STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 02-4268PL
KANWALJIT S. SERAI, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Administrative Law Judge Don W. Davis of the Division of Administrative Hearings held a formal hearing in this cause on January 28-30, 2003, in Tallahassee, Florida. The following appearances were entered:

APPEARANCES

For Petitioner: John E. Terrel, Esquire
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

For Respondent: Steven R. Andrews, Esquire
Andrews & Walker, P.A.
822 North Monroe Street
Tallahassee, Florida 32303-6141

STATEMENT OF THE ISSUE

At issue in this case is whether the Respondent's license as a physician should be disciplined for alleged violations of

Section 458.331(1), Florida Statutes, as set forth in the Administrative Complaint.

PRELIMINARY STATEMENT

By an Administrative Complaint, the Department of Health (Petitioner) charged that Kanwaljit S. Serai, M.D. (Respondent), violated Section 458.331(1)(q), Florida Statutes, through the inappropriate prescription of legend drugs; Section 458.331(1)(t), Florida Statutes, through the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonable prudent similar physician as being acceptable under similar conditions and circumstances; through failure to keep adequate medical records justifying the course of treatment with regard to specific patients in violation of Section 458.331(m), Florida Statutes; and the exercise of influence within the patient-physician relationship to obtain sexual favors in violations of Sections 458.331(j) and 458.329, Florida Statutes.

The Administrative Complaint was filed with the Department of Health on September 26, 2001. The case was referred to the Division of Administrative Hearings on November 4, 2002.

At the formal hearing, Petitioner introduced 23 exhibits and the testimony of Roger Nemeth; Tommy Gore; Tina Rivers; Linda Butler; Thomas Hicks, M.D.; Raymond M. Pomm, M.D.; Kathy L. Redfearn; Harry Knight; and Respondent.

At the formal hearing, Respondent presented 6 exhibits, testified on his own behalf, and presented the testimony of Andrew Miller, Tamara McNamara, and Tina Rivers.

FINDINGS OF FACT

1. Petitioner is the state department responsible for regulating the practice of medicine in Florida pursuant to Sections 20.165 and 20.43, and Chapters 456, 458, Florida Statutes.

2. Respondent is Kanwaljit S. Serai, M.D. At all times material to this matter he has been a licensed physician in the State of Florida, having been issued license No. ME 0042038. His last known address on record with Petitioner is 5054 Crawfordville Road, Tallahassee, Florida 32310.

3. Respondent was born and educated in India, receiving his medical and surgical credentials in that country. He came to the United States in 1979. He has been licensed in the State of Florida since 1983. Respondent is Board-certified in the area of family practice.

4. Demerol is a Schedule II narcotic that is indicated for relief of moderate to severe pain. Demerol carries a high potential for abuse or addiction.

5. Dilaudid is a Schedule II narcotic that contains hydromorphone. Hydromorphone is a powerful narcotic analgesic indicated for the relief of moderate to severe pain, and carries

a high potential for abuse and addiction. Dilaudid is a heavy-duty painkiller that should only be used in terminal illnesses.

6. Lorcet contains Hydrocodone bitartrate and acetaminophen which, when mixed together, is a Schedule III controlled substance. Lorcet is indicated for the relief of moderate to moderately severe pain. Lorcet has a potential for abuse and addiction.

7. Lortab contains Hydrocodone bitartrate and acetaminophen (Tylenol) which, when mixed together, is a Schedule III controlled substance. Lortab is indicated for the relief of moderate to moderately severe pain. Lortab has a potential for misuse, abuse, dependency, and in the person who is prone to addiction, it can contribute to and accelerate his addiction.

8. Methadone is a Schedule II controlled substance. Methadone is indicated for the relief of severe pain, for detoxification treatment in cases of narcotic addiction, and for the temporary maintenance treatment of narcotic addiction. Methadone can produce drug dependence of the morphine type. Psychological dependence, physical dependence, and tolerance may develop upon repeated administration of methadone.

9. Oxycontin contains Oxycodone, a Schedule II controlled substance. Oxycodone is a narcotic analgesic indicated for the relief of moderate to moderately severe pain and carries a high

potential for dependency, producing and feeding into the addiction of a person who has an addictive behavior.

10. Percocet contains Oxycodone, a Schedule II controlled substance. Oxycodone is a narcotic analgesic indicated for the relief of moderate to moderately severe pain and carries a high potential for abuse and dependence.

11. Valium contains Diazepam, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Diazepam is a benzodiazepine anxiolytic (anti-anxiety drug) and muscle relaxant. The abuse of Diazepam can lead to physical or psychological dependence.

12. Vicodin contains Hydrocodone bitartrate, a Schedule III controlled substance. Hydrocodone is a narcotic analgesic indicated for the relief of moderate to severe pain on a short-term basis. Vicodin is a highly addictive medication.

13. Xanax contains alprazolam, a Schedule IV controlled substance. Alprazolam is a benzodiazepine anxiolytic, and the abuse of alprazolam can lead to physical and psychological dependence. Xanax is indicated for the short-term relief of symptoms of anxiety and is highly addictive.

14. On January 20, 1999, Patient L.D., a 27-year-old female, presented to Respondent at his Family Practice clinic located at 5054 Crawfordville Road, Tallahassee, Florida (Family Practice clinic), with complaints of chronic migraine headaches.

Patient L.D. informed Respondent that a neurologist had previously treated her for the headaches through prescription of Lortab 10 mg, 120 tablets per month, and Demerol 100 mg, four injectable per month. Respondent took a minimal history and physical and did not obtain an adequate history regarding Patient L.D.'s substance abuse and her prior experience with narcotic analgesics.

15. Respondent failed to perform a complete neurologic evaluation of Patient L.D. He should have, but did not look in her eyes to see if there was any indication that she may have had swelling in the brain. Also, Respondent should have examined her heart and lungs in regard to possible neurological problems.

16. On January 20, 1999, Respondent prescribed for Patient L.D. Lortab 10 mg, 120 tablets and Demerol 100 mg injectable, without sufficient medical justification. Respondent continued to prescribe these medications through February 1999. On March 8, 1999, Respondent admonished Patient L.D. for obtaining prescriptions from her neurologist, in addition to the prescriptions that she was obtaining from Respondent, but continued Patient L.D. on Lortab and Demerol.

17. On March 11, 1999, Patient L.D. presented to Respondent with multiple symptoms of narcotic withdrawal. Respondent began prescribing Methadone 5 mg, to be taken four at

a time, four times a day (80 mg/day) for the migraine headaches. In general, methadone is not an appropriate drug to use for migraine headaches.

18. Methadone is primarily used for cancer patients or drug-addicted patients. Methadone patients have to be monitored carefully and there must be an abundance of documentation detailing: evidence of opioid toxicity; functional status, both physical and psychosocial; and evidence of aberrant behavior, such as escalating the dose or frequent “loss” of prescriptions. Respondent’s medical records do not contain this type of documentation on Patient L.D.

19. Respondent continued to prescribe Methadone in the same amounts from March 11, 1999, through August 2001. Respondent prescribed an excessive and inappropriate amount of Methadone to this patient. In addition, while prescribing the Methadone, Respondent continued prescribing Demerol to Patient L.D. This prescribing practice was inappropriate. Respondent was not monitoring Patient L.D. on a regular basis or attempting to wean her off of Methadone.

20. Respondent prescribed medications in an inappropriate and excessive manner to Patient L.D.

21. Respondent failed to practice medicine within an acceptable standard of care for Patient L.D. in regard to his prescribing practice, his failure to obtain an adequate history

and physical, his failure to obtain appropriate tests, and obtain appropriate referrals.

22. Respondent failed to keep medical records that adequately documented the course and scope of treatment for Patient L.D. in regard to his prescription practice, the history and physicals for the patient, as well as the decision to not refer this patient out to the appropriate specialists in pain management and addiction therapy.

23. On May 6, 1999, Patient V.Y., a 30-year-old female presented to Respondent at his Family Practice clinic complaining of abdominal pain and exhibiting hepatomegalia (enlarged liver) secondary to Hepatitis C. Hepatitis C is a chronic disease which rarely causes pain. Patients with Hepatitis C are at-risk for primarily liver cancer, and certainly an enlarged liver that is painful should alert one to the possibility of cancer or other conditions. Without any further history or examination, Respondent prescribed Dilaudid 2 mg, two times a day.

24. On November 17, 1999, Patient V.Y. presented to Respondent with the continued pain. Without further history and only documenting “same” for the diagnosis, Respondent increased Patient V.Y.’s prescription to Dilaudid 4 mg, two times a day, quantity 20.

25. On November 24, 1999, Patient V.Y. presented to Respondent with the continued pain. Without further history and only documenting “same” for the diagnosis, Respondent prescribed Dilaudid 4 mg, two times a day, quantity 20.

26. On December 1, 1999, Patient V.Y. presented to Respondent with continued complaints of pain. Without further history and only documenting “same” for the diagnosis, Respondent prescribed Dilaudid 4 mg, two times a day, quantity 20. Respondent also noted “pending f/u with We Care.” We Care is a clinic in Tallahassee that assists with examinations and tests.

27. On December 8, 1999, Patient V.Y. presented to Respondent with the continued pain. Without further history or examination, Respondent prescribed the normal dosage of Dilaudid and, in addition, prescribed Valium 10 mg, two times a day. The only added note was “stressed out job divorce holidays.” The record also notes that there was no follow-up contact with We Care.

28. On January 5, 2000, Patient V.Y. presented to Respondent again for treatment. Respondent’s notes indicated that We Care rejected the patient without any explanation concerning the rejection. Respondent prescribed Dilaudid 4 mg, quantity 20.

29. On June 23, 2000, Respondent noted in his record that the patient could not cope with a reduction in drugs. Respondent then increased the amount of drugs he prescribed for Patient V.Y., prescribing Dilaudid and Valium with increases in Dilaudid until July 2001.

30. On May 1, 2001, Patient V.Y. was admitted to the Emergency Room of Tallahassee Memorial Hospital (TMH) with an overdose of Dilaudid and Valium. The following notes are contained in TMH's medical records:

> ". . .suggest d/c dilaudid for pain control of hepatitis – not indicated and cleared by liver" "She should NOT be on chronic narcotics for hepatitis pain control" "Dilaudid is not indicated for HepC/Cirrhosis especially since it is cleared by the liver."

31. Respondent should have never prescribed Dilaudid and Valium to Patient V.Y. Both Dilaudid and Valium are detoxified through the liver. If the liver is having problems, as was evident with this patient, it was contraindicated to prescribe these drugs to her because her liver was damaged. Respondent did not appropriately treat the Hepatitis C for Patient V.Y.

32. Although Respondent had previously referred Patient V.Y. for a gastroenterology study and for an ultrasound due to her enlarged, painful liver, he did not follow up on this referral or test and simply continued to prescribe the same medication for this patient.

33. During the treatment and care of Respondent for Patient V.Y., Respondent was having a sexual relationship with her.

34. Respondent prescribed medications inappropriately and excessively to Patient V.Y.

35. Respondent did not practice medicine within the acceptable standard of care for Patient V.Y. by his manner of prescribing medication, his incomplete physicals and histories, as well as his inappropriate sexual relationship with the patient.

36. Respondent failed to keep appropriate medical records for Patient V.Y. and failed to adequately document the course and scope of treatment in regard to the prescription practice, his treatment of the Hepatitis C and liver problems, his decision not to seek appropriate referrals, as well as his failure to follow up or order appropriate tests.

37. On May 3, 1999, Patient S.W., a 39-year-old female with a history of a mechanical soft tissue injury of the cervical and lumbar spine with a nine percent permanent impairment rating, presented to Respondent at his Family Practice clinic with back, neck, and head pain. Without rendering a complete history or physical examination, Respondent prescribed Dilaudid 4 mg, quantity 10, along with other medications.

38. On June 1, 1999, Patient S.W. presented to Respondent with the same findings again and Respondent, without rendering a complete history or physical examination, prescribed Lortab 5/500 mg, quantity 15.

39. On December 11, 2000, Patient S.W. presented to Respondent with the same findings. Respondent prescribed Dilaudid and Xanax. Respondent's notes indicated that the patient did not get the Magnetic Resonance Imaging test (MRI) that he had recommended because her car broke down.

40. On May 3, 2001, Patient S.W. finally presented for an MRI of her back and neck. This test revealed a bulging disc at L5-S1 and one at C6-7. However, these are common findings and were not the source of her pain.

41. Patient S.W. continued to see Respondent until August 2001. During this period of time, Respondent continued to prescribe Dilaudid and Lortab, and began prescribing, along with other medications: Xanax .5 mg with a gradual increase to 1 mg., Lorcet Plus, Percocet 10/650 mg, and Oxycontin 40 mg.

42. Patient S.W. was clinically stable during the treatment and care of Respondent; however, medications were adjusted and changed and increased without adequate explanation. The medications prescribed by Respondent to Patient S.W. were excessive amounts of narcotics for a condition that did not require that much pain medication. Respondent never rendered a

complete history or physical examination and did not perform sufficient testing and appropriate referrals on this patient. Respondent should have referred Patient S.W. to a physical therapist and/or pain management center rather than trying to take care of her himself.

43. During the treatment and care of Respondent for Patient S.W., Respondent was having a sexual relationship with her, which Respondent has admitted to in the prehearing stipulation. This relationship was inappropriate and Respondent fell below the applicable standard of care by engaging in this sexual relationship.

44. Respondent prescribed medications inappropriately and excessively to Patient S.W.

45. Respondent did not practice medicine within the acceptable standard of care for Patient S.W. by his manner of prescribing medication, his incomplete physicals and histories as well as his inappropriate sexual relationship with the patient.

46. Respondent failed to keep appropriate medical records for Patient S.W. adequately documenting the course and scope of treatment in regard to his prescription practice, the history and physicals for the patient, as well as the decision to not refer this patient out to the appropriate specialists.

47. On June 10, 1999, Patient J.M., 37-year-old male, presented to Respondent at his Family Practice clinic for a burn on his forearm. Respondent appropriately treated this condition. There is an unsigned note in Respondent's records dated June 30, 1999, about this patient running a "scam." The scam apparently involved the patient attempting to get narcotic medications at every clinic in town.

48. Patient J.M. approached the Leon County Sheriff's Office (LCSO) with a tip about Respondent prescribing narcotics without adequate justification.

49. On January 20, 2000, Patient J.M., now an undercover informant with LCSO, presented to Respondent at his Family Practice clinic with a history of a narcotic addition. Without any counseling or a referral, Respondent prescribed Vicodin, quantity 20.

50. On January 26, 2000, Patient J.M. presented to Respondent with the same findings as before. Respondent proceeded to prescribe Vicodin, quantity 20, without any counseling or a referral and despite the prior note dated June 30, 1999.

51. On February 3, 2000, Patient J.M. presented to Respondent with the same findings as before. Respondent proceeded to prescribe Vicodin, quantity 20, without any

counseling or a referral and despite the note in his file dated June 30, 1999.

52. On February 19, 2001, Patient J.M. presented to Respondent with a tooth abscess. Respondent treated the problem and prescribed Vicodin for pain. Although Respondent did not violate the standard of care on this visit, the prescribing of Vicodin to a known drug addict was unwise.

53. Respondent did not do a complete history, physical examination, or seek proper testing or consultation of Patient J.M. before prescribing Vicodin. Respondent should have referred Patient J.M. to an addiction specialist. The medical records do not justify prescribing Vicodin to a patient who was already addicted to it.

54. Respondent prescribed medications inappropriately and excessively to Patient J.M.

55. Respondent did not practice medicine within the acceptable standard of care for Patient J.M. by his manner of prescribing medication, his incomplete physicals and histories for each of the visits detailed above except the June 10, 1999, and February 19, 2001 visits.

56. Respondent failed to keep appropriate medical records for Patient J.M. and failed to adequately document and justify the course and scope of treatment accorded to this patient.

57. On February 5, 2000, Officer Butler/Patient L.P., a 31-year-old female and undercover officer with LCSO, completed a brief history and physical form for Respondent. She was there as part of her official duties.

58. On February 24, 2000, Officer Butler/Patient L.P. presented to Respondent at his Family Practice clinic with a history of an addiction to pain pills. There was no nurse present during Respondent's examination of this patient. The extent of the physical examination of Officer Butler/Patient L.P. was that Respondent took a light and made an “S” shape across her face. He lifted her shirt and listened to her heart then took the palm of his hand and rubbed it across her breast, and then checked her abdomen. Respondent then proceeded to kiss this patient. Without further examination or medical history, Respondent noted “Drug dependence” in Officer Butler/Patient L.P.’s medical record and prescribed Vicodin ES, one tablet, three times a day for one week for the patient.

59. On March 9, 2000, Officer Butler/Patient L.P. presented to Respondent for additional Vicodin pills. At this visit, Respondent again checked Officer Butler/Patient L.P.’s heart and lungs and told her to lift her shirt. When she did not lift it high enough, he lifted it higher himself. Officer Butler/Patient L.P. indicated to Respondent that she had received 21 Vicodin off the street the past week.

60. There was no nurse present during this examination. Respondent kissed Officer Butler/Patient L.P. and silently mouthed to Officer Butler/Patient L.P. if she wanted to make love. She did not respond to this message. Respondent then, without a complete history and physical examination, and only indicating “Same” in the patient's medical record, prescribed Vicodin ES, quantity 19.

61. Again, on March 23, 2000, Officer Butler/Patient L.P. presented to Respondent for additional Vicodin pills. She indicated to Respondent that she had received 20 Vicodin off the street during the past week. There was no nurse present during this examination. Respondent inquired about meeting Officer Butler/Patient L.P. outside of the clinic on a personal basis.

62. Again, without a complete history and physical examination, and only indicating “Same” in Officer Butler/Patient L.P.’s medical record, Respondent prescribed Vicodin ES, quantity 20, during this visit.

63. During the time Officer Butler/Patient L.P. was under the treatment and care of Respondent, there was never a referral to a pain management specialist or drug addiction or rehab clinic. Notably, Officer Butler/Patient L.P. presented to Respondent with no alleged chronic pain, only her written statement that she was a drug addict. As a result, Respondent launched into his own self-prescribed treatment plan to reduce

Officer Butler/Patient L.P. from her dependency, a task which should be performed under the jurisdiction of a licensed treatment center.

64. Respondent's medical records for Officer Butler/Patient L.P. included a very limited history and physical, no blood work completed, no prior records, an incomplete history regarding why she was addicted or what brought her to the point of addiction, and no explanation as to why she was drug-dependent. There was no legitimate purpose or justification for prescribing Vicodin to Officer Butler/Patient L.P.

65. Respondent made sexual advances towards Officer Butler/Patient L.P. He inappropriately touched and kissed her. Also, Respondent suggested to Officer Butler/Patient L.P. that they have sex. Respondent has admitted to having a sexual relationship with Officer Butler/Patient L.P. in the prehearing stipulation form.

66. Respondent prescribed medications inappropriately and excessively to Officer Butler/Patient L.P., and did not practice medicine within the acceptable standard of care. This is exemplified in regard to Officer Butler/Patient L.P. by Respondent's manner of prescribing medication, his incomplete physicals and histories, as well as his inappropriate sexual relationship with the patient.

67. Respondent failed to keep medical records that adequately documented the course and scope of treatment for Officer Butler/Patient L.P. This is exemplified by Respondent's prescription practice, the history and physicals for this patient, as well as the decision to not refer this patient out to the appropriate specialists (pain management and addiction specialists).

68. On January 3, 2002, Respondent presented to a Physician Recovery Network (PRN) evaluator as a self-referral. This evaluator was Barbara Stein, M.D. The PRN is the impaired practitioners program for the Board of Medicine, pursuant to Section 456.076, Florida Statutes. PRN is an independent program that monitors the evaluation, care and treatment of impaired healthcare professionals. PRN oversees random drug screens and provides for the exchange of information between the treatment providers, PRN, and the Department for the protection of the public.

69. Raymond M. Pomm, M.D., a Board-certified psychiatrist and addictionologist, is the medical director of the PRN. Dr. Pomm is charged with responsibility for the oversight of the program and documentation of compliance and noncompliance with PRN monitoring contracts.

70. During the evaluation with Dr. Stein, Respondent admitted his inappropriate relationships with Patients V.Y. and

S.W. Respondent was advised that a doctor-patient relationship was not being formed and that any conclusions or results from the evaluation would be sent to the PRN.

71. Respondent underwent various tests, including, but not limited to, the Minnesota Multiphasic Personality Inventory-2 and the Millon Clinical Multiaxial Inventory-III tests. Respondent was defensive and did not provide full disclosure of his situation on these tests.

72. The Diagnostic Statistical Manual, Fourth Edition (DSM- IV) is the guidebook that all mental health professionals refer to when they are applying clinical information to criteria, diagnostic criteria, and rendering diagnoses.

73. Utilizing the DSM- IV, Dr. Stein opined that Respondent had antisocial and narcissistic personality traits and could not practice with skill and safety to patients at this time.

74. Dr. Stein opined that, although Respondent does not perceive that he has a problem, Respondent should seek treatment. The treatment should be in an inpatient professional boundary violation program. Then, Respondent should seek outpatient weekly-to-biweekly cognitive behavioral therapy geared towards sexual offenders, professional boundary violators and personality disordered individuals with a licensed PRN-approved provider for at least two years. He should also

receive a series of courses on professional boundaries and be re-assessed one year after treatment is initiated to determine whether he is safe to practice medicine. Dr. Stein opined that a PRN contract was premature because Respondent has no conception whatsoever that he has a problem.

75. Following this evaluation by Dr. Stein, Respondent was seen during the period March 13, 2002, to April 5, 2002, by Thomas Hauth, M.D. Dr. Hauth's final diagnosis for Respondent establishes that there were no diagnoses under any of the Axes, which register psychiatric or psychological problems. Dr Hauth opined that Respondent could return to practice under appropriate treatment.

76. Respondent has seen Mr. Andrew Miller, a licensed social clinical worker, during the period April 10, 2002, through the date of the final hearing. Respondent has been receiving supportive treatment, as opposed to remedial treatment. The PRN is not aware of Respondent's treatment with Mr. Miller. In addition, Respondent did not comply with any of the other recommendations made by Dr. Stein.

77. Although Respondent sought help from Mr. Miller, he did not contact the PRN to seek approval of this therapy. In fact, after the initial evaluation by Dr. Stein and supplying the report from Dr. Hauth, Respondent had no other dealings with the PRN.

78. Dr. Pomm's testimony also establishes a diagnostic concern regarding Respondent. If there were no diagnoses on Axis I or II, then there is no psychiatric condition and, in the case of Respondent, one is dealing strictly with a predatory sexual violator. Dr. Pomm's testimony further establishes that such an individual should be dealt with in a legal sense without involvement from a psychiatric point of view.

79. Respondent can not practice medicine with skill and safety at this time. Further, he is not an appropriate candidate for the PRN program because of his diagnoses, or lack thereof, and his lack of insight and motivation.

CONCLUSIONS OF LAW

80. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding, pursuant to Sections 120.569, and 120.57(1), and 456.073, Florida Statutes.

81. When the Board finds any person guilty of any of the grounds set forth in Section 458.331(1), Florida Statutes, 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 $5,000 for each count or separate offense.

(e) Issuance of a reprimand.

(f) Placement of the physician on probation for such 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 re-examination, 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.

82. The burden of proof is on the party asserting the affirmative of an issue before an administrative tribunal, Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981). Petitioner has the burden of proof in this proceeding. To meet its burden, Petitioner must establish facts upon which its allegations are based by clear and convincing evidence. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern Company, 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1st DCA 1987), and Sections 120.57(1)(j) and 458.331(3), Florida Statutes (2000).

83. Section 458.331(1)(t), (j), (q), and (m), Florida Statutes, provide, in pertinent part, as follows:

> Grounds for disciplinary action; action by the board and department.-
> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
>
> * * *
>
> (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 of 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 reasonable 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.
>
> * * *
>
> (j) Exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity. A

patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his or her physician.

* * *

(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.

* * *

(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.

84. Rule 64B8-9.008, Florida Administrative Code, provides, in pertinent part, as follows:

(1) Sexual contact with a patient is sexual misconduct and is violation of Sections 458.329 and 458.331(1)(j), Florida Statutes.

> (2) For purposes of this rule, sexual misconduct between a physician and a patient includes, but is not limited to;
> (a) Sexual behavior or involvement with a patient including verbal or physical behavior which . . .
>
> * * *
>
> 1. may reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it;
> 2. may reasonably be interpreted as intended for the sexual arousal or gratification of the physician, the patient or any third party; or
> 3. may reasonably be interpreted by the patient as being sexual.
>
> * * *
>
> (7) A patient's consent to, initiation of, or participation in sexual behavior or involvement with a physician does not change the nature of the conduct nor lift the statutory prohibition.

85. Petitioner has demonstrated by clear and convincing evidence that Respondent has committed the offenses set forth in the Administrative Complaint. Respondent has prescribed inappropriately, or in excessive amounts and/or without adequate medical justification, legend drugs to patients. Respondent has failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonable prudent similar physician as being acceptable under similar conditions and circumstances. Respondent has failed to keep medical records that

justified his course and scope of treatment for patients. Respondent has exercised influence within the patient-physician relationship with patients for the purpose of engaging them in a sexual relationship.

86. In the present case, two significant aggravating factors exist. The Board of Medicine has disciplined Respondent two prior times. The Board of Medicine entered a Final Order on June 15, 1989, disciplining Respondent for violations of Section 458.331(1)(t), (l), and (n), Florida Statutes. Additionally, the Board of Medicine entered a Final Order on June 25, 1992, disciplining Respondent for violations of Section 458.331(1)(c) and (x), Florida Statutes.

87. The disciplinary guidelines of the Board of Medicine, found at Rule 64B-8.001, Florida Administrative Code, provide a range of penalties for violations of the provisions of Section 458.331, Florida Statutes. A violation of Section 458.331(1)(t), Florida Statutes, has a range from two (2) years' probation to revocation or denial, and an administrative fine from $1,000.00 to $10,000.00. A violation of Section 458.331(1)(j), Florida Statutes, has a range from one (1) year's suspension and a reprimand and an administrative fine of $5,000.00 to revocation or denial, and an administrative fine of $10,000.00. A violation of Section 458.331(1)(q), Florida Statutes, has a range from one (1) year's probation to

revocation or denial, and an administrative fine from $1,000.00 to $10,000.00. A violation of Section 458.331(1)(m), Florida Statutes, has a range from a reprimand to denial or two (2) years' suspension followed by probation, and an administrative fine from $1,000.00 to 10,000.00.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law and the Recommended Range of Penalty under Rule 64B8-8.001(2), Florida Administrative Code, and Aggravating and Mitigating Circumstances under Rule 64B8-8.001(3), Florida Administrative Code, it is

RECOMMENDED that the Board enter a final order finding Respondent guilty of the charges set forth in the Administrative Complaint and revoking Respondent’s license.

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

DON W. DAVIS
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 21st day of March, 2003.

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4052 Bald Cypress Way, Bin A02
Tallahassee, Florida 32399-1701

William W. Large, General Counsel
Department of Health
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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.