, the greater weight of the evidence is to the effect that the history documented by the Respondent was "appropriate."[6] There is no clear and convincing evidence that the Respondent failed to adequately document an appropriate diagnosis of Patient N. A.'s condition. To the contrary, the greater weight of the evidence is to the effect that the Respondent's diagnoses are standard diagnoses that are widely recognized and accepted.[7] There is no clear and

convincing evidence that the Respondent failed to adequately document referrals to any specialists for further evaluation of Patient N. A.'s condition. To the contrary, the greater weight of the evidence is to the effect that the Respondent made appropriate efforts to have the patient seen by other physicians and that those efforts were sufficiently documented.[8] There is no clear and convincing evidence that the Respondent failed to adequately document the results of any diagnostic tests or studies. In this regard, the evidence fails to identify any specific tests or studies that were not adequately documented.

39. There is clear and convincing evidence that on several occasions the Respondent failed to adequately document physical examinations before increasing Patient N. A.'s narcotic prescriptions.[9] These several failures to adequately document physical examinations constitute violations of Section 458.331(1)(m), Florida Statutes.

40. Count Three of the Administrative Complaint alleges that the Respondent violated Section 458.331(1)(q), Florida Statutes, by reason of the following acts and failures to act alleged in paragraph 52 of the Administrative Complaint:

> 52. Respondent prescribed, dispensed, administered, mixed, or otherwise prepared a legend drug, including any controlled substance, other than in the course of the physician's professional practice, in that Respondent continued to increase Patient N.A.'s various narcotic prescriptions

> without conducting physical examinations or evaluating her medical history.

41. The scope of the physician misconduct encompassed by the language of Section 458.331(1)(q), Florida Statutes, was discussed at length in the recommended order in Department of Health, Board of Medicine v. Leland M. Heller, M.D., DOAH Case No. 00-4747PL, 2001 WL 666972. There the judge stated:

> 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. 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.

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. 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.
>
> 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.

42. The observations quoted immediately above are equally applicable here. And for those same reasons, the charge that the Respondent in this case has violated Section 458.331(1)(q), Florida Statutes, should be dismissed.

43. With regard to the appropriate penalty to be imposed in this case, in its proposed recommended order the Petitioner suggests, in the context of an assumption that it would prevail on all three counts in the Administrative Complaint, that the appropriate penalty would be: ". . . a penalty that includes payment of an Administrative Fine in the amount of $5,000.00 to be paid within 180 days, completion of the USF prescribing abusable drugs course within 180 days, completion of the FMA records keeping course within 180 days, two (2) years probation

during which time a quarterly review of 25% of Respondent's files shall be conducted by a monitor for the first year and a quarterly review of 10% of his cases for the following year, and payment of costs." The penalty suggested by the Petitioner is certainly within the range of penalties authorized by statute and would appear to be a reasonable penalty if the Petitioner had proved all of the facts that form the basis for all of the violations alleged in the Administrative Complaint. But the Petitioner did not prove all of those facts and did not establish all of the violations charged in the Administrative Complaint. In this regard it is especially significant to note that with regard to Count Three of the Administrative Complaint, the Petitioner was proceeding on a flawed interpretation of Section 458.331(1)(q), Florida Statutes. Thus, even if all of the facts alleged in support of the violation charged in Count Three were to be proved or admitted, such facts would not constitute a violation of Section 458.331(1)(q), Florida Statutes. With regard to the other two counts of the Administrative Complaint, although there is clear and convincing evidence to prove some conduct by the Respondent that constitutes violations of subsection (m) of Section 458.331(1), Florida Statutes, the vast majority of the other conduct alleged to be the factual predicate for the charges in Counts One and Two was not proved by clear and convincing evidence. Where the

conduct proved at the final hearing is substantially less than the conduct alleged in the Administrative Complaint, it appears that the penalty should be substantially less than that proposed by the Petitioner in its proposed recommended order.

RECOMMENDATION

On the basis of the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a final order be issued in this case to the following effect:

(a) Dismissing Count One of the Administrative Complaint for insufficient evidence to establish a violation of Section 458.331(1)(t), Florida Statutes;

(b) Concluding that the Respondent is guilty of having violated Section 458.331(1)(m), Florida Statutes, in some of the ways charged in Count Two of the Administrative Complaint;

(c) Dismissing Count Three of the Administrative Complaint for insufficient evidence to establish a violation of Section 458.331(1)(q), Florida Statutes; and,

(d) Imposing a penalty on the Respondent consisting of the following: (1) a requirement that the Respondent pay, within 180 days of the issuance of the final order in this case, an administrative fine in the amount of $1,000.00, and (2) a requirement that the Respondent complete, within 180 days of the issuance of the final order in this case, the FMA records-

keeping course, or some similar course regarding the proper preparation of medical records.

DONE AND ENTERED this 21st day of February, 2003, in Tallahassee, Leon County, Florida.

____

MICHAEL M. PARRISH
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of February, 2003.

ENDNOTES

1/ By means of a letter dated August 12, 2002, which was received on August 13, 2002, counsel for the Respondent, while noting that "the record in this case is technically closed," nevertheless seeks to supplement the record in this case with a copy of a document purportedly prepared by the Petitioner's expert witness (Dr. Chaitoff) which is asserted to conflict with Dr. Chaitoff's testimony at the final hearing. The letter requests that the judge in this case take "judicial notice" of the document enclosed with the letter. The document submitted with the letter of August 12, 2002, is simply too little, too late. The document has not been considered during the preparation of this Recommended Order. At this point it is perhaps appropriate to also mention that not a great deal of weight has been given to much of Dr. Chaitoff's expert opinion testimony. This is due in substantial part to the fact that other expert witness testimony was more persuasive. It is also due in substantial part to the fact that Dr. Chaitoff greatly undermined the persuasiveness and reliability of his opinion testimony with the following question and answer early in his cross-examination:

Q. Do you agree that reasonable experts could disagree with all your opinions that you gave here?

A. Yes.

2/ The Patient N. A. sought the services of the Respondent because Dr. Lentz discontinued the care and treatment of patients who required pain management.

3/ The Respondent's diagnosis was also very similar to the initial diagnosis by Dr. Lentz when he examined the patient some five months earlier.

4/ The allegations in the Administrative Complaint address matters that allegedly took place during the period that began on October 20, 1998, when the patient first presented to the Respondent, and ended with the patient's visit to the Respondent on April 20, 2000. The Patient N. A. has continued to see the Respondent since April 20, 2000, and still receives care and treatment from the Respondent. The Patient N. A. appears to be very satisfied with the care and treatment she has received from the Respondent. She did not initiate the complaint that led to the Administrative Complaint in this case.

5/ While there is clear and convincing evidence of shortcomings in the Respondent's documentation of a number of physical examinations of the patient that should have been made, there is no clear and convincing evidence that such physical examinations were not performed; only that, if performed, they were inadequately documented in the patient's medical records.

6/ See Dr. Chaitoff's testimony at lines 8 and 9 of page 70 of the hearing transcript.

7/ See Dr. Brookoff's testimony at lines 10 through 21 of page 19 of the transcript of the May 21, 2002, deposition.

8/ See Dr. Brokoff's testimony on page 37 and on the top half of page 38 of the transcript of the May 21, 2002, deposition.

9/ These several occasions of failure to adequately document physical examinations include the occasions specifically mentioned in paragraphs 12 through 18 of the findings of fact.

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.