STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner,	)	
vs.	)	Case Nos. 11-5691PL 11-5692PL
JACINTA IRENE GILLIS, M.D., Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice to all parties, the final hearing was conducted in this case on December 5 and 6, 2011, in Ft. Myers, Florida, before Administrative Law Judge R. Bruce McKibben of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Robert J. Bobek, Esquire
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For Respondent: Jacinta Irene Gillis, M.D., pro se
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STATEMENT OF THE ISSUES

The issues in this case, as set forth in the Amended Administrative Complaints in each respective case, are as follows:

DOH Case No. 2010-01128/DOAH Case No. 11-5692

Count One. Whether Respondent, Jacinta Irene Gillis, M.D. (hereinafter referred to herein as "Dr. Gillis"), violated sections 458.331(1)(nn) and 458.326, Florida Statutes (2008 and 2009), by:

a. Failing to diagnose patient M.G. with intractable pain prior to prescribing a controlled substance under Schedules II-V, as provided in section 893.03, from on or about December 19, 2008 through December 30, 2009;

b. By inappropriately or excessively prescribing potentially lethal, highly abused, controlled substances, to wit: oxycodone, oxycontin, Percocet, and Valium, to M.G. without justification during the same time period;

c. By inappropriately or excessively prescribing controlled substances to M.G. prior to exploring other treatment modalities or rehabilitation; and

d. By failing to order a urine drug screen on M.G. at any time during her course of treatment.

Count Two. Whether Dr. Gillis failed to keep legible medical records justifying the course of treatment for M.G. in one or more of the following ways:

a. By failing to document justification for inappropriately or excessively prescribing controlled substances during her course of treatment; and

b. By failing to document justification for not ordering a urine drug screen during the course of treatment.

Count Three. Whether Dr. Gillis failed to meet the required standard of care in regards to her treatment of M.G. in one or more of the following ways:

a. By inappropriately or excessively prescribing controlled substances without justification;

b. By failing to confirm whether M.G. presented to a psychiatrist or psychologist after the initial referral by Dr. Gillis;

c. By failing to order a urine drug screening of M.G. during her course of treatment; and

d. By inappropriately or excessively prescribing controlled substances prior to exploring other modalities or rehabilitation.

Count Four. Whether Dr. Gillis prescribed controlled substances, other than in the course of her professional practice, by prescribing controlled substances inappropriately or excessively in one or more of the following ways:

a. By inappropriately or excessively prescribing controlled substances prior to exploring other treatment modalities or rehabilitation for M.G.;

b. By inappropriately or excessively prescribing controlled substances without ordering a urine drug screening for M.G.; and

c. By inappropriately or excessively prescribing controlled substances to M.G. without justification.

DOH Case No. 2008-20661/DOAH Case No. 11-5961

Count One. Whether Dr. Gillis violated section 458.331(1)(nn), Florida Statutes (2008),[1/] and Florida

Administrative Code Rule 64B8-9.013(3) in one or more of the following ways:

a. By failing to perform or document performing a complete physical exam of R.S.;

b. By failing to explore or document exploring other treatment modalities or rehabilitation for R.S.;

c. By failing to obtain or document obtaining a complete medical history of R.S.;

d. By failing to document the nature or intensity of R.S.'s pain;

e. By failing to document the current or past treatments of R.S.'s pain;

f. By failing to document information on the effect of pain on R.S.'s physical or psychological function;

g. By failing to develop or document developing a treatment plan for R.S.; and

h. By failing to determine or document determining if there were any underlying or coexisting diseases or conditions for R.S.

Count Two. Whether Dr. Gillis violated sections 458.331(1)(nn) and 458.326 in one or more of the following ways:

a. By failing to diagnose R.S. with intractable pain prior to prescribing controlled substances, i.e., Percocet;

b. By prescribing 90 tablets of Percocet 10/325 to R.S. without justification;

c. By prescribing Percocet to R.S. without exploring other treatment modalities or rehabilitation; and

d. By inappropriately prescribing Percocet to R.S. after R.S. reported that he was not currently being treated for pain.

Count Three. Whether Dr. Gillis failed to keep legible medical records justifying the course of treatment for R.S. in one or more of the following ways:

a. By failing to document justification for prescribing Percocet to R.S.;

b. By failing to document a complete physical examination of R.S. prior to prescribing Percocet;

c. By failing to document a complete medical history of R.S. prior to prescribing a controlled substance;

d. By failing to document a urine screen on R.S.; and

e. By failing to document a diagnosis of intractable pain for R.S.

Count Four. Whether Dr. Gillis violated sections 458.331(1)(nn) and 458.326 in one or more of the following ways:

a. By failing to perform or document performing a complete physical examination of D.H. on either of two visits;

b. By failing to obtain or document obtaining a complete medical history on D.H.;

c. By failing to explore or document exploring other treatment modalities or rehabilitation for D.H.;

d. By failing to document the nature or intensity of D.H.'s pain;

e. By failing to document the current or past treatments of D.H.'s pain;

f. By failing to document information on the effect of pain on D.H.'s physical or psychological function;

g. By failing to develop or document a treatment plan for D.H.; and

h. By failing to determine or document determining if there were any underlying or coexisting diseases or conditions for D.H.

Count Five. Whether Dr. Gillis violated sections 458.331(1)(nn) and 458.326 in one or more of the following ways:

a. By failing to diagnose D.H. with intractable pain prior to prescribing a controlled substance, i.e., oxycodone;

b. By prescribing 120 tablets of 30 mg oxycodone without justification;

c. By prescribing 120 tablets of 30 mg oxycodone prior to exploring other treatment modalities or rehabilitation for D.H.; and

d. By prescribing oxycodone to D.H. after D.H. reported that he was not experiencing any pain.

Count Six. Whether Dr. Gillis failed to keep legible medical records justifying the course of treatment for D.H. in one or more of the following ways:

a. By failing to document justification for prescribing 120 tablets of 30 mg oxycodone;

b. By failing to document a complete physical examination of D.H. prior to prescribing a controlled substance;

c. By failing to document a complete medical history of D.H.;

d. By failing to document urine drug screening of D.H. prior to prescribing a controlled substance; and

e. By failing to document a diagnosis of intractable pain for D.H. prior to prescribing a controlled substance.

PRELIMINARY STATEMENT

This case was originally opened at the Division of Administrative Hearings ("DOAH") under Case Nos. 11-4058PL and 11-4062PL. Pursuant to a motion filed by Respondent, Department of Health, Board of Medicine (hereinafter the "Department"), jurisdiction was relinquished to the Department so that the Administrative Complaints could be amended and presented to the probable cause board. When the files were reopened at DOAH, they were opened under the style and case numbers appearing above. Dr. Gillis disputes the allegations in the Amended Administrative Complaints and requested a formal administrative hearing.

At the final hearing, the Department presented the testimony of four witnesses: Daniel Negersmith, a deputy with the Pinellas County Sheriff's Office (PCSO); Robert Johnson, deputy with PCSO; Robert Osterland, detective with PCSO; and Dr. Marc Gerber, accepted as an expert in pain medicine. The Department's Exhibits 1 through 3, 6, and 17 were admitted into evidence. Official recognition was taken of the statutes and rules offered in Exhibits 7 through 16. Dr. Gillis called Negersmith, Johnson and Dr. Gerber as witnesses in her case-in-chief. Dr. Gillis did not testify. Dr. Gillis's Exhibits 8 through 11 were admitted into evidence.

The parties advised that a transcript of the final hearing would be ordered. By rule, the parties have ten days from the date the transcript is filed to file proposed recommended orders. The Transcript was filed on January 9, 2012. Dr. Gillis filed a "Post Order Recommendation" on January 3, 2012, which is accepted as her Proposed Recommended Order ("PRO"). On January 5, 2012, Dr. Gillis refiled her Post Order Recommendation, stating that the Department refused to provide her a copy of the final hearing Transcript "as agreed in court." Dr. Gillis offered to resubmit her Post Order Recommendation with citations to the record if the Department provided her a copy of the Transcript. The Department filed its PRO on January 19, 2012. Each party's PRO was duly considered in the preparation of this Recommended Order. Dr. Gillis filed a response to the Department's PRO on February 1, 2012, but it was not considered in the preparation of the Recommended Order, as there is no provision in the Rules of Procedure for such a response.

FINDINGS OF FACT

1. The Department is the state agency having responsibility for monitoring health care professionals, including medical doctors. Dr. Gillis is a medical doctor licensed in Florida, North Carolina, and Iowa. She is not board-certified in any area of medicine, but claims to be

"eligible" for board-certification in the field of internal medicine.

2. Dr. Gillis received her medical degree from Meharry Medical College in Nashville, Tennessee, in 1997. She completed her internal medicine residency in 2003. Her medical career includes the following places of employment:

- Medical director/staff physician at Tennessee prison for women: March-August 2003;
- Hospitalist at Hilton Head Regional Medical Center: August 2003-February 2004;
- Pain management "specialist" in Atlanta, Georgia: March-September 2004;
- Staff physician for Illinois Correctional Facilities: September 2004-January 2005;
- Pain specialist/physician in Rock Island, Illinois: March-September 2005;
- Hospitalist at Brommen Medical Center in Bloomington, Illinois: May-August 2005;
- Hospitalist at Horizon Medical Center in Dixon, Tennessee: September 2005-January 2006;
- Pain specialist for National Health Services Clinic in Nashville, Tennessee: June-August 2006;
- Hospitalist at Kedlic Medical Center in Richland, Washington: September 2006-January 2007;
- Hospitalist at Auburn Regional Medical Center in Auburn, Washington: January-June 2007;
- Hospitalist at Mercy Medical Center in Sioux City, Iowa: July-August 2007;

- Hospitalist at Albermarle Medical Center in Elizabeth City, North Carolina: September-December 2007;

- Hospitalist at National Medical Affiliates in Punta Gorda, Florida: January-July 2008;

- Pain management specialist at UR Medical Clinic in St. Petersburg, Florida: July-November, 2008; and

- Pain management specialist at Dollar Medical Clinic in St. Petersburg, Florida: January 2009-October 2010.

3. The Department is pursuing sanctions against Dr. Gillis based on her provision of medical care to three patients: D.H., R.S. and M.G. Both D.H. and R.S. are pseudonyms used by Deputies Negersmith and Johnson, respectively, as part of an undercover investigation of the clinic where Dr. Gillis was working in 2008. Their initials are used throughout this order for continuity, because all of the patient records and other evidence used those initials, rather than patient names. M.G. was a bona fide patient of Dr. Gillis's while she was operating another clinic in 2009-2010.

4. In 2008, Dr. Gillis worked at a clinic operated by UR Medical Group, Inc., located in Pinellas Park, Florida. The clinic (referred to herein as the "UR Clinic") was owned by Renee Demasso, a non-physician. Dr. Gillis was the only medical doctor on staff at the clinic when she worked there. Another employee at the clinic was Quinton Knight, a large African-American male, who served as the office receptionist. The

clinic had a "recruiter" named Jason Norris.[2/] A recruiter is a person hired by the clinic to find new patients for the clinic's medical staff, i.e., for Dr. Gillis.

5. On August 4, 2008, Negersmith, posing as D.H., was escorted to the UR Clinic by Norris. Upon arrival, he was given a patient information sheet to fill out. Norris directed him to write "severe lower back pain" on the sheet as the purpose of the visit. D.H. filled out the sheet, providing the following information:

- His pseudonym, address and contact information;
- His gender, marital status, height and weight;
- A fake social security number and date of birth;
- A fake driver's license number;
- His supposed occupation, i.e., a lineman for a private employer;
- A purported ailment, i.e., "severe lower back pain, weakness in knees" as the purpose for his visit;
- No insurance information;
- Neck/back pain and headaches as his medical history;
- A signature and date.

6. All of the information provided was, of course, false. That is, D.H. was a fictitious name for a person pretending to be a patient. After filling out the form, D.H. discussed with Norris the cost of seeing the doctor. Norris said it would be a

$350 charge. After approximately 45 minutes, D.H. was escorted to another waiting area, a vestibule separate from the main waiting area.

7. After a short wait of five to ten minutes, D.H. was shown into an examination room where he met Dr. Gillis. D.H. was told to weigh himself on a floor scale and told Dr. Gillis his weight, 264 pounds. She then took his blood pressure which was 140/80. Dr. Gillis told D.H. that he might want to take some medication to lower his blood pressure.

8. Dr. Gillis inquired as to the history of his present illness. According to the History and Physical Form (referred to herein as the patient chart) filled out by Dr. Gillis as she talked with the patient, D.H. said he had no pain (zero on a one-to-ten scale). Dr. Gillis wrote that D.H. "has difficulty explaining what he is really feeling" and that D.H. said muscle relaxers do not work for him. D.H. then told Dr. Gillis that oxycodone helps him to relax.

9. Dr. Gillis then had D.H. perform three simple tasks: walking a short distance on his toes, walking on his heels, and raising his arms above his head. D.H. walked as directed, but he could not raise his arms higher than shoulder height because he was concealing a firearm in his waistband and raising his arms any higher would have revealed the weapon.[3/] So he raised his arms up to shoulder height and then lowered them. D.H.

cannot remember whether Dr. Gillis asked him why he could not raise his arms higher. Her notations on the patient chart indicate only that D.H. has less strength in his right foot (leg) and less range of motion in his left arm.

10. At the conclusion of the examination, Dr. Gillis listed "chronic back and neck problems, chronic pain symptoms, non-specific" as the assessment and treatment plan for D.H. The lower left corner of the patient chart has an indication saying "needs records." D.H. purposefully avoided using the word "pain" throughout his examination. The only mention of pain was on the intake sheet he filled out, where he checked a box entitled neck/back pain. D.H. told Dr. Gillis that oxycodone helped him relax. She did not inquire as to whether he was taking any other medications or suggest any other modalities or treatment with D.H.

11. After the examination, D.H. went back to the front office where he received a prescription for 120 tablets of 30 mg oxycodone and for 90 tablets of 600 mg Motrin. He handed Norris $350 in cash, which Norris then gave to Knight. No receipt was provided for the payment. D.H. then went to a local pharmacy and had the prescription filled. Pursuant to prior arrangements, he gave 60 of the oxycodone tablets to Norris for sale on the street.[4/] The remaining tablets were placed into

locked storage. Norris did not know D.H. was a police officer, of course.

12. On August 27, 2008 (23 days later), D.H. appeared at the UR Clinic again. This time he was accompanied by Deputy Johnson who was posing as patient R.S. The deputies arrived at the clinic and looked for Norris, who was usually hanging around the parking lot. However, Norris was not there, and the deputies could not reach him via telephone, so they decided to go into the clinic anyway and see if they could obtain additional drugs. When D.H. and R.S. came into the clinic without Norris accompanying them, Knight became very upset and agitated. D.H. told Knight that Norris had recently changed his cell phone number, and it was not possible to contact him right then. R.S. started to walk out of the office, but Knight called him back and asked him for $350 and a copy of his identification. Knight then gave R.S. a patient information sheet to fill out. D.H. was not asked to fill out any paperwork at that time.

13. D.H. was then escorted to the examination room where he saw Dr. Gillis again. No tests or physical examination were conducted. The only thing Dr. Gillis asked D.H. was whether he had brought his medical records with him. D.H. told her he had not had time to get them from his prior doctor yet. Dr. Gillis instructed D.H. not to come back to the clinic without his

medical records. At the foot of the chart, Dr. Gillis wrote "Dr. Rew, family doctor; 2 weeks records; brought in personally." The note was not explained by Dr. Gillis.

14. The patient chart filled out by Dr. Gillis on the second visit was extremely abbreviated in content. Under chief complaint, Dr. Gillis wrote, "patient states treatment plan is working; no complaints." The chart contains his vital signs: pulse of 142/80 and weight of 268 pounds. The history of present illness section of the form says only that D.H has a zero out of ten level of pain with treatment. She noted that D.H. has "no changes from prior testing" and added a note to "refill meds." The assessment and treatment plan section says "chronic back and neck problem." According to D.H., he never mentioned any problem to Dr. Gillis.

15. Dr. Gillis did not inquire as to whether D.H. was currently taking any medications, but wrote, "oxycodone #120" and "Motrin 600 #90" on the current medications section of the chart. There was no physical examination of any kind performed on this visit.

16. D.H. then went out to the office and got his prescription for 120 tablets of 30 mg oxycodone. Dr. Gillis never asked him whether he had taken all of the prior prescription, nor did she discuss pain with him. As part of his

cover, D.H. intentionally avoided the use of the word "pain" when talking to Dr. Gillis.

17. Meanwhile, R.S. completed his patient information sheet, providing the following information:

- His pseudonym, address and contact information;
- His gender, marital status, height and weight;
- A fake social security number and date of birth;
- A fake driver's license number;
- His occupation (carpenter work) and employer (unemployed);
- Purpose of visit, which D.H. listed as "stiffness in both shoulders";
- No auto accident involved and no insurance available;
- Medical history options of high blood pressure and neck/back pain were checked in the list of various diseases and conditions listed on the sheet;
- An allergy to Keflex;
- Referred to clinic by a friend.

18. R.S. was then taken back to an examination room where he met Dr. Gillis. He, too, contrived not to mention the word pain in his conversations with Dr. Gillis. He simply said he had a stiff shoulder.

19. Dr. Gillis took his vital signs and had R.S. do the same physical tests that D.H. had performed in his first visit. R.S. remembers Dr. Gillis listening to his chest with a stethoscope and then examining his shoulder.

20. The patient chart filled out by Dr. Gillis during R.S.'s visit contained the following information: "Chief complaint--Self employed; carpentry; history of surgery on back, shoulder problems one year ago; surgery and thus pain; no history of pain management." She correctly noted that R.S. was not currently on any medications.

21. Dr. Gillis's assessment and treatment plan for R.S. was listed on the chart as chronic shoulder pain. There is no explanation for that notation. At the bottom corner of the chart, Dr. Gillis wrote "MRI of neck/shoulder; Dr. Wood, Pinellas County Orthopedic." That notation was not explained further by Dr. Gillis.

22. R.S. went back to the front office where he was handed a prescription for Percocet 10/325, even though he never asked for medication. The Percocet was at the maximum strength (10 mg) for oxycodone content for that medication. R.S. then left the office, identified photographs of Dr. Gillis and Knight for his superiors and had no further involvement with the investigation.

23. The testimony of Negersmith and Johnson as to their undercover actions was credible. Each of them had a clear and unambiguous memory of the events and did not appear to have any prejudices or ill intent that might negatively affect their

testimony. The truth and veracity of their statements is accepted.

24. At some point in time after the August 27, 2008, visit, the PCSO decided they had enough evidence to prosecute the UR Clinic as a "pill mill." As part of that prosecution, Dr. Gillis was pulled over in a traffic stop one day as she was leaving the clinic. After detaining her and explaining the charges that were being filed, the deputies advised Dr. Gillis to retain all patient records for patients she had been treating at the clinic. Later, Dr. Gillis cooperated with the sheriff's office and provided sets of original patient records to them. Dr. Gillis thereafter left her employment with the UR clinic and opened her own clinic.

25. Patient M.G. presented to Dr. Gillis at her new place of employment, Dollar Medical Clinic, on December 19, 2008. Dr. Gillis was the owner and operator of this new clinic.

26. M.G. filled out a patient information sheet which garnered the following information about him:

- Name, address and contact information;
- Marital status (married), and emergency contact information;
- Height, weight, and date of birth;
- Purpose of visit, listed as "refill on meds, follow-up on surgery."
- Auto accident on November 17, 2007;

- Insurance company information; and
- Medical history of neck/back pain, headaches, and arthritis.

27. M.G. was then examined by Dr. Gillis. She filled out a patient chart for him that listed a history of surgery and treatments for pain. The patient chart lists Dr. Spuza and Dr. Nucci as physicians from whom M.G. had received care in the past.

28. The patient chart noted that M.G. needed to be referred to a psychiatrist or psychologist as soon as possible. There was also a note indicating that M.G.'s MRI needed to be confirmed. Then there was a note written by Dr. Gillis saying "[p]atient is not going to be patient." There was no explanation as to what that note meant. The assessment and plan of treatment was then listed as "pain dependent" (although the writing on the patient chart is not very clear, and no testimony was elicited from Dr. Gillis to confirm what was written) and that the patient was advised about decreasing his pain medications.

29. M.G. complained of pain at an eight on the one to ten scale with "treatment with oxycodone times four," presumably meaning four times per day.

30. Upon completion of her examination of M.G., Dr. Gillis wrote him a prescription for 240 tablets of 30 mg oxycodone,

120 tablets of 40 mg oxycontin, 30 tablets of 10 mg valium, and 60 tablets of 500 mg naprosyn. According to the prescription, M.G. was supposed to take one of the oxycodone tablets every three hours, 24 hours per day, i.e., eight times per day. That was in addition to the oxycontin, which was to be taken every six hours. According to Dr. Gerber, "no pain doctor in the country would write a prescription like that." It would also be almost impossible for a patient to take all of those medications as prescribed.

31. Approximately one month later, on January 16, 2009, M.G. returned to Dr. Gillis for the first of several follow-up visits. The patient chart filled out by Dr. Gillis that day indicates the chief complaint by M.G. to be "pain, top of buttocks radiating down leg to foot on left side." M.G. said his pain level was an eight out of ten with his medications. Dr. Gillis wrote a note to refill the medications and that there were "no acute changes" to M.G.'s condition. This time, the assessment and treatment plan was abbreviated as "A/P." This was the beginning of very cursory notes in the patient charts for M.G. The notes on the chart became shorter and less detailed as time went on. The "A/P" was listed as chronic neck pain and dental issues.

32. Dr. Gillis then wrote prescriptions for 240 more oxycodone tablets, 120 more oxycontin tablets, 30 valium and

30 amoxicillin tablets. There is no record in the chart as to why the amoxicillin was added to M.G.'s medication regimen. There is no justification for providing essentially the same regimen of treatment when the patient was complaining of pain at a level of eight out of ten.

33. M.G. came back for another follow-up on February 13, 2009. At that visit, Dr. Gillis charted the chief complaint as "thorac lumbar surgery [indecipherable] months ago." Again M.G. complained of a level of pain at eight out of ten when using his medications. Dr. Gillis noted her intent to refill the medications and that there were no acute changes in M.G.'s condition. His "A/P" was listed as chronic back pain. A prescription for the same medications, same doses, and same amounts as the previous visit was issued.

34. M.G. returned on March 12, 2009, for a follow-up visit. The chief complaint at that time was "patient has difficulty [indecipherable]." Under history of present illness, Dr. Gillis wrote that M.G. has no history of pain prior to surgery and that he gets no relief from valium or Soma. There is no prescription for Soma in the records, so M.G. must have been getting that drug from some other source. There is no indication Dr. Gillis inquired as to where he got the medication, whether he was on any other medications, or how often he was taking the medication.

35. Dr. Gillis again wrote that there were no acute changes in M.G.'s condition although he did not present with the same chief complaint. The "A/P" appears to be chronic back pain, although the writing is not clear. Prescriptions for oxycodone and oxycontin were renewed as before, and a prescription for Ambien was added. The valium prescription was not refilled. No explanation for the change in the drug regimen was provided by Dr. Gillis.

36. On April 4, 2009, M.G. returned for another visit. This time his chief complaint was that he ran out of medications and had a seizure. There is no indication that Dr. Gillis inquired as to the type of seizure or whether M.G. had received any treatment for it. There is no evidence as to when M.G. ran out of his medications or how many pills he had taken since the prior visit. M.G. still complained of pain at a level of eight out of ten with his treatment. There is no indication of his pain level after he ran out of his medications. The "A/P" was listed as chronic back pain. The prescriptions written by Dr. Gillis for this visit were the same as the previous visit.

37. For his next visit, May 12, 2009, there is no chief complaint listed on the patient chart. Dr. Gillis again wrote that there was no acute change in the patient's condition, that M.G.'s pain level was 6.5 out of ten with his treatment, and that the prescriptions should be refilled. The same oxycodone

and oxycontin prescriptions (240 and 120 tablets, respectively) were written, along with the Ambien prescription.

38. M.G. visited Dr. Gillis again on June 12, 2009. The chief complaint for that visit was low back pain caused by tripping over a toy car at his home. M.G.'s pulse and weight were measured, and there was a note on the chart that M.G. had "CBP" (which is presumably chronic back pain) and a toothache. A notation at the bottom of the chart said "25$," but is not explained. Dr. Gillis prescribed the same regimen of 240 pills of oxycodone and 120 pills of oxycontin. In the current medications section of the chart, Dr. Gillis wrote "Meds." That notation was not explained. As in each of the previous visits, Dr. Gillis did not perform a urine screen to determine whether M.G. had been taking the medications or not.

39. M.G. came back to see Dr. Gillis on July 6, 2009. The chart for that visit says the chief complaint by M.G. was a surgical procedure called percantaneous distectomy and that M.G. "had care since the procedure." There is also a note that indicates "5 procedures," but the note is not explained. M.G. reported his pain level as five out of ten, with medications, and ten out of ten, without. Dr. Gillis prescribed the same, oxycodone and oxycontin medications as in the previous visits. There is no explanation as to why the medication levels were the

same, even though M.G. was reporting less pain than in prior visits and had undergone surgery during the interim.

40. M.G.'s next visit to Dr. Gillis was on August 5, 2009. His chief complaint on that day is essentially unreadable, and Dr. Gerber could not decipher it at all. There is a mention of Xanax in the chart, but its purpose is not explained. M.G.'s pain level is listed as six out of ten, with medications, ten out of ten, without. That is close to the pain levels described in the prior visit. However, without some sort of physical or functional exam or a psychological assessment, it was impossible to determine whether M.G. was functioning, no matter what his pain level. Dr. Gillis refilled the oxycodone and oxycontin prescriptions and added a prescription for ten tablets of Percocet 1/650, a minimal and almost useless dose. The "A/P" listed chronic lower back pain and seizure activities, but there was no discussion as to what seizures occurred or when.

41. On September 9, 2009, M.G. presented with a complaint of a stiff neck. The chart mentioned an MRI, but did not explain or elaborate on it. The assessment of the patient was listed as "Ch LBP" (presumably chronic lower back pain), but there was no explanation of the relationship between the assessment and the presenting problem. There was no documentation of care in treatment on the patient chart.

Dr. Gillis refilled the oxycodone and oxycontin and also added a prescription for Mobic, an anti-inflammatory medication.

42. M.G. came back to visit Dr. Gillis on October 7, 2009. The chief complaint said M.G. had good and bad days and that the last surgery did not have good results. His pain level was down to six out of ten, with medications, and ten out of ten, without. Chronic lower back pain continues to be the assessment and treatment plan notation. Nonetheless, he was prescribed the exact same levels of oxycodone and oxycontin as all of the other visits.

43. On November 4, 2009, M.G. returned to see Dr. Gillis. A different patient chart form was utilized by Dr. Gillis at that visit. The form includes a question, "Hello, how are you doing?" to which M.G. responded, "Terrible." M.G. said the ongoing treatment was working, but that he was not sleeping better. His pain level on that day was back up to seven out of ten, with medications. In her notes, Dr. Gillis said to "refill with adjustment with valium." There is no explanation as to why valium would be added to M.G.'s medication regimen.

44. M.G. then visited Dr. Gillis on December 2, 2009. In response to the question about how he was feeling, M.G. said he was "planning for surgery; not doing good." He said the treatment was working and he was sleeping better. The assessment update on the chart said chronic lower back pain with

exacerbations. The exacerbations were not explained. M.G. was prescribed the same medications as the previous visit.

45. M.G.'s thirteenth and last monthly visit to Dr. Gillis occurred on December 20, 2009. When asked how he felt, M.G. answered "Alright." He said the treatment was working, but that some of his medications had been stolen. He reported not having oxycodone for nine days and oxycontin for seven days (or, possibly, not having nine oxycodone tablets or seven oxycontin tablets, the record is not clear.) He also said he had taken his medications that very day, but there was no indication in the record as to which medications he was talking about. He said his lower back pain was at a level of seven to eight on that day. Dr. Gillis did not inquire about the inconsistent statements and refilled his prescriptions anyway.

46. The patient records for M.G. do not discuss whether he was paying for the cost of the prescriptions out-of-pocket or whether insurance was covering some of the cost. The cost of the medications would have been approximately $600.00 per month.

47. It is clear that M.G. presented as a complex patient and was obviously receiving medical care elsewhere at the same time he was being treated by Dr. Gillis. He was apparently receiving medications from other sources at the same time Dr. Gillis was treating him. Dr. Gillis was at least somewhat aware of M.G.'s other medical care, but she never did monitoring

or screening of M.G. that would have given her insight into how her treatment plan was interacting with M.G.'s other treatment. And, once Dr. Gillis saw that her treatment was not alleviating M.G.'s pain, she should have referred him to a board-certified pain management specialist.

48. Dr. Marc Gerber was accepted at final hearing as an expert witness for the Department. Dr. Gerber is a board-certified pain management specialist who currently treats patients with pain management issues. Dr. Gerber's testimony was clear, concise, and credible. He did not appear to have any prejudice against Dr. Gillis as a person, but was very concerned about how she was practicing medicine. His testimony forms the basis for the following findings of fact.

49. Relying upon the patient charts and patient information sheets provided by Dr. Gillis, there does not appear to have been a diagnosis of intractable pain for M.G. Intractable pain is pain for which, in the generally accepted course of medical practice, the cause cannot be removed and otherwise treated. There does not appear to have been an appropriate and complete physical examination of M.G. performed by Dr. Gillis.

50. The oxycodone and oxycontin prescriptions for M.G. over a 13-month period are excessive. Despite her initial note wherein she advised M.G. that his medication levels must be

decreased, Dr. Gillis continued the same regimen of oxycodone and oxycontin throughout M.G.'s treatment. There is no indication the medications were working, as M.G. continued to complain about pain for the entire 13 months he was under Dr. Gillis' care. Other than adding other medications, Valium, Mobic, Percocet, and Ambien for very brief periods, there was no change to M.G.'s prescription regimen. The patient charts for the visits to Dr. Gillis do not contain any justification for why the medications were prescribed in those quantities.

51. The amount of oxycodone and oxycontin prescribed was, in itself, excessive. According to the prescriptions, M.G. was supposed to take one oxycontin every six hours. Oxycontin is a time-release medication that should only be taken once every 12 hours at most. M.G. was prescribed eight tablets of 30 mg oxycodone per day, i.e., one every four hours or two every eight hours--in addition to the oxycontin. The totality of those medications could be lethal.

52. There are no indications in the patient charts that Dr. Gillis was taking vital signs and doing a physical evaluation of M.G. at every visit. Nonetheless, she continued to prescribe the high dosages of potentially lethal medications.

53. Most importantly, Dr. Gillis never had a urine drug screen done on M.G. Such a test would have revealed whether M.G. was actually taking the drugs he was prescribed. It would

have provided a determination of the level of drugs or other substances in M.G.'s body and then how the drugs were affecting him. A urine drug screen done at the time of M.G.'s earliest visit would have established a baseline for measuring the effectiveness and utility of future prescriptions. For a patient such as M.G., with a history of surgeries, a need for psychiatric evaluation, and a propensity to take large amounts of drugs, a urine drug screen would have been an essential element of the periodic review required for all such patients.

54. Dr. Gillis erroneously stated that she had rejected D.H. and R.S. as patients after their first and second visits, respectively. The evidence shows that both "patients" voluntarily stopped visiting the clinic after completing their undercover work. Neither of the patients was told by Dr. Gillis not to return (although D.H. was told not to come back without bringing his medical records).

55. Dr. Gillis did not testify at final hearing and did not provide any credible rebuttal to the facts asserted by the Department's witnesses. Dr. Gillis did demonstrate an understanding of the practice of medicine through her questioning of the Department's medical expert, but her treatment of patients R.S., D.H. and M.G. was deficient. The Department did not specifically allege, nor was there any evidence to support that Dr. Gillis intentionally practiced

medicine in an inappropriate manner. However, her treatment of the patients in question indicates serious shortcomings in her ability to effectively and appropriately manage pain for her patients. Furthermore, Dr. Gillis represented herself at final hearing and, without assistance of counsel, was not able to effectively present a strong defense to the Department's allegations. Although she was given ample opportunity to testify concerning her care and treatment of the patients at issue, she declined to do so. Although the Department's perception of Dr. Gillis' treatment of D.H., R.S. and M.G. was based on its expert's review of medical records only, Dr. Gillis's refusal to testify left Dr. Gerber's perception as the only reliable source of information.

CONCLUSIONS OF LAW

56. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to sections 120.57 and 120.569, Florida Statutes (2011).

57. The burden of proof in this case is on the Department to prove, by clear and convincing evidence, that sanctions or discipline should be imposed on Dr. Gillis based on the facts presented. Dep't of Banking & Fin. V. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996).

58. The Department has the right to impose discipline on physicians licensed by the State of Florida. Grounds for discipline are found in section 458.331. In the 2008 version of Florida Statutes, which are relevant to this proceeding, the following grounds for disciplinary actions are listed:

> (q) Prescribing, dispensing, or 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 [which] shall not be construed to require more than one instance, event, or act.
>
> 2. Committing gross medical malpractice.
>
> 3. Committing repeated medical malpractice as defined in s. 456.50. . .
>
> 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 . . . 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.

* * *

(nn) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

59. Section 458.326 states:

Intractable pain; authorized treatment.—-

(1) For the purposes of this section, the term "intractable pain" means pain for which, in the generally accepted course of medical practice, the cause cannot be removed and otherwise treated.

(2) Intractable pain must be diagnosed by a physician licensed under this chapter and qualified by experience to render such diagnosis.

(3) Notwithstanding any other provision of law, a physician may prescribe or administer any controlled substance under Schedules II-V, as provided for in s. 893.03, to a person for the treatment of intractable pain, provided the physician does so in accordance with that level of care, skill, and treatment recognized by a reasonably prudent physician under similar conditions and circumstances.

(4) Nothing in this section shall be construed to condone, authorize, or approve mercy killing or euthanasia, and no treatment authorized by this section may be used for such purpose.

60. Medical malpractice is defined as "the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. . . ." § 456.50(1)(g).

61. The standards for the use of controlled substances for the treatment of patients with intractable pain are set forth in Florida Administrative Code Rule 64B8-9.013 (the "Rule"). The Rule also directs practicing physicians to the Physicians Manual: An Informational Outline of the Controlled Substances Act of 1970, published by the U.S. Drug Enforcement Agency, for specific rules governing controlled substances, as well as applicable state regulations.

62. The Rule recognizes that controlled substances, including opioid analgesics, may be essential to the treatment of intractable pain. However, the Rule cautions physicians to use such drugs only when relying upon current knowledge. Further, physicians are cautioned to assess patients and adjust dosages according to the intensity and duration of the pain.

63. Evaluation of the patient is an essential standard set forth in the Rule. It includes a complete medical history and physical examination of the patient, including current and past treatments, underlying or co-existing diseases or conditions, and the effect of the pain on the patient's psychological and physical functioning. After evaluation, a treatment plan is the

next important standard to be met. The treatment plan should be written with objectives that can be used to determine treatment success and shall state whether other diagnostic evaluations or treatments are planned.

64. Under the standard for medical records in the Rule, the physician is required to keep accurate and complete records which must include at least the following:

> 1. The complete medical history and a physical examination, including history of drug abuse or dependence, as appropriate;
>
> 2. Diagnostic, therapeutic, and laboratory results;
>
> 3. Evaluations and consultations;
>
> 4. Treatment objectives;
>
> 5. Discussion of risks and benefits;
>
> 6. Treatments;
>
> 7. Medications (including date, type, dosage, and quantity prescribed;
>
> 8. Instructions and agreements;
>
> 9. Drug testing results; and
>
> 10. Periodic reviews. Records must remain current, maintained in an accessible manner, readily available for review, and must be in full compliance.

65. Chapter 456 addresses health professions, including physicians. Section 456.072 sets forth the grounds for

discipline; section 456.073 outlines the process for disciplinary proceedings.

66. The Department has established by clear and convincing evidence that Dr. Gillis failed to perform a complete physical examination on R.S. and D.H. The controlled substances prescribed to those two patients were, thus, inappropriate and excessive. There is inadequate evidence as to the nature of the physical examination for M.G.

67. The Department has established by clear and convincing evidence that Dr. Gillis failed to diagnose M.G. with intractable pain, but prescribed controlled substances in excessive amounts without proper monitoring, evaluation, or assessments. The failure to order a urine drug screen for M.G. despite prescribing voluminous quantities of opioid analgesics violated the standard of care.

68. Dr. Gillis violated the standard of care by not documenting or considering other treatment modalities for patients R.S., D.H., and M.G. Further, Dr. Gillis's repeated prescription of controlled substances to M.G. with differing complaints and results was a violation of the standard of care.

69. Despite noting the need for psychological evaluation for M.G., Dr. Gillis failed to confirm whether M.G. had received such an evaluation, while continuing to prescribe large quantities of a controlled substance to the patient.

70. Dr. Gillis prescribed potentially lethal doses of oxycodone and oxycontin to M.G. without sufficient justification. She also prescribed valium, Percocet and other drugs without sufficiently documented bases.

71. Dr. Gillis is guilty of committing medical malpractice based on the findings set forth herein.

72. In DOAH Case No. 11-5692,as to Count One involving patient, M.G., Dr. Gillis:

- Failed to diagnose M.G. with intractable pain prior to prescribing controlled substances;
- Inappropriately and excessively prescribed potentially lethal controlled substances;
- Excessively prescribed controlled substances; and
- Failed to order a urine drug screen when necessary.

73. As to Count Two involving M.G., Dr. Gillis:

- Failed to document justification for excessive prescription of controlled substances; and
- Failed to document her rationale for failing to order a urine drug screen.

74. As to Count Three involving M.G., Dr. Gillis violated the required standard of care by:

- Inappropriately and excessively prescribing controlled substances without justification;
- Failing to confirm whether the patient presented to a psychiatrist or psychologist;
- Failing to order a urine drug screen; and

- In appropriately and excessively prescribing controlled substances prior to exploring other modalities.

75. As to Count Four involving M.G., Dr. Gillis:

- Inappropriately and excessively prescribed controlled substances prior to exploring other treatment modalities;

- Inappropriately and excessively prescribed controlled substances without ordering a urine screen; and

- Inappropriately and excessively prescribing controlled substances without justification.

76. In DOAH Case No. 11-5961, as to Count One concerning patient R.S., Dr. Gillis violated section 458.331(1)(nn):

- By failing to perform or document performing a complete physical examination;

- Failing to explore or document exploring other treatment modalities;

- Failing to obtain or document obtaining a complete medical history;

- Failing to document the nature and intensity of pain;

- Failing to document the current or past treatments;

- Failing to document information on the effect of pain on the patient's physical or psychological function;

- Failing to develop or document developing a treatment plan; and

- Failing to determine or document determining if there were any underlying or coexisting diseases or conditions for the patient.

77. As to Count Two for patient R.S., Dr. Gillis violated sections 458.331(1)(nn) and 458.326 by:

- Failing to diagnose intractable pain;
- Prescribing Percocet without justification; and
- Prescribing Percocet without exploring other treatment modalities.

78. As to Count Three for patient R.S., Dr. Gillis failed to keep legible medical records justifying the course of treatment by:

- Failing to document justification for prescribing Percocet;
- Failing to document a complete physical examination prior to prescribing a controlled substance;
- Failing to document a complete medical history prior to prescribing a controlled substance;
- Failing to document a urine screen; and
- Failing to diagnose intractable pain.

79. As to Count Four for patient D.H., Dr. Gillis violated sections 458.331(1)(nn) and 458.326 by:

- Failing to perform or document performing a complete physical examination on either of his visits;
- Failing to obtain or document obtaining a complete medical history;
- Failing to explore or document exploring other treatment modalities;
- Failing to document the intensity or nature of the pain;

- Failing to document current or past treatments of the pain;

- Failing to document information on the effect of pain on the patient's physical or psychological function;

- Failing to develop or document developing a treatment plan; and

- Failing to determine if there were any underlying or coexisting diseases or conditions.

80. As to Count Six relating to patient D.H., Dr. Gillis failed to keep legible medical records by:

- Failing to document justification for prescribing 120 tablets of 30mg oxycodone;

- Failing to document a complete physical examination prior to prescribing a controlled substance;

- Failing to document a complete medical history;

- Failing to document a urine drug screening; and

- Failing to document a diagnosis of intractable pain prior to prescribing a controlled substance.

RECOMMENDATION

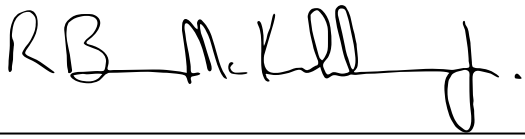
Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a final order be entered by the Department of Health suspending the license of Respondent, Jacinta Irene Gillis, M.D., until such time as Dr. Gillis can demonstrate competency in the practice of medicine, especially as it relates to pain management, to the satisfaction of the Board of Medicine.

It is further

RECOMMENDED that the final order assess the cost of investigating and prosecuting this case and that payment of such costs be a condition precedent to ending the suspension of Dr. Gillis's license to practice.

DONE AND ENTERED this 3rd day of February, 2012, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of February, 2012.

ENDNOTES

[1/] All statutory references are to Florida Statutes (2008), unless otherwise noted.

[2/] Norris did not testify at the final hearing. He is currently incarcerated in the Pinellas County Jail following his arrest for armed robbery of a pharmacy.

[3/] Negersmith was carrying a firearm because he had been advised that Norris sometimes robbed patients after they picked up their prescription from the pharmacy.

[4/] D.H. observed Norris selling the pills on the street in a drug deal.

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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.