STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE	)	
Petitioner,	)	
vs.	)	Case No. 06-2825PL
PETER N. BRAWN, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case before Larry J. Sartin, an Administrative Law Judge of the Division of Administrative Hearings, on October 18, 2006, by video teleconference between Miami and Tallahassee, Florida.

APPEARANCES

For Petitioner: April Dawn M. Skilling
Warren J. Pearson
Assistants General Counsel
Prosecution Services Unit
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STATEMENT OF THE ISSUE

The issue in this case is whether Respondent, Peter N. Brawn, M.D., committed violations of Chapter 458, Florida Statutes (2001), as alleged in an Administrative Complaint filed by Petitioner, the Department of Health, on November 23, 2005, in DOH Case Number 2002-12896, as amended; and, if so, what disciplinary action should be taken against his license to practice medicine in the State of Florida.

PRELIMINARY STATEMENT

On or about November 23, 2005, the Department of Health filed an Administrative Complaint against Peter N. Brawn, M.D., an individual licensed to practice medicine in Florida, before the Board of Medicine, in which it alleged that Dr. Brawn had committed violations of Section 458.331(1)(g), Florida Statutes (2001). Dr. Brawn disputed the allegations of fact contained in the Administrative Complaint and requested a formal administrative hearing pursuant to Section 120.569(2)(a), Florida Statutes (2005).

On August 4, 2006, the matter was filed with the Division of Administrative Hearings with a request that an administrative law judge be assigned the case to conduct proceedings pursuant to Section 120.57(1), Florida Statutes (2005). The matter was designated DOAH Case Number 06-2825PL and was assigned to the undersigned.

The final hearing was scheduled by Notice of Hearing entered August 17, 2006, for October 12, 2006. By Order Granting Continuance and Re-scheduling Hearing, Petitioner's Request for an Alternative Hearing Date was granted, and the final hearing was re-scheduled for October 18, 2006.

On October 5, 2006, Petitioner filed a Motion to Amend Administrative Complaint in order to correct scrivener's errors as to specific statutory provisions and rule numbers. The motion was granted by Order on October 16, 2006.

On October 5, 2006, a Joint Stipulation was filed by the parties. The Joint Stipulation contains, in relevant part, stipulated facts. Those facts have been included in this Recommended Order.

The final hearing was held via video teleconference between Miami and Tallahassee. Petitioner presented the testimony of Jaiser Figuereo and Evelyn Garrido-Morgan, Investigators for, respectively, the Department of Health and the Agency for Health Care Administration. Petitioner offered and had admitted Exhibits 1, 3 through 13, and 15. A ruling was reserved on Petitioner's Exhibit 2, a certified copy of a Final Order entered in DOH Case Number 2002-15991 (DOAH Case Number 05-1640PL) in which the Florida Board of Medicine disciplined Dr. Brawn's license to practice medicine.

The parties were invited to address the admissibility of Petitioner's Exhibit 2 in their proposed recommended orders, which they did. After full consideration of the matter, Petitioner's Exhibit 2 is hereby admitted. The question of whether Dr. Brawn has previously been disciplined is an issue that must be considered in deciding appropriate sanctions, if the allegations of the Administrative Complaint, as amended, are proved. See Fla. Admin. Code R. 64B8-8.001(3). Such disciplinary action does not constitute an alleged "violation" which the case law cited by Dr. Brawn clearly contemplates must be pled. Dr. Brawn is presumed to be aware of the rules governing discipline of his license, and he was clearly aware of his prior disciplinary history. There is, therefore, no prejudice to Dr. Brawn by admitting Petitioner's Exhibit 2.

The Transcript of the formal hearing was filed with the Division of Administrative Hearings on October 30, 2006. By Notice of Filing of Transcript issued on October 31, 2006, the parties were informed that the Transcript had been filed and that they had until November 29, 2006, to file proposed recommended orders. Both parties timely filed a Proposed Recommended Order on November 29, 2006, and each has been fully considered in rendering this Recommended Order.

All further references to Florida Statutes and the Florida Administrative Code are to the 2001 versions unless otherwise noted.

FINDINGS OF FACT

A. The Parties.

1. Petitioner, the Department of Health (hereinafter referred to as the "Department") is the agency of the State of Florida charged with the responsibility for the investigation and prosecution of complaints involving physicians licensed to practice medicine in Florida. § 20.43 and Chs. 456 and 458, Fla. Stat. (2006).

2. Respondent, Peter N. Brawn, M.D., is, and was at all times material to this matter, a physician licensed to practice medicine in Florida, having been issued license number ME 75202.

3. Dr. Brawn is board-certified in pathology.

4. Dr. Brawn's address at the times relevant to this proceeding was 525 Caroline Street, Key West, Florida 33040.

B. Dr. Brawn's Status as a Dispensing Practitioner.

5. At the times relevant to this proceeding, Dr. Brawn was registered with the Board of Medicine (hereinafter referred to as the "Board"), as a "Dispensing Practitioner."

6. Dr. Brawn had informed the Department on March 25, 2002, that he did not dispense medical drugs for a fee, but also stated that he wished to remain on the dispensing practitioner

register. He, therefore, was registered as a dispensing practitioner at the times relevant.

7. The Department is statutorily required to conduct inspections at the offices of dispensing practitioners for the purpose of determining whether the practitioner is in compliance with the statutes and rules applicable to his or her dispensing practice.

C. The Events of April 15-16, 2002.

8. On or about April 15, 2002, Jaiser Figuereo, an investigator for the Department's Investigation Services Unit, traveled to Dr. Brawn's office to conduct an inspection of his dispensing practice. Dr. Brawn had no prior notice of the inspection.

9. Upon arriving at Dr. Brawn's premises, which were located in a "typical Key West home," Investigator Figuereo entered an unlocked front gate and walked up the front porch to the front door. Finding the front door open, Investigator Figuereo entered the building where she found several ladies in a room who appeared to be accessing the internet at computer terminals. She identified herself to the ladies and asked to speak with Dr. Brawn. Shortly thereafter, a gentleman came downstairs and indicated he was Dr. Brawn. Investigator Figuereo verified Dr. Brawn's identity with his driver's license.

10. Investigator Figuereo, who was new to her position, did not feel comfortable proceeding with the inspection alone because of her concern that the office was being used to dispense medications via the internet. Therefore, she told Dr. Brawn that she would return the following day to conduct the office inspection.

11. After leaving the office, Investigator Figuereo returned to the hotel where she was staying with other investigators with whom she had traveled to Key West. Those investigators were employees of the Agency for Health Care Administration (hereinafter referred to as "AHCA"). Investigator Figuereo explained what she had seen at Dr. Brawn's office and requested assistance from fellow Investigators Evelyn Garrido-Morgan, Jose Rodriguez, and Paul Randall.

12. On April 16, 2002, Investigators Figuereo, Garrido-Morgan, Rodriquez, and Randall drove to Dr. Brawn's office to conduct the inspection, where they were met by Dr. Brawn.

13. As the inspection progressed, Investigator Figuereo, among other things, completed an AHCA Investigative Services Inspection Form for Dispensing Practitioners (hereinafter referred to as the "Inspection Form"). The Inspection Form lists 28 inquiries which investigators are to make during the inspection of a dispensing practitioner. The investigator is

supposed to make a determination of and note on the form whether the 28 areas of inquiry are "satisfactory."

14. Dr. Brawn's personal office was accessible by walking around the front porch of the house to the left side of the building. Sitting outside the door to his office was a refrigerator, which Dr. Brawn identified as the one he used to store medications which required refrigeration. The refrigerator, which had no visible means of being locked, could be accessed by anyone who entered the front gate and climbed the stairs to the porch.

15. Investigators Figuereo and Garrido-Morgan found the inside of the refrigerator to be dirty and observed a foul smell about it. The following was found inside the refrigerator: (1) insulin, which requires refrigeration to remain safe and effective for patient use; (2) uncapped, unlabeled syringes containing an unidentified clear liquid; (3) a vial, which was leaking, containing a brown substance which appeared to be blood (this observation was not, however, proved); and (4) a substance that was described as either "spoiled food" or "fish or bait or something."

16. When asked by Investigator Figuereo why he had stored the uncapped, unlabeled syringes in the refrigerator, Dr. Brawn responded that he could not otherwise dispose of them because he did not know where his "sharps container" was located.

17. Upon entering Dr. Brawn's office, the investigators found it cramped in size, dusty, and messy. It did not appear that the office was air-conditioned and the atmosphere was described as "musty." Medications were stored on Dr. Brawn's desk, three shelves on the side of the office, and in a closet. Dr. Brawn's office was the only place the investigators found on the premises where non-refrigerated medications were being stored.

18. The investigators observed that opened medicine bottles containing pills were scattered among boxes lying around the office. Uncontained pills were also found lying on a counter and Dr. Brawn's desk. Open manufacturer-type medicine containers were also found.

19. Investigators Figuereo and Garrido-Morgan also found expired and unexpired medications stored mixed together in Dr. Brawn's office.

20. The investigators found 19 boxes of expired "Baycol" during their inspection of Dr. Brawn's office. Baycol is a medication that was recalled by its manufacturer on August 8, 2001. The recall was supported by the Food and Drug Administration in a publication bearing the same date. Because of the recall, the investigators confiscated the 19 boxes of medication. Following the removal of the Baycol from Dr.

Brawn's office, the medication was transferred to the Department's evidence custodian.

21. Investigator Garrido-Morgan gathered the remaining expired medications found during the inspection and, while accompanied by Dr. Brawn, proceeded to dispose of them down a toilet within the office.

22. Of the 28 areas of inquiry on the Inspection Form completed by Investigator Figuereo during the inspection of Dr. Brawn's office, it was found that 15 of the 28 areas of inquiry were not satisfactory. Petitioner's Exhibit 1. Relevant to the charges of the Administrative Complaint, as amended, the following areas of inquiry were determined to be unsatisfactory:

> . . . .
>
> 3. Generic drug sign displayed. {465.025(7), F.S.}{64B8-8.011(3)(b)10, F.A.C.}
>
> 4. Stock medications appropriately labeled for dispensing from a licensed manufacturer. {499.007(2), F.S.}
>
> . . . .
>
> 6. Outdated medications removed from stock. {499.007(2), F.S.}{64B16-28.110, F.A.C.}
>
> 7. Medications requiring refrigeration appropriately stored. {64B16-28.104, F.A.C.}
>
> . . . .

16. Patient record contains medical history required for counseling. {64B16-27.800, F.A.C.}

17. Controlled substances securely maintained and stored in a locked cabinet. {21 CFR 1301.75}

. . . .

20. Controlled substance prescriptions provide practitioner's name/address and DEA number. {893.04(1)(c)2, F.S.}

. . . .

25. Controlled substance biennial inventory conducted. {893.07(1)(a), F.S.}

23. Dr. Brawn did not display in a prominent, clear, and unobstructed place at or near where prescriptions were being dispersed by him, the notice required by Section 465.025(7), Florida Statutes.

24. Dr. Brawn's office contained medications which were loose and, therefore, not properly labeled. The syringes stored in the refrigerator lacked proper labels, required by Section 499.007(2), Florida Statutes.

25. There were expired prescription medications (outdated) stored, unquarantined, in Dr. Brawn's office inconsistent with Florida Administrative Code Rule 64B16-28.110.

26. The medications stored within Dr. Brawn's refrigerator were not properly stored. The refrigerator was unlocked and easily accessible and unsanitary.

27. The only patient records maintained by Dr. Brawn, as he admitted during the investigation, consisted of a copy of an internet questionnaire completed by patients and submitted via computer. The questionnaire lacked information about a patient's date of birth, age, gender, medical and drug history, and new and refilled prescriptions received from Dr. Brawn's office.

28. The evidence failed to prove that Dr. Brawn had any controlled substances on the premises. The only direct testimony on this issue was that of Ms. Figuereo who indicated that she saw unsecured controlled substances. She did not, however, indicate what controlled substances or how she identified them, or where she saw the medications. Given this lack of specificity and testimony that Dr. Brawn had indicated he had no controlled substances, it is found that the Department failed to prove there were any controlled substances found during the inspection. It cannot, therefore, be found that Dr. Brawn did not use a proper prescription form for controlled substances. While the form provided to the investigators was not adequate, the evidence failed to prove that Dr. Brawn used that form to prescribe controlled substances.

29. Dr. Brawn admitted that he did not have a biennial inventory of controlled substances, stating that he was not aware one was required.

30. At the conclusion of the inspection, Dr. Brawn signed the Inspection Form which had been completed by Investigator Figuereo.

31. Dr. Brawn was told that the investigators would return in 30 days to see if the deficiencies noted had been rectified. Upon returning the Dr. Brawn's office, Ms. Figuereo was told that Dr. Brawn was out of town.

CONCLUSIONS OF LAW

A. Jurisdiction.

32. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569, 120.57(1), and 456.073(5), Florida Statutes (2006).

B. The Charges of the Administrative Complaint.

33. Section 458.331(1), Florida Statutes, authorizes the Board to impose penalties ranging from the issuance of a letter of concern to revocation of a physician's license to practice medicine in Florida if a physician commits one or more acts specified therein.

34. In its Administrative Complaint, as amended, the Department has alleged that Dr. Brawn has violated Section 458.331(1)(g), Florida Statutes.

C. The Burden and Standard of Proof.

35. The Department seeks to impose penalties against Respondent through the Administrative Complaint, as amended, that include suspension or revocation of his license and/or the imposition of an administrative fine. Therefore, the Department has the burden of proving the specific allegations of fact that support its charge that Dr. Brawn violated Sections 458.331(1)(g), Florida Statutes, by clear and convincing evidence. See Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Pou v. Department of Insurance and Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998). See also Section 120.57(1)(j), Florida Statutes (2006)("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.").

36. What constitutes "clear and convincing" evidence was described by the court in Evans Packing Co. v. Department of Agriculture and Consumer Services, 550 So. 2d 112, 116 n.5 (Fla. 1st DCA 1989), as follows:

> . . . [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 evidence 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 the firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

See also In re Graziano, 696 So. 2d 744 (Fla. 1997); In re Davey, 645 So. 2d 398 (Fla. 1994); Walker v. Florida Department of Business and Professional Regulation, 705 So. 2d 652 (Fla. 5th DCA 1998)(Sharp, J., dissenting).

D. Section 458.331(1)(g), Florida Statutes.

37. Section 458.331(g), Florida Statutes (2001), defines the following disciplinable offense: "[f]ailing to perform any statutory or legal obligation placed upon a licensed physician."

38. The specific "statutory or legal obligation" placed upon Dr. Brawn which the Department has alleged in the Administrative Complaint, as amended, he violated is Section 465.0276(2)(b), Florida Statutes, which provides:

> (2) A practitioner who dispenses medicinal drugs for human consumption for fee or remuneration of any kind, whether direct or indirect, must:
>
> . . . .
>
> (b) Comply with and be subject to all laws and rules applicable to pharmacists and pharmacies, including, but not limited to, this chapter and chapters 499 and 893 and all federal laws and federal regulations.

39. The specific laws and rules "applicable to pharmacists and pharmacies" which the Department has alleged Dr. Brawn failed to comply with are included in the Administrative Complaint, as amended, in paragraph 8. In particular, it is alleged that Dr. Brawn:

a. failed to display a generic sign, as required by Section 465.025(7), Florida Statutes (2001), and Rule 64B8-8.011(3)(b)10, Florida Administrative Code (hereinafter referred to as "FAC");

b. failed to maintain an adequate refrigerated storage facility, as required by Rule 64B16-28.104, FAC;

c. failed to maintain a safe, clean and sanitary prescription department, as required by Rule 64B16-28.105, FAC;

d. failed to remove outdated medications from stock, as required by Section 499.0121(5)(a)2., Florida Statutes (2001), and Rule 64B16-28.110, FAC;

e. failed to maintain appropriate labeling, as required by Section 499.007(2), Florida Statutes (2001), and Rule 64B16-18.108, FAC;

f. failed to maintain patient records containing medical history required for counseling, as required by Rule 64B16-27.800, FAC;

g. failed to store controlled substances in a locked cabinet as, required by 21 CFR 1301.75;

h. failed to include practitioner's name and DEA number on prescriptions, as

required by Section 893.04(1)(c)2, Florida Statutes (2001).

i. failed to conduct a biennial inventory, as required by Section 893.07(1), Florida Statutes (2001).

40. The evidence clearly and convincingly proved that Dr. Brawn violated Section 458.331(1)(g), Florida Statutes, by failing to comply with some, but not all, of the statutory and legal obligations placed upon him as a dispensing practitioner.

41. In particular, the Department proved that Dr. Brawn violated Section 465.025(7), Florida Statutes. Section 465.025(7), Florida Statutes, provides the following:

> Every community pharmacy shall display in a prominent place that is in clear and unobstructed view, at or near the place where prescriptions are dispensed, a sign in block letters not less than 1 inch in height which shall read: "CONSULT YOUR PHARMACIST CONCERNING THE AVAILABILITY OF A LESS EXPENSIVE GENERICALLY EQUIVALENT DRUG AND THE REQUIREMENTS OF FLORIDA LAW."

42. Dr. Brawn failed to post any generic drug sign in compliance with Section 465.025(7), Florida Statutes.

43. The Department proved that Dr. Brawn violated Florida Administrative Code Rule 64B16-28.104, which provides the following:

> There shall be provided in each pharmacy adequate facilities for the proper storage of pharmaceuticals which require refrigeration, and such pharmaceuticals shall be stored therein, and in such manner as to preserve their therapeutic activity.

Dr. Brawn's unsecured and unsanitary refrigerator failed to comply with the requirement of this rule.

44. The Department proved that Dr. Brawn violated Florida Administrative Code Rule 64B16-28.105, which provides:

> Any establishment which is issued a pharmacy permit which shall be found guilty of operating a prescription department under unclean, unsanitary, overcrowded or unhealthful conditions, which endanger the safety or health of the public served by such establishments shall be subject to disciplinary action, including revocation or suspension of said permit, pursuant to the provisions of Chapter 465. F.S.

Dr. Brawns' dispensing facilities, with unexpired and expired medication stored together and stored outside their containers clearly violated this rule.

45. The Department proved that Dr. Brawn violated Section 499.0121(5)(a)2., Florida Statutes, which provides that "[p]rescription drugs must be examined at least every 12 months, and drugs for which the expiration date has passed must be removed and quarantined," and Florida Administrative Code Rule 64B16-28.110, which provides the following:

> Persons qualified to do so shall examine the stock of the prescription department of each pharmacy at a minimum interval of four months, and shall remove all deteriorated pharmaceuticals, or pharmaceuticals which bear upon the container an expiration date which date has been reached, and under no circumstances will pharmaceuticals or devices which bear upon the container an

> expiration date which has been reached be sold or dispensed to the public.

Dr. Brawn failed to segregate expired medications from unexpired ones in violation of the foregoing rule as alleged in the Administrative Complaint, as amended, in violation of both the statute and the rule.

46. The Department proved that Dr. Brawn had in his possession drugs which are considered "misbranded" pursuant to Section 499.007(2), Florida Statutes. Section 499.007(2), Florida Statutes, provides that "[a] drug or device is misbranded":

> (2) Unless, if in package form, it bears a label containing:
>
> (a) The name and place of business of the manufacturer or distributor; in addition, for a medicinal drug, as defined in s. 499.003, the label must contain the name and place of business of the manufacturer of the finished dosage form of the drug. For the purpose of this paragraph, the finished dosage form of a medicinal drug is that form of the drug which is, or is intended to be, dispensed or administered to the patient and requires no further manufacturing or processing other than packaging, reconstitution, and labeling; and
>
> (b) An accurate statement of the quantity of the contents in terms of weight, measure, or numerical count; however, under this section, reasonable variations are permitted, and the department shall establish by rule exemptions for small packages.

The "misbranded" drugs found during the inspection were in violation of the requirements for labeling established in Florida Administrative Code Rule 64B16-28.108. The Department, therefore, proved that Dr. Brawn violated the rule.

47. The Department proved that Dr. Brawn violated Florida Administrative Code Rule 64B16-27.800, which provides, in part, the following:

> (1) A patient record system shall be maintained by all pharmacies for patients to whom new or refill prescriptions are dispensed. The patient record system shall provide for the immediate retrieval of information necessary for the dispensing pharmacist to identify previously dispensed drugs at the time a new or refill prescription is presented for dispensing. The pharmacist shall ensure that a reasonable effort is made to obtain, record and maintain the following information:
>
> (a) Full name of the patient for whom the drug is intended;
> (b) Address and telephone number of the patient;
> (c) Patient’s age or date of birth;
> (d) Patient’s gender;
> (e) A list of all new and refill prescriptions obtained by the patient at the pharmacy maintaining the patient record during the two years immediately preceding the most recent entry showing the name of the drug or device, prescription number, name and strength of the drug, the quantity and date received, and the name of the prescriber; and
> (f) Pharmacist comments relevant to the individual’s drug therapy, including any other information peculiar to the specific patient or drug.

> (2) The pharmacist shall ensure that a reasonable effort is made to obtain from the patient or the patient's agent and shall record any known allergies, drug reactions, idiosyncrasies, and chronic conditions or disease states of the patient and the identity of any other drugs, including over-the-counter drugs, or devices currently being used by the patient which may relate to prospective drug review. The pharmacist shall record any related information indicated by a licensed health care practitioner.

Dr. Brawn's "medical records" failed to comply with the foregoing rule.

48. The evidence failed to prove clearly and convincingly that Dr. Brawn violated 21 CFR 1301.75 by failing to store controlled substances in a locked cabinet or that he violated Section 893.041(1)(c)2, Florida Statutes, by failing to include information required on prescriptions for controlled substances.

49. Finally, the Department proved clearly and convincingly that Dr. Brawn, by failing to conduct a biennial inventory, violated Section 893.07(1)(a), Florida Statutes:

> Every person who engages in the manufacture, compounding, mixing, cultivating, growing, or by any other process producing or preparing, or in the dispensing, importation, or, as a wholesaler, distribution, of controlled substances shall:
>
> (a) On January 1, 1974, or as soon thereafter as any person first engages in such activity, and every second year thereafter, make a complete and accurate record of all stocks of controlled

> substances on hand. The inventory may be prepared on the regular physical inventory date which is nearest to, and does not vary by more than 6 months from, the biennial date that would otherwise apply. As additional substances are designated for control under this chapter, they shall be inventoried as provided for in this subsection.

E. The Appropriate Penalty.

50. In determining the appropriate punitive action to recommend to the Board in this case, it is necessary to consult the Board's "disciplinary guidelines," which impose restrictions and limitations on the exercise of the Board's disciplinary authority under Section 458.331, Florida Statutes. See Parrot Heads, Inc. v. Department of Business and Professional Regulation, 741 So. 2d 1231 (Fla. 5th DCA 1999).

51. The Board's guidelines are set out in Florida Administrative Code Rule 64B8-8.001(2), which provides, in pertinent part, that the penalty guideline for a violation of Section 458.331(1)(g), Florida Statutes, ranges from a letter of concern to revocation, and an administrative fine from $1,000.00 to $10,000.00.

52. Florida Administrative Code Rule 64B8-8.001(3) provides that, in applying the penalty guidelines, the following aggravating and mitigating circumstances are to be taken into account:

(3) Aggravating and Mitigating Circumstances. Based upon consideration of aggravating and mitigating factors present in an individual case, the Board may deviate from the penalties recommended above. The Board shall consider as aggravating or mitigating factors the following:

(a) Exposure of patient or public to injury or potential injury, physical or otherwise: none, slight, severe, or death;

(b) Legal status at the time of the offense: no restraints, or legal constraints;

(c) The number of counts or separate offenses established;

(d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;

(e) The disciplinary history of the applicant or licensee in any jurisdiction and the length of practice;

(f) Pecuniary benefit or self-again inuring to the applicant or licensee;

(g) The involvement in any violation of Section 458.331, Florida Statutes, of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure;

(h) Any other relevant mitigating factors.

53. In its Proposed Recommended Order, the Department has requested that it be recommended that Dr. Brawn's license be reprimanded, that he be required to pay an administrative fine

of $5,000.00, and that he be required to attend continuing education classes as determined by the Board. Dr. Brawn as suggested that the penalty, if any, be limited to a Letter of Concern and an administrative fine of $1,000.00.

54. Having carefully considered the facts of this matter in light of the provisions of Florida Administrative Code Rule 64B8-8.001, it is concluded that the Department's proposed penalty, with a reduction of $1,000.00 in the amount of the fine due to the failure to prove Dr. Brawn violated 21 CFR 1301.75 and Section 893.041(1)(c)2., Florida Statutes, is reasonable.

RECOMMENDATION

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

RECOMMENDED that a final order be entered by the Board of Medicine finding that Peter M. Brawn, M.D., has violated Section 458.331(g), Florida Statutes (2001), as described in this Recommended Order, issuing a reprimand of Dr. Brawn's license to practice medicine, requiring that he pay an administrative fine of $4,000.00, and requiring that he attend appropriate continuing education classes in number and of a nature determined by the Board.

DONE AND ENTERED this 28th day of December, 2006, in Tallahassee, Leon County, Florida.

LARRY J. SARTIN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of December, 2006.

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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 these cases.