STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 10-2814PL
JOHN R. CHRISTENSEN, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case on August 26, 2010, by video teleconference, with the parties appearing in West Palm Beach, Florida, before Patricia M. Hart, a duly-designated Administrative Law Judge of the Division of Administrative Hearings, who presided in Tallahassee, Florida.

APPEARANCES

For Petitioner: Greg S. Marr, Esquire
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For Respondent: Marc P. Ganz, Esquire
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STATEMENT OF THE ISSUE

Whether the Respondent committed the violations alleged in the Amended Administrative Complaint dated March 26, 2010, and, if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

In an eight-count Amended Administrative Complaint dated March 26, 2010, the Department of Health ("Department") charged John P. Christensen, M.D., with having violated section 458.331(1)(q), Florida Statutes (2006),[1] by prescribing controlled substances other than in the course of his professional practice and with having violated section 458.331(1)(t) by failing to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. The charges arose out of Dr. Christensen's care and treatment of patient A.L. between February 12, 2007, and June 29, 2007.

In support of its charge that Dr. Christensen violated section 458.331(1)(q), the Department alleged in Count One of the Amended Administrative Complaint that, on six occasions, Dr. Christensen "prescribed excessive and/or inappropriate amounts of methadone, and/or oxycodone, and/or alprazolam" to A.L.[2] In support of its charge that Dr. Christensen violated section 458.331(1)(t), the Department alleged in Count Two of the Amended Administrative Complaint that Dr. Christensen

committed medical malpractice by "failing to diagnose a history of anxiety to support prescribing Alprazolam"; "failing to order screening urine toxicology to rule out usage of illicit substances or confirm usage of prescribed medications"; "failing to refer Patient A.L. to a psychiatrist and/or addiction specialist and/or a rehabilitation center for substance abuse"; and "failing to order diagnostic tests to justify the course of treatment for patient A.L.." In Counts Three through Eight, the Department supported its charges that Dr. Christensen violated section 458.331(1)(t) with allegations that Dr. Christensen committed medical malpractice when he wrote prescriptions for pain medications written by Dr. Christensen for A.L. on six occasions between February 12, 2007, and June 29, 2007.[3]

On August 3, 2010, Dr. Christensen filed Respondent's Second Motion to Strike Expert, and the Department filed its response in opposition to the motion on August 6, 2010. The motion was based on the failure of the Department's expert witness to provide documents at his deposition, which Dr. Christensen had requested that he produce in a subpoena duces tecum. After argument on the motion at the final hearing, the motion was denied, but Dr. Christensen was advised that accommodations would be made to allow his counsel to be fully prepared to cross-examine the Department's expert witness and avoid any prejudice to Dr. Christensen. Although

Dr. Christensen's counsel cross-examined the Department's expert witness and did not ask for any of the suggested accommodations, such as reconvening the hearing to allow cross-examination of the Department's expert witness or allowing Dr. Christensen to cross-examine the Department's expert witness in a deposition taken subsequent to the final hearing, Dr. Christensen's counsel did not withdraw his objection to the testimony of the Department's expert witness.

At the hearing, the Department presented the testimony of David M. Glener, M.D., and Petitioner's Exhibits 1 and 2 were offered and received into evidence. Dr. Christensen testified in his own behalf and presented the testimony of Richard L. Rauch, M.D., by means of a videotape and transcript of his deposition, in lieu of his live testimony. Respondent's Exhibits 3, 5, 7, 8, and 10 were offered and received into evidence.[4] In addition, Joint Exhibits A, B, and C (the transcript and videotape of Dr. Rauch's deposition testimony) were offered and received into evidence.

Finally, Dr. Christensen offered into evidence Respondent's proposed exhibits 1-J and 1-K. The Department objected to the admission of these proposed exhibits on the grounds of relevance. Respondent's proposed exhibit 1-J consists of the medical records maintained by Fredric Swartz, M.D., a physician who was treating A.L. for pain management and prescribing pain

medications for A.L. during the period extending from December 21, 2006, through June 25, 2007. Respondent's proposed exhibit 1-K consists of the medical records of Dr. John Uribe, who performed surgery on A.L.'s left knee in 2002. The Department argued that these records were not relevant to the charges contained in the Amended Administrative Complaint, since those charges involved only the treatment Dr. Christensen provided to A.L. Dr. Christensen argued that these materials were relevant because the records of Dr. Swartz were reviewed by the Department's expert witness and because the records of Dr. Uribe go to the weight and credibility of the testimony of the Department's expert witness. Having considered the arguments of the parties and having reviewed the evidence in its entirety, the undersigned has concluded that Respondent's proposed exhibits 1-J and 1-K are not relevant to the issues presented in the Amended Administrative Complaint or to the weight and credibility of the testimony of the Department's expert witness.

The two-volume transcript of the proceedings was filed with the Division of Administrative Hearings, and the parties timely filed their proposed findings of fact and conclusions of law, which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing, the facts stipulated to by the parties in the Joint Prehearing Stipulation, and on the entire record of this proceeding, the following findings of fact are made:

1. The Department is the state agency responsible for the investigation and prosecution of complaints involving physicians licensed to practice medicine in Florida. See § 456.072, Fla. Stat. The Board of Medicine ("Board") is the entity responsible for regulating the practice of medicine and for imposing penalties on physicians found to have violated the provisions of section 458.331(1). See § 458.331(2), Fla. Stat.

2. At the times pertinent to this proceeding, Dr. Christensen was a physician licensed to practice in Florida, having been issued license number 92135, and he practiced with the A1A Health & Wellness Clinic ("Clinic"), specializing in pain management.

3. In 1975, Dr. Christensen received a degree in chiropractic, and he specialized in chiropractic orthopedics. Dr. Christensen has been practicing chiropractic orthopedics in the Palm Beach, Florida, area since 1975, although he took time away from his practice to attend medical school and to obtain a master's degree in public health.

4. Dr. Christensen received his medical degree in 1995, and he completed a one-year internship in internal medicine. Dr. Christensen was certified in preventive medicine by the American Board of Preventive Medicine on January 22, 2007, and, after passing an examination, he was credentialed in March 2007 by the American Academy of Pain Management. Between February 9, 1997, and February 1998, Dr. Christensen was certified as an addiction professional by the American Association of Acupuncture and Oriental Medicine and the American College of Addictionology and Compulsive Disorders after having taken a 120-hour program in addictionology.

5. Dr. Christensen first saw A.L. at the Clinic on February 12, 2007. At the time, A.L. was 21 years old, having been born on September 17, 1985.

6. At the February 12, 2007, office visit, A.L. completed a Personal History form in which he stated that he was self-employed and worked in construction; that his major complaint was knee and back pain; and that the condition of which he complained began when he was 13 years old, which would have been in or about 1998. A.L. also noted on the Personal History form that he had seen other doctors for "pain management," but he did not include the names of any of the doctors who had provided pain management treatment.

7. Dr. Christensen completed the New Patient History Form at A.L.'s first office visit. He noted that A.L. complained of intense, sharp, incapacitating pain in his left knee, with associated pain in his lower back. A.L. reported that he had had multiple surgeries on his knee that had been unsuccessful.

8. Dr. Christensen performed a general examination of A.L. to confirm that he was alert and oriented and that his organ systems functioned properly. Dr. Christensen noted that A.L. was thin, but he did not identify any abnormal finding. Dr. Christensen did note that A.L. complained of anxiety. Because of A.L.'s complaints, however, Dr. Christensen focused his examination on A.L.'s left knee and lower back.

9. Dr. Christensen observed scars on A.L.'s left knee, which confirmed the multiple surgeries that A.L. reported, and he also noted muscle atrophy of A.L.'s left leg, a condition that Dr. Christensen attributed to lack of exercise of the left leg. Dr. Christensen performed several orthopedic tests targeted at A.L.'s left knee and lower back, and Dr. Christensen's objective physical examination confirmed A.L.'s subjective complaints of pain.

10. The differential diagnosis noted by Dr. Christensen on the New Patient History Form was multiple failed knee surgeries with associated lower back pain and lumbar disc syndrome. Dr. Christensen concluded that A.L. most likely had a lumbar

disc problem because of A.L.'s abnormal gait resulting from the knee injury and the resulting pressure on A.L.'s pelvis.

11. Dr. Christensen also noted on the New Patient History Form that A.L. reported that, each month for years, he had taken 60 to 90 80-milligram tablets of Oxycontin; 400 to 600 30-milligram tablets of Roxicodone; 200+ 40-milligram tablets of Methadone; 60 to 90 2-milligram tablets of Xanax; and 3 bottles of Oxifast. Based on these medications, dosages, and quantities, Dr. Christensen considered A.L. overmedicated, and he intended, during his treatment of A.L., to gradually reduce the amount of medications prescribed for A.L.

12. Oxycontin and Methadone are pain medications, and Oxycontin and Roxicodone are trade names for the generic drug Oxycodone. Oxifast is a liquid form of Oxycodone, and Xanax is a drug used to treat anxiety. Both Oxycodone and Methadone are classified as schedule II controlled substances in section 893.03(2), Florida Statutes, and have a high potential for abuse; Xanax, which is the trade name for the generic drug Alprazolam, is classified as a schedule IV controlled substance in section 893.03(4), with a low potential for abuse relative to schedule I, II, and III controlled substances.

13. As part of his initial office visit with Dr. Christensen, A.L. signed a Pain Management Agreement, in which he agreed that, among other things, he would not take any

pain medications not prescribed by Dr. Christensen or seek treatment from any other doctors in order to obtain pain medications; prescriptions would be filled at the same pharmacy, which A.L. identified as "Gordons Pharmacy"; he would take the medications prescribed in the manner indicated on the label; he agreed to random urine drug tests; and he understood he would be discharged by Dr. Christensen if he failed to abide by the Pain Management Agreement. Dr. Christensen went over this agreement with A.L. during this initial office visit, and he emphasized that the agreement was a legal document that, if breached, would result in A.L.'s being discharged as Dr. Christensen's patient.

14. In his typed notes for A.L.'s February 12, 2007, office visit, Dr. Christensen stated:

> Subjective: Mr. [L] indicated on his first visit today that he is feel constant severe pain in his left knee causing him to limp which refers pain to the lower back. Mr. L additionally reports restricted movement pain localized in the right lumbar, left lumbar, right lower lumbar area, and left lower lumbar area. Mr. [L] stated that for years he is made fairly comfortably by taking pain pills but his low back pain is a lot more uncomfortable due to bending, driving, lifting, and standing. He also stated today that he is experiencing constant severe pain in the area of the left knee joint and related he has had 7 failed knee surgeries since he was 13 years old. Mr. [L] additionally made particular comment about stiffness, restricted movement, and inflexibility pain localized in the left kneecap. Mr. [L]'s knee joint pain feels worse due to bending, standing, and walking.

> He states that taking pain pills reduces the severity of the pain.

Dr. Christensen also noted in his typed notes that A.L. rated the level of knee joint and low back pain at nine on a scale of one to ten; Dr. Christensen's handwritten notes indicate that A.L. rated the level of pain at "10+".

15. Dr. Christensen's assessment, as reflected in his typed notes, was that A.L. showed a persistent chronic symptomatology; that is, Dr. Christensen considered A.L.'s knee and lower back pain to be a chronic and stable condition, with no hope of improvement given that A.L. rejected additional surgery on his left knee as an option.

16. Dr. Christensen also requested at the February 12, 2007, office visit that A.L. provide him with any MRI reports or other radiologic studies as soon as possible, and A.L. provided several radiological consultation reports the day after his initial office visit. The reports included an MRI of A.L.'s left knee done on or about April 1998; an MRI of A.L.'s lumbosacral spine done on or about December 2000; an MRI of A.L.'s left knee done on February 9, 2001; an MRI of A.L.'s left knee done on August 23, 2002; and a radiological study of A.L.'s cervical spine and a CT scan of A.L.'s brain in April 2006. Dr. Christensen reviewed the reports and confirmed that A.L.'s

diagnosis was an osteochondral defect of his left knee, most likely from a sports injury.

17. Dr. Christensen did not order additional diagnostic studies of A.L.'s knee and lower back because he concluded, as a chiropractic orthopedist and based both on his objective findings from the physical examination of A.L. and on his review of the radiological reports, that A.L.'s injury would not get better on its own; that additional diagnostic tests would show only that A.L.'s condition had gotten worse; and that the results of additional diagnostic tests would not change his diagnosis or treatment of A.L.

18. The treatment plan for A.L. that Dr. Christensen outlined in his typed notes is as follows:

> One month appointment is scheduled for the patient. Pain medication that he was taking was reviewed and a decreased amount of pain medicine was prescribed. He was given a book on Subutex/Suboxone. I covered our pain management agreement, cautioned of side effects, addiction, health concepts, physical therapy, patient is too young for knee replacement, etc. Our plan is to reduce the patients [sic] present intake of pain meds . . . to a lessor [sic] amount each month as we are able.

19. Dr. Christensen believed that A.L. was taking too much pain medication. He wanted to help A.L. undo the damage that had been done by the excessive pain medications that Dr. Christensen believed had been prescribed for A.L., and

Dr. Christensen planned to reduce the amount gradually to a more appropriate level of medication.

20. Accordingly, on February 12, 2007, Dr. Christensen wrote A.L. prescriptions for 60 40-milligram tablets of Methadone, with instructions to take one tablet two times per day; 300 30-milligram tablets of Roxicodone, with instructions to take two tablets five times per day; and 60 2-milligram tablets of Xanax, with instructions to take one tablet two times per day. Based on the quantities and dosages of medications that A.L. reported he was taking as of February 12, 2007, Dr. Christensen eliminated the prescriptions for Oxycodone and Oxifast and significantly reduced the number of 30-milligram Roxicodone tablets and 40-milligram Methadone tablets A.L. could take each month.

21. Dr. Christensen prescribed Xanax for A.L. because A.L. reported to Dr. Christensen that he had anxiety; because Dr. Christensen observed that he was anxious during the office visit and knew that pain could cause anxiety; and because A.L. reported to Dr. Christensen that he had been taking Xanax prior to February 12, 2007. Although Dr. Christensen prescribed less Xanax for A.L. than A.L. reported that he had been taking, Dr. Christensen did not want to A.L. to stop taking Xanax abruptly because A.L. could have seizures and die.

22. The prescriptions written for A.L. by Dr. Christensen significantly decreased the amount of pain medication A.L. was reportedly taking prior to February 12, 2007, but Dr. Christensen was satisfied that the prescriptions would provide a sufficient amount of medication to control A.L.'s pain.

23. Dr. Christensen felt that he could not refuse to prescribe pain medications for A.L. on February 12, 2007, because, once a patient has been on pain medications for years, as A.L. reportedly had, stopping the pain medications abruptly could result in very severe withdrawal symptoms. In addition, Dr. Christensen was concerned that, if he did not prescribe pain medications for A.L., A.L. would not continue his treatment with Dr. Christensen.

24. As part of his treatment plan, Dr. Christensen also discussed with A.L. on February 12, 2007, health concepts such as improving his diet, getting exercise, considering physical therapy, setting goals, and increasing spiritual awareness. In addition, he gave A.L. information on Suboxone, a drug used primarily to prevent withdrawal symptoms when the amount of opioids such as Roxicodone is significantly reduced. Although A.L. was not interested in discussing Suboxone at the February 12, 2007, office visit, Dr. Christensen intended to continue discussing the drug with A.L. at subsequent office

visits because Dr. Christensen's ultimate plan was to wean A.L. off of opioids completely.

25. A.L. continued treatment with Dr. Christensen until June 29, 2007, seeing Dr. Christensen on March 12, 2007; April 10, 2007; May 7, 2007; June 2, 2007; and June 29, 2007. As recorded in Dr. Christensen's typed notes, A.L. complained at each office visit of "constant severe pain" in his lower back and his left knee area, with restricted movement in the lower back area and "stiffness, restricted movement, and inflexibility pain localized in the left kneecap." At each office visit, A.L. rated his knee and/or lower back pain at nine on a scale of one to ten, except that, at the office visit on May 7, 2007, A.L. rated his knee joint pain at eight on a scale of one to ten.

26. Dr. Christensen reviewed A.L.'s systems at each office visit and conducted a physical examination focused on A.L.'s left knee and back. Dr. Christensen's assessment of A.L.'s status at each office visit was that his condition was chronic and/or stable.

27. At A.L.'s March 12, 2007, Dr. Christensen prescribed 60 40-milligram tablets of Methadone, with instructions to take one tablet two times per day; 300 30-milligram tablets of Roxicodone, with instructions to take two tablets five times per day; and 60 2-milligram tablets of Xanax, with instructions to take one tablet two times per day.

28. In his handwritten notes of the March 12, 2007, office visit, Dr. Christensen noted that A.L. was stable on the pain medications prescribed. On March 12, 2007, A.L. also completed a Pain Outcomes Profile, in which he rated his pain generally as five or six on a scale of one to ten; A.L. rated his level of anxiety as seven on a scale of one to ten.

29. In his handwritten notes of the April 10, 2007, office visit, Dr. Christensen stated that he had a long discussion with A.L. about weaning him off of the pain medications and developing goals for doing so. Dr. Christensen drew a graph in his notes of the April 10, 2007, office visit to illustrate his discussion with A.L. about taking one 30-milligram Roxicodone ten times at a time instead of two. Dr. Christensen noted that A.L. wanted to take the Roxicodone tablets more often than ten times per day, and Dr. Christensen explained to A.L. that he needed to take enough pain medication to control his pain but not enough that he would go into a state of euphoria because that would lead to addiction.

30. Dr. Christensen expanded on his point about weaning A.L. off of the large dose of Roxicodone in his typewritten notes of the April 10, 2007, office visit:

> I explained the concept of 2 roxicodone's [sic] (60 mg) verse [sic] 30 mg taken more often. 2 tabs can cause excess, waste, build tolerance and the patient will run out of meds. Taking the roxicone [sic] 30 mg

> tablets one at a time will allow the patient to dose himself better, decrease tolerance, reduce waste, laste [sic] longer. Less pain, and ultimately take less pain meds. I showed him how 240 roxies would provide more pain relief than 300 roxies if taken 1 at a time more often then [sic] taking 2 or more at a time which is how the patient was taking them.

31. On April 10, 2007, Dr. Christensen prescribed 60 40-milligram tablets of Methadone, with instructions to take one tablet two times per day and 60 2-milligram tablets of Xanax, with instructions to take one tablet two times per day. Dr. Christensen also prescribed 300 30-milligram tablets of Roxicodone, but he instructed A.L. to take one tablet ten times per day rather than two tablets five times per day.

32. A.L. completed a Pain Outcomes Profile at the April 10, 2007, office visit, and he rated his pain level generally at five on a scale of one to ten; A.L. rated his level of anxiety at seven on a scale of one to ten.

33. A.L. also signed an A1A Health & Wellness Clinic Patient Informed Consent and Notice of Material Risks for Treatment of Intractable Pain with Controlled Substances on April 10, 2007, in which A.L. confirmed that Dr. Christensen had recommended and A.L. had requested treatment with opioid pain medication. By signing the form, A.L. also confirmed that he and Dr. Christensen had discussed alternative therapies,

including drug cessation treatment using Suboxone and potential side effects and risks of controlled substances.

34. At A.L.'s next office visit, on May 7, 2007, Dr. Christensen prescribed 60 40-milligram tablets of Methadone, with instructions to take one tablet two times per day and 60 2-milligram tablets of Xanax, with instructions to take one tablet two times per day. Dr. Christensen decreased A.L.'s prescription for Roxicodone from 300 30-milligram tablets to 240 30-milligram tablets, with instructions to take one tablet eight times per day. Dr. Christensen also noted in his typewritten notes that A.L. refused physical therapy and that Suboxone/Subutex was discussed with A.L. but that A.L. indicated that he was "not at all interested."

35. At A.L.'s June 2, 2007, office visit, Dr. Christensen further reduced to 210 the number of 30-milligram Roxicodone tablets he prescribed for A.L., and he instructed A.L. to take one tablet seven times per day. Dr. Christensen noted in the Follow Up Visit form that he completed on June 2, 2007, that A.L. was not happy about the decrease in the number of Roxicodone tablets and complained that he would be in pain. Dr. Christensen noted that he explained again that the goal was to get A.L. drug-free. Dr. Christensen also discussed additional knee surgery as an option, but he noted that A.L. emphatically refused further surgery.

36. Dr. Christensen included on the Follow Up Visit form for the June 2, 2007, office visit a notation that states in part that A.L. brought with him a "Drug Class II w/o Script (it was meds prescribed by in wrong bottle.)." There is no further explanation or mention of this in either Dr. Christensen's handwritten notes or typewritten notes for the June 2, 2007, office visit.

37. A.L.'s final office visit to Dr. Christensen was on June 29, 2007. Dr. Christensen noted on the Follow Up Visit form that A.L. complained of knee pain that was "unbearable" at times. Dr. Christensen also noted that A.L. was experiencing increased lower back pain because he was walking with a limp.

38. Dr. Christensen again decreased to 180 the number of 30-milligram Roxicodone tablets he prescribed for A.L., with one tablet to be taken every six hours. Dr. Christensen noted: "Patient will be underdosed but it was explain [sic] the importance of ↓ Roxi More H_2O, reviewed [pain management] contract & goals of ↓ meds over time." According to the notes on the Follow Up Visit form, Dr. Christensen intended to let A.L. stabilize at 180 30-milligram Roxicodone tablets per month and to talk with A.L. again about beginning Suboxone.

39. Dr. Christensen believed that the amount of medications that A.L. claimed to be taking at the first office visit on February 12, 2007, was clearly excessive, but he

believed that A.L. was telling the truth. Although doubts about A.L.'s truthfulness regarding his medications crossed Dr. Christensen's mind, he chose to believe A.L. was telling the truth for several reasons.

40. First, Dr. Christensen believed that a physician must assume that a patient is telling the truth, especially a complex patient like A.L., unless there is an objective reason for doubting the patient's veracity.

41. Second, Dr. Christensen considered A.L. to be a model patient; he was clean, polite, fully alert, and competent. In addition, A.L. continued to keep his appointments with Dr. Christensen even though Dr. Christensen was decreasing the amount of Roxicodone he prescribed for A.L. each month.

42. Third, Dr. Christensen was aware from his physical examinations of A.L. and from A.L.'s medical history that A.L. had long-standing problems with his knee that caused him pain. A.L. reported that he had been on pain medication for approximately ten years, and, even though Dr. Christensen thought the amount of medications A.L. reported he was taking at his first office visit with Dr. Christensen on February 12, 2007, was excessive, Dr. Christensen thought that A.L. could conceivably be taking the amount of pain medications he reported because, over time, A.L. probably had built up a tolerance for the pain medications and needed to take more of the medication.

Dr. Christensen was concerned about the amount of pain medication A.L. reportedly was taking, however, and, therefore, one of Dr. Christensen's goals for A.L.'s treatment was to reduce the amount of pain medications A.L. was taking and, eventually, to wean him off of pain medications entirely.

43. Fourth, an incident occurred early in his relationship with A.L. that made Dr. Christensen doubt A.L.'s veracity, but this assessment was proven wrong. Shortly after his first office visit on February 12, 2007, A.L. returned to Dr. Christensen's office and asked for a replacement prescription for Roxicodone, explaining that the prescription was in the pocket of his jeans and that the prescription had been damaged when his mother washed the jeans. Dr. Christensen thought that A.L. was simply seeking an additional amount of the pain medication. Dr. Christensen told A.L. he would have to bring in the damaged prescription, but Dr. Christensen doubted that he would do so. A.L. brought in the prescription, which had obviously been damaged, and Dr. Christensen felt badly because he had misjudged A.L. He taped the damaged prescription in A.L.'s medical file to remind himself that he should not prejudge his patients.

44. Even though A.L. had consented to urine drug tests in the Pain Management Agreement he signed on February 12, 2007, Dr. Christensen did not order A.L. to submit to a urine

toxicology screening test on his initial office visit, as a condition of Dr. Christensen's taking him on as a patient, nor did Dr. Christensen order A.L. to submit to a random urine toxicology screening test during the time A.L. was Dr. Christensen's patient. Given the extremely large amount of pain medications A.L. reported to Dr. Christensen that he had been taking prior to his first office visit on February 12, 2007, and Dr. Christensen's concern that A.L. was overmedicated, Dr. Christensen should have considered asking A.L. to submit to a urine toxicology screening test as provided in the Pain Management Agreement.

45. Even if Dr. Christensen had administered one or more urine toxicology screening tests to A.L., however, the results of the test would have revealed only the types of drugs in A.L.'s system; that is, the urine toxicology screening test could have confirmed that A.L. was taking the medications that he reported to Dr. Christensen on February 12, 2007, and would have identified any illicit drugs he was taking at the time of the test; it would not, however, have provided any information on the quantities of drugs in A.L.'s system and, therefore, would not have confirmed the quantities of drugs A.L. reported to Dr. Christensen that he was taking at the time of his first office visit.

Summary and findings of ultimate fact

46. A few words of explanation are necessary before proceeding with the analysis of the evidence in this case. Given A.L.'s tragic death in July 2007, it is difficult for all concerned in this case to restrict their analysis of the evidence to those facts of which Dr. Christensen was aware during the time he treated A.L., yet it is essential that the evidence be viewed from this perspective. It became apparent during the course of this hearing that A.L. did not disclose certain matters to Dr. Christensen that might have changed the course of Dr. Christensen's treatment of A.L. These matters are irrelevant to the issues presented in the Department's Administrative Complaint; they are not part of the record in this case; and they have not, therefore, been considered in the preparation of this Recommended Order.

Counts One and Three through Eight

47. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Christensen prescribed Roxicodone, Methadone, or Xanax for A.L. inappropriately or in excessive amounts or that he breached the standard of care in prescribing these medications. The Department's expert witness testified that Dr. Christensen violated the standard of care because the combination, quantities, and dosages of the medications Dr. Christensen

prescribed for A.L. were excessive. The Department's expert witness did not, however, identify the standard of care that would have governed Dr. Christensen's treatment of A.L., nor did he provide a clear explanation of the basis for his opinion that the combination, quantities, and dosages of medications Dr. Christensen prescribed for A.L. were excessive, especially considering the combination, quantities, and dosages of medications that A.L. reported to Dr. Christensen that he was taking at the time of his first office visit with Dr. Christensen.

48. Rather, the Department's expert witness repeatedly stated his opinion, based on "his knowledge of pharmacology and more than 20 years[']experience,"[5] that the prescriptions written by Dr. Christensen, if taken by A.L. as directed, would be "100 percent lethal, 100 percent of the time."[6] The Department's expert witness gave no cogent explanation for his opinion that the combination, quantities, and dosages of the drugs would be 100 percent lethal, 100 percent of the time,[7] which opinion, in any event, is refuted by the fact that A.L. was successfully treated by Dr. Christensen with the same combination of drugs, albeit with decreasing quantities of Roxicodone, for a period of four and one-half months.[8] In addition, in formulating his opinion that the quantities and dosages of the medications Dr. Christensen prescribed for A.L.

were excessive, the Department's expert witness apparently did not consider the possibility that A.L. had, over the years, developed a tolerance for these medications.[9]

49. In fact, the Department's expert witness did not give credence to A.L.'s complaints of pain; he did not believe that A.L. should have been treated with narcotics for pain; and it can reasonably be inferred from his testimony that the Department's expert witness would have refused to treat A.L. The Department's expert witness dismissed A.L.'s complaints of pain as not credible, stating that "[t]he patient is extremely young to have any pain complaints."[10] The Department's expert witness testified that, if he had been consulted, he "would have recommended a trial of spinal cord stimulation"; that Dr. Christensen could have "prescribe[d] an appropriate brace for the knee"; or that Dr. Christensen might have chosen "to then make a referral to an orthopedic surgeon" for surgery on A.L.'s knee.[11] The testimony of the Department's expert witness as to the treatment he would have provided to A.L. was repeatedly conditioned by the word "if"; if A.L.'s reported knee problem were confirmed, and if the Department's expert witness had agreed to treat A.L. In fact, on the basis of the written medical records alone, the Department's expert witness dismissed A.L. as "a liar and probably a substance abuser and certainly diverting his medication" and labeled as "outlandish" A.L.'s

"self reported history of medication and prescription" and his "claims of being prescribed high dosages and lethal quantities" of controlled substances.[12]

50. In rendering his opinion that the combination, quantities, and dosages of the medications Dr. Christensen prescribed for A.L. were excessive and in violation of the standard of care, the Department's expert witness did not acknowledge in his testimony that Dr. Christensen considered the quantities, dosages, and number of different pain medications that A.L. reported on his first office visit to be excessive; that Dr. Christensen concluded that A.L. was overmedicated; that Dr. Christensen's treatment plan focused on decreasing the quantity of medications prescribed for A.L.; that Dr. Christensen did, in fact, refuse to write A.L. prescriptions for Oxycodone and Oxifast; that, at A.L.'s first office visit, Dr. Christensen wrote prescriptions for Roxicodone and Methadone for A.L. that were for quantities substantially smaller than those A.L. reportedly was taking; that Dr. Christensen assumed that A.L. was truthful when he reported that he was taking 60 to 90 two-milligram Xanax; that Dr. Christensen could not eliminate Xanax from the prescriptions he wrote for A.L. because abrupt withdrawal from Xanax could cause death; that Dr. Christensen reduced by one-third the number of two-milligram Xanax he prescribed for A.L.; that Dr. Christensen introduced at A.L.'s

first office visit the possibility of A.L.'s using Suboxone to help in weaning him off of opioid analgesics such as Roxicodone and Methadone; that Dr. Christensen steadily decreased the quantity of Roxicodone he prescribed for A.L., until the amount was substantially less than the amount A.L. reportedly was taking at the time of his first office visit with Dr. Christensen. By failing to indicate that he considered these factors in rendering his opinions and by making the broad and unsupported assertion that the medications prescribed by Dr. Christensen for A.L. were 100 percent lethal, 100 percent of the time, the Department's expert witness substantially diminished the credibility of his opinions.

51. Rather than taking an objective view of the treatment that Dr. Christensen provided A.L. from February 12, 2007, to June 29, 2007, the Department's expert witness demonstrated throughout his testimony a disdain for Dr. Christensen as a physician. This disdain for Dr. Christensen is made particularly clear when the Department's expert witness attributed to Dr. Christensen a purely economic motive in his treatment of A.L. The Department's expert witness testified that Dr. Christensen, in common with "most pill mills or physicians like the subject," had "a huge economic incentive" for his treatment of A.L.[13] These statements demonstrated a bias against Dr. Christensen that substantially diminished the

credibility of his testimony, in general, for the following reasons. First, there was no allegation in the Administrative Complaint and no evidence in this record to support the categorization of Dr. Christensen by the Department's expert witness as a physician associated with a "pill mill." Second, in reaching his conclusion that Dr. Christensen's motivation for treating A.L. was purely financial, the Department's expert witness assumed, in the absence of even a scintilla of evidence in this record, that Dr. Christensen required his patients to pay a substantial amount of cash for each office visit and that Dr. Christensen was a "dispensing physician," that is, a physician who sells drugs as well as prescribing them.[14]

Count Two

52. In Count Two of the Administrative Complaint, the Department charged Dr. Christensen with violating the standard of care in four respects, which are discussed in detail below.

A. Failure to diagnose a history of anxiety

53. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Christensen's treatment of A.L. fell below the standard of care because he failed "to diagnose a history of anxiety to support prescribing Alprazolam."[15] Dr. Christensen noted on the New Patient History Form completed during A.L.'s first office visit on February 12, 2007, that A.L. reported a history of

anxiety as a psychiatric condition, and A.L. also reported that he was currently taking Alprazolam, or Xanax. On each of A.L.'s subsequent office visits to Dr. Christensen, A.L. reported on the Pain Outcomes Profile that he had significant feelings of anxiety, and Dr. Christensen observed that A.L. exhibited anxious behaviors during his office visits. The Department's expert witness apparently overlooked this information in Dr. Christensen's medical records because he testified that he could find no justification for prescribing Alprazolam for A.L.[16]

B. Failure to order urine toxicology screening test

54. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Christensen's treatment of A.L. fell below the standard of care because he failed "to order screening urine toxicology to rule out usage of illicit substances or confirm usage of prescribed medications." The Department's expert witness identified the standard of care at the times pertinent to this proceeding as requiring patients to submit to intermittent urine toxicology screening studies so that the patient wouldn't know when such testing would take place. The Department's expert witness further explained that it was always a matter of clinical judgment as to when to require a patient to submit to a urine toxicology screening study, even to a patient such as A.L., who had reported taking a large quantity of pain

medications at the time of his first office visit to Dr. Christensen.

55. The Department's expert witness testified that, given the amount of pain medications A.L. reported to Dr. Christensen that he was taking at the time of A.L.'s first office visit, a urine toxicology screening study of A.L. at the first office visit would be "indicated," but the Department's expert witness did not testify that Dr. Christensen violated the standard of care by failing to require A.L. to submit to such a study at that first office visit or during the time he was treating A.L. In fact, according to Dr. Christensen's expert witness, at the times pertinent to this proceeding, it would not be within the standard of care to require a patient to submit to a urine toxicology screening study within the first four and one-half months of treatment.[17]

56. Finally, there is no indication in the record that Dr. Christensen had any reason to suspect that A.L. was taking illicit substances; the primary concern Dr. Christensen, and the Department's expert witness, had with respect to A.L. was the quantity of pain medications he was reportedly taking at the time of his first office visit. Because a urine toxicology screening study reveals only the types of substances in the urine and not the quantity of such substances, a urine toxicology screening study would not have revealed whether A.L.

was lying about the quantities of pain medications he reported to Dr. Christensen on his first office visit, as was concluded by the Department's expert witness; such a study would have revealed only whether A.L. was, in fact, taking these substances, a concern that, based on the information available to him, Dr. Christensen did not have at A.L.'s first or subsequent office visits. According to the standard of care identified by the Department's expert witness, Dr. Christensen did not deviate from this standard of care by using his clinical judgment to decide not to require A.L. to submit to a urine toxicology screening study.

C. Failing to refer A.L. for treatment for substance abuse

57. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Christensen's treatment of A.L. fell below the standard of care because he failed "to refer Patient A.L. to a psychiatrist and/or addiction specialist and/or rehabilitation center for substance abuse." The only mention of Dr. Christensen's failure to refer A.L. to a psychiatrist, addiction specialist, or rehabilitation center in the testimony of the Department's expert witness was in answer to the question of the Department's counsel: "Would respondent's failure to do so in this case fall below the standard of care?" The

Department's expert witness answered: "Given his [A.L.'s] claims of previous medication prescription and usage, yes."[18] The Department's expert witness never defined the standard of care to which he was referring, and his opinion, therefore, is not persuasive on this issue.[19]

D. Failure to order diagnostic tests

58. The evidence presented by the Department is not sufficient to establish with the requisite degree of certainty that Dr. Christensen's treatment of A.L. fell below the standard of care because he failed "to order diagnostic tests to justify the course of treatment for patient A.L." The Department's expert witness testified that he would "not be prepared to say that [Dr. Christensen's failure to order a diagnostic test to justify his course of treatment for A.L. fell below the standard of care] because there's no justification for the course of treatment regardless of any study or consultation that the subject could have initiated."[20] There was no allegation in the Administrative Complaint that Dr. Christensen violated the standard of care because there was no justification for the treatment he provided A.L., and this testimony is irrelevant to a determination of whether Dr. Christensen should have ordered additional diagnostic tests for A.L.

59. The Department's expert witness did, however, go on to state that, under the circumstances of this case, "a reasonable

and prudent physician . . . should have, at the very least, ordered an MRI study of the knee, [and] performed a comprehensive physical examination of the effected [sic] joint" and that "many physicians would have ordered an MRI of the knee or at the very least, perform [sic] a very detailed and well documented physical examination and then written down his treatment plan and the justification for his treatment plan."[21] To the extent that this testimony constitutes the articulation of the standard of care by the Department's expert witness, the opinion of the Department's expert witness that Dr. Christensen fell below this standard of care is unsupportable for two reasons.

60. First, the Department's expert witness incorrectly identified the report of the MRI of A.L.'s knee done in 1998 as the only MRI report in Dr. Christensen's medical records. The Department's expert witness overlooked the report in Dr. Christensen's medical records of the post-surgical MRI done of A.L.'s left knee on August 23, 2002, four and one-half years before A.L.'s first office visit to Dr. Christensen in February 2007. Therefore, the opinion of the Department's expert witness that Dr. Christensen fell below the standard of care for failing to order an MRI is not persuasive because it is based on the incorrect assumption that the most recent MRI of

A.L.'s knee was done nine years prior to his first office visit with Dr. Christensen.

61. Second, Dr. Christensen did a comprehensive physical examination of A.L.'s left knee joint. Dr. Christensen, aided by his background in chiropractic orthopedics, performed several tests on A.L.'s left knee, which, together with the post-operative MRI done in August 2002, led him to the conclusion that, if anything, the condition of A.L.'s left knee would not have improved, and probably would have worsened, over the intervening years. Dr. Christensen documented the results of the examination in the typed notes he prepared on February 12. 2007, and set out his diagnosis and treatment plan for A.L. Therefore, the opinion of the Department's expert witness that Dr. Christensen fell below the standard of care for failing to conduct a comprehensive physical examination of A.L.'s left knee and to document the results of the examination and the treatment plan for A.L. is unpersuasive because the Department's expert witness apparently overlooked this information in A.L.'s medical records.[22]

CONCLUSIONS OF LAW

62. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to sections 120.569 and 120.57(1), Florida Statutes (2010).

63. The Department seeks to impose penalties against Dr. Christensen 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 violations alleged in the Administrative Complaint by clear and convincing evidence. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Pou v. Dep't of Ins. & Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998); and § 120.57(1)(j), Fla. Stat. (2010)("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.").

64. "Clear and convincing" evidence was described by the court in Evans Packing Co. v. Dep't of Agric. & Consumer Serv., 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).

65. Judge Sharp, in her dissenting opinion in Walker v. Fla. Dep't of Bus. & Prof'l Regulation, 705 So. 2d 652, 655 (Fla. 5th DCA 1998)(Sharp, J., dissenting), described clear and convincing evidence as follows:

> Clear and convincing evidence requires more proof than preponderance of evidence, but less than beyond a reasonable doubt. In re Inquiry Concerning a Judge re Graziano, 696 So. 2d 744 (Fla. 1997). It is an intermediate level of proof that entails both qualitative and quantative [sic] elements. In re Adoption of Baby E.A.W., 658 So. 2d 961, 967 (Fla. 1995), cert. denied, 516 U.S. 1051, 116 S. Ct. 719, 133 L. Ed. 2d 672 (1996). The sum total of evidence must be sufficient to convince the trier of fact without any hesitancy. Id. It must produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Inquiry Concerning Davie, 645 So. 2d 398, 404 (Fla. 1994).

66. Section 458.331(2), Florida Statutes, provides that the Board may impose discipline on a licensed physician for violating any provision of section 458.331(1). In its eight-count Administrative Complaint, the Department has charged Dr. Christensen with violations of sections 458.331(1)(q) and 458.331(1)(t), Florida Statutes, which provide:

> (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) Notwithstanding s. 456.072(2) but as specified in s. 456.50(2):
>
> 1. Committing medical malpractice as defined in s. 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed 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. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross medical malpractice," "repeated medical malpractice," or "medical malpractice," or any combination thereof, and any publication by the board must so specify.

67. With respect to section 458.331(1)(t), section 456.50(1)(g), Florida Statutes, defined medical malpractice in pertinent part as follows: "'Medical malpractice' means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure." Section 766.102(1), Florida Statutes, provided in pertinent

part: "The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."

68. Based on the findings of fact herein, the Department has failed to prove by clear and convincing evidence that Dr. Christensen prescribed legend drugs, including controlled substances, for A.L. in excessive or inappropriate quantities or that Dr. Christensen committed medical malpractice in his care and treatment of A.L. The Department has, therefore, failed to prove by clear and convincing evidence that Dr. Christensen violated sections 458.331(1)(q) and 458.331(1)(t).

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a final order dismissing the Administrative Complaint filed against John P. Christensen, M.D., by the Department of Health.

DONE AND ENTERED this 28th day of June, 2011, in Tallahassee, Leon County, Florida.

Patricia M. Hart
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 June, 2011.

ENDNOTES

[1]/ All references herein to the Florida Statutes are to the 2006 edition unless otherwise indicated.

[2]/ It is noted that, in paragraph 16 of its Administrative Complaint, the Department alleged that A.L. died on or about July 2, 2007, "from combined drug toxicity." No evidence was presented to support this allegation, and the parties did not include this fact in the facts to which the parties stipulated in the Joint Pre-Hearing Stipulation. It, nonetheless, appears that the fact of A.L.'s death is undisputed. Significantly, the Department did not allege in its Administrative Complaint that Dr. Christensen was responsible in any way for A.L.'s death.

[3]/ In his Order on Respondent's Motion to Strike, Administrative Law Judge John G. Van Laningham held that the facts alleged in Counts Two through Eight of the Amended Administrative Complaint, even though set forth as multiple acts of medical malpractice, constitute a single "incident" of medical malpractice, as that term is defined in section 456.50(1)(d)2., Florida Statutes.

[4]/ Respondent's Exhibit 10 is a Verified Opinion of Medical Expert Pursuant to Florida Statute 766.203(3) attested to by Gregory B. Collins, M.D., and obtained as part of In Re: Presuit Investigation of Claim Pursuant to Florida Statutes Chapter 766, regarding a lawsuit that A.L.'s personal representative sought to file against Dr. Christensen. The Department objected to Respondent's Exhibit 10 on the grounds of hearsay and relevance, and that exhibit was received into evidence subject to the limitations on the use of hearsay found in section 120.57(1)(c), Florida Statutes 2010 ("Hearsay evidence may be used for the purpose of supplementing or explaining other evidence, but it shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.").

[5] Transcript, volume 1, at page 39.

[6]/ Id. at pages 38, 46-47, and 94.

[7]/ The only attempt the Department's expert witness made to explain the basis for his opinion that the combination of drugs prescribed by Dr. Christensen would be 100 percent lethal, 100 percent of the time, is as follows:

> . . . [A] reasonable and prudent physician would not combine Xanax, Alprazolam, with high dose opioid therapy because there is a synergy between the two medications and that would very likely result in the patient's death.
>
> In other words, the cause of the respiratory repression associated with opioid analgesics, namely Oxycodone [Roxicodone] and Methadone in this case, when combined with a respiratory repression that can be associated with Alprazolam, there is a synergy where one plus one equals three and that's why very often this combination will result in death.

Id. at page 41. This "explanation" is simply insufficient to establish with any degree of certainty the soundness of the Department's expert witness's opinions that the prescriptions were excessive and the treatment without justification.

[8]/ It is noted that, although the medical records of Dr. Swartz were not received into evidence because they were not relevant to the charges against Dr. Christensen, there was testimony that another pain management physician was treating A.L. and writing him prescriptions for pain medications during the time he was being treated by Dr. Christensen. Dr. Christensen, however, was not aware during the time he treated A.L. that A.L. was seeing another pain management physician, and there was no allegation in the Administrative Complaint, and no evidence presented at the hearing, that Dr. Christensen was in any way responsible for A.L.'s death.

[9]/ The Board of Medicine recognizes the potential that persons taking opioid analgesics such as the pain medications prescribed by Dr. Christensen for A.L. will develop a tolerance for the medications and that it will sometimes be necessary "to increase the dose of opioid to achieve the same level of analgesia." Fla. Admin. Code R. 64B8-9.013(2)(c)(effective October 19, 2003); see also R. 64B8-9.013(1)(b)("Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics . . .) and R. 64B8-9.013(1)(c), (f), and (i).

[10]/ Transcript, volume 1, at page 32.

[11]/ Id. at pages 46 and 102-03. The Department's expert witness refused to agree on cross-examination that pain medications would have been indicated for A.L. given the condition of his knee, but, when reminded of his answer to this question during his deposition, the Department's expert witness acknowledged that "opioid analgesics could be part of the treatment plan" for A.L. Id. at pages 102-03.

[12]/ Id. at pages 36 and 37.

[13]/ Id., at page 51.

[14]/ Id.

[15]/ This meaning of this allegation is unclear. A "diagnosis" implies that a physician has made an independent determination of the nature of a medical or, in this case, a mental condition; "history," as used in the context of this allegation, implies that the patient is providing the information regarding a medical or mental condition already diagnosed by another physician.

[16]/ It should be noted that, in addition to overlooking the notations in Dr. Christensen's medical records that A.L. reported that he suffered from anxiety, the Department's expert witness testified that he would not have prescribed Alprazolam, or Xanax, for anxiety because Xanax is "simply not the correct treatment for anxiety"; Transcript, volume 1,, at page 105; this contradicted his earlier testimony that the only legitimate medical use of Xanax was to treat anxiety and panic disorder. Id. at page 40. The Department's expert witness also testified that his practice was "to avoid prescribing anti-depressants and anti-anxiety medications." Id. at page 106.

[17]/ The standards for use of controlled substances for the treatment of pain established by the Board of Medicine that were effective in 2007 provided the following:

> If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician should employ the use of a written agreement between physician and patient outlining patient responsibilities, including, but not limited to:
>
> 1. Urine/serum medication levels screening when requested;
>
> 2. Number and frequency of all prescription refills; and
>
> 3. Reasons for which drug therapy may be discontinued (i.e., violation of agreement).

As noted in the findings of fact, Dr. Christensen required A.L. to sign such an agreement, and Dr. Christensen explained the terms of the agreement to A.L. in detail.

[18]/ Transcript, volume 1, at page 43.

[19]/ The Board of Medicine has defined "substance abuse" in Florida Administrative Code Rule 64B8-9.013(2)(h) as follows: "For the purpose of this rule, 'substance abuse' is defined as the use of any substance for non-therapeutic purposes of use of medication for purposes other than those for which it is prescribed." The Department presented no evidence that A.L. was

taking the medications prescribed by Dr. Christensen for a purpose other than to control the pain in his back and knee, and there was nothing in the medical records of Dr. Christensen that would indicate that A.L. was abusing those medications, especially in light of Dr. Christensen's consistent reduction of the amount of Roxicodone he prescribed for A.L.

[20]/ Transcript, volume 1, at page 45-46. The Department's expert witness refused a second time to state an opinion that Dr. Christensen violated the standard of care by not ordering diagnostic tests:

> Q. . . . Would the standard of care have required the respondent to have ordered additional diagnostic tests to justify his course of treatment of this patient.
>
> A. As I said before, there is no justification for the course of treatment the subject proceeded with.

Id. at page 47.

[21]/ Id. at pages 46 and 47-48.

[22]/ It is noted that the Department's expert witness did not criticize the quality of Dr. Christensen's examination of A.L.'s knee at any point in his testimony.

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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.