STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case No. 12-79PL
HERBERT R. SLAVIN, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case before Edward T. Bauer, an Administrative Law Judge of the Division of Administrative Hearings, on June 22 and September 14, 2012, by video teleconference at sites in Tallahassee and Lauderdale Lakes, Florida.

APPEARANCES

For Petitioner: Sharmin Hibbert, Esquire
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For Respondent: Andrea Wolfson, Esquire
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent committed the allegations contained in the Amended Administrative Complaint, and if so, the penalty that should be imposed.

PRELIMINARY STATEMENT

On October 31, 2011, Petitioner, Department of Health, Board of Medicine, filed a two-count Administrative Complaint ("Complaint") against Respondent, Dr. Herbert Slavin. In Count I of the Complaint, Petitioner alleged that Respondent violated section 458.331(1)(t), Florida Statutes, in that his treatment of patient L.V. fell below the appropriate standard of care in one or more of the following ways: (a) by incorrectly diagnosing L.V. with hypothyroidism; (b) by prescribing a medication (desiccated thyroid) that was not medically indicated; (c) by prescribing an inappropriate dosage of the medication (assuming that desiccated thyroid was, in fact, medically indicated); (d) by failing to manage the care his physician assistant provided to L.V.; (e) by failing to adequately supervise the activities of his physician's assistant, as related to the treatment of L.V.; and (f) by failing to correctly interpret and/or respond to L.V.'s laboratory data. As an overlapping allegation, Petitioner further charged, in Count II of the Complaint, that Respondent failed to adequately supervise the activities of his physician assistant "as [they] related to the medical care and

treatment provided to . . . L.V.," contrary to section 458.331(1)(dd).

Respondent timely requested a formal hearing to contest the allegations, and, on January 6, 2012, the matter was referred to the Division of Administrative Hearings ("DOAH") and assigned to Administrative Law Judge John G. Van Laningham.

On June 14, 2012, Petitioner moved to amend its Complaint in order to clarify several of the underlying factual assertions. (The Amended Administrative Complaint, which was attached to Petitioner's motion, did not include any additional charges or theories of guilt.) Judge Van Laningham conducted a telephonic hearing on the motion on June 15, 2012, during which Petitioner represented that it no longer intended to pursue any allegation that Respondent had failed to supervise his physician assistant——remarks that Judge Van Laningham and Respondent's counsel reasonably interpreted as an abandonment of Count II, as well as theories (d) and (e) of Count I. An order granting Petitioner's motion was issued the same day, and, on June 21, 2012, Judge Van Laningham transferred the instant matter to the undersigned for further proceedings.

As noted above, the final hearing in this matter was held on June 22, 2012, during which the undersigned ruled that Petitioner would not be permitted to pursue Count II or theories (d) or (e) of Count I. In support of the remaining allegations,

Petitioner presented the testimony of three witnesses (L.V., Dr. Elton Shapiro, and Dr. Vanessa Rodriguez) and introduced 17 exhibits, labeled 1-7 and 9-18.[1/] Respondent testified on his own behalf, presented the testimony of Shirley Jimenez, and introduced two exhibits, numbered 1-2, which included the deposition transcript of Respondent's expert witness, Dr. Edwin Lee. At the conclusion of the hearing, the undersigned granted the request of Respondent's counsel for a deadline of 20 days from the filing of the final hearing transcript for the submission of proposed recommended orders.

The final hearing Transcript was filed with DOAH on October 24, 2012. Thereafter, the undersigned granted the parties' joint request to extend the proposed recommended order deadline to December 20, 2012. Both parties submitted proposed recommended orders, which the undersigned has considered in the preparation of this Recommended Order.

FINDINGS OF FACT

A. The Parties

1. Petitioner Department of Health has regulatory jurisdiction over licensed physicians such as Respondent. In particular, Petitioner is authorized to file and prosecute an administrative complaint, as it has done in this instance, when a panel of the Board of Medicine has found probable cause exists

to suspect that the physician has committed one or more disciplinable offenses.

2. At all times relevant to this proceeding, Respondent was a physician licensed in the State of Florida, having been issued license number ME 36889, and his medical office was located at 7200 West Commercial Boulevard, Suite 210, Fort Lauderdale, Florida.

3. As mentioned previously, Petitioner alleges in this cause that Respondent's treatment of patient L.V. fell below the minimum standard of care in that: thyroid medication was prescribed in the absence of medical necessity; or, even assuming that some amount of thyroid medication was indicated, L.V. was prescribed excessive doses of the drug. To facilitate the reader's understanding of these issues, the factual recitation will be preceded by a brief description of the thyroid gland and anterior pituitary, as well as the hormones secreted by these glands.

B. Relevant Glands and Hormones

4. The thyroid gland (or simply, "the thyroid") is one of the human body's primary endocrine glands. The thyroid secretes several thyroid hormones——Triiodothyronine ("T3"), the active form of thyroid hormone; and Thyroxine ("T4"), which is inactive——that control and regulate the body's metabolism, development, growth, and temperature.

5. The production of T3 and T4 is regulated by thyroid-stimulating hormone ("TSH"), which is produced by the anterior pituitary gland. Generally speaking, when thyroid hormone levels are low, the production of TSH increases; conversely, TSH production decreases when thyroid hormones concentrations are high. Accordingly, a high TSH level is suggestive of an underactive thyroid or hypothyroidism, while a depressed level of TSH indicates an overactive thyroid or hyperthyroidism.

C. Treatment of L.V.

6. On October 7, 2008, patient L.V., a 57-year-old female, presented to Respondent's medical office to address, in the patient's words, "hormonal problems."

7. As it was her first visit to Respondent's office, L.V. was asked to complete a new patient intake form that solicited, among other information, her current symptoms and previous medical conditions. In the form, L.V. disclosed a variety of complaints: dizziness, fatigue, insomnia, forgetfulness, a rapid heartbeat,[2/] and post-menopausal symptoms.

8. After completing the paperwork referenced above, L.V. was seen by Shirley Jimenez, Respondent's physician assistant, who conducted a physical examination[3/] and gathered a complete history. During her visit with Ms. Jimenez, L.V. revealed, as an additional complaint, that she occasionally experienced intolerance to cold.

9. At the conclusion of the October 7, 2008, appointment, Ms. Jimenez recommended, with Respondent's approval, that blood work be conducted——to determine, among other things, the levels of T3, T4, and TSH——and that L.V. return for a follow-up appointment in several weeks.

10. On or about October 21, 2008, the results of L.V.'s blood work were forwarded to Respondent for his review. With respect to L.V.'s levels of T3, T4, and TSH, the laboratory report indicated the following values and reference ranges (i.e., the levels deemed "normal" by the laboratory):

Hormone	Result	Reference Ranges
T3, Free:	264 pg/dL	230-420 pg/dL
T4, Free:	1.1 ng/dL	0.8-1.8 ng/dL
TSH:	2.94 mIU/L	0.40-4.50 mIU/L

11. L.V.'s next office appointment was on October 23, 2008, during which she met Respondent for the first time. On that date, Respondent determined, based upon a review of L.V.'s complaints and symptoms (fatigue, dizziness, cold intolerance, forgetfulness, and low basal body temperature) and an examination of the laboratory results——as enumerated above, a T3 level at the low end of the reference range and a TSH value greater than 2.50 mIU/L, considered by Respondent to be high in light of L.V.'s symptoms——that the patient suffered from thyroid

dysfunction. Notably, and contrary to Petitioner's allegations, Respondent did not diagnose L.V. with hypothyroidism.[4/]

12. Believing that L.V.'s symptoms could be alleviated by increasing her T3 level into the upper half of the typical range (i.e., 350 pg/dL), Respondent prescribed a low dosage of desiccated thyroid——a medication prepared from pig thyroids, which contains both T3 and T4——in the amount of .25 grain, which L.V. was instructed to take twice daily.[5/] By all accounts, L.V. began taking the desiccated thyroid medication on or about October 23, 2008, and continued to do so until April 19, 2009.

13. L.V. appeared for her third appointment on November 12, 2008, during which the patient made no indication of adverse side effects from the desiccated thyroid. At the conclusion of the office visit, Respondent refilled L.V.'s prescription at the same dosage.

14. One month later, on December 12, 2008, a second blood sample was collected from L.V. The results, which were reported to Respondent on December 22, 2008,[6/] indicated little to no change in L.V.'s levels of T3, T4, and TSH:

Hormone	Result	Reference Ranges
T3, Free:	255 pg/dL	230-420 pg/dL
T4, Free:	1.0 ng/dL	0.8-1.8 ng/dL
TSH:	3.00 mIU/L	0.40-4.50 mIU/L

15. During her next office appointment, which occurred on December 29, 2008, L.V. once again reported no adverse side effects from the medication. L.V. did, however, state that she continued to suffer from vertigo, fatigue, and forgetfulness. In light of these persistent symptoms, as well as the laboratory results that revealed no meaningful change in the levels of T3, T4, and TSH (indeed, the T3 value had decreased slightly), Respondent increased the dosage of desiccated thyroid to .5 grain twice daily.

16. L.V. appeared for her fifth office visit on January 13, 2009, at which time she reported, once again, that she continued to experience vertigo and fatigue. Respondent concluded, reasonably, that L.V. should be continued on desiccated thyroid at the current dosage due to the relatively short amount of time that had elapsed (15 days) since the medication's increase to .5 grain twice daily; in other words, Respondent believed that the additional time was needed for the higher dosage to produce results.

17. On February 10, 2009, L.V. provided a third blood sample, the results of which were reported to Respondent 14 days later. In contrast to the previous sample, which demonstrated little or no change in L.V.'s hormone levels, the February 10 laboratory report showed that the medication was beginning to

achieve the desired effect——i.e., increases in the T3 and T4 hormones, as well as a corresponding decrease in TSH:

Hormone	Result	Previous Result	Reference Ranges
T3, Free:	293 pg/dL	255 pg/dL	230-420 pg/dL
T4, Free:	1.1 ng/dL	1.0 ng/dL	0.8-1.8 ng/dL
TSH:	1.78 mIU/L	3.00 mIU/L	0.40-4.50 mIU/L

18. L.V.'s final office appointment, at least as an active patient of Respondent's, was on February 24, 2009. During the visit, L.V. reported some improvement with her vertigo and fatigue, and, as was the case during each of the prior appointments, L.V. neither disclosed, nor did Respondent or his staff detect, any adverse side effects from the thyroid medication. In light of L.V.'s continued symptoms; her T3 level, which was still significantly below Respondent's target of 350 pg/dL; and demonstrated ability to tolerate the medication, Respondent determined that an increase of the desiccated thyroid to .5 grain three times daily would prove helpful.

D. L.V.'s Hospitalization

19. Nearly two months later, on April 19, 2009, L.V. presented to the emergency room at Coral Springs Medical Center ("Coral Springs") and reported that she was experiencing "chest pains"; she also informed the medical staff that she had been suffering, for approximately three weeks, from persistent

diarrhea——a condition that L.V. had experienced on multiple occasions over the years, long before she began taking the desiccated thyroid medication prescribed by Respondent. Based upon the nature of the complaints, L.V. was promptly admitted to the hospital for evaluation and treatment.

20. L.V. remained hospitalized at Coral Springs for the next several days, during which time no evidence of a cardiac event was discovered. Indeed, the treating cardiologist summed up L.V.'s symptoms as follows: "Non-cardiac chest pain. The less said about this the better. No further investigation needed."

21. With respect to L.V.'s diarrhea, the treating endocrinologist, Dr. Vanessa Rodriguez, attributed the symptom to iatrogenic hyperthyroidism (i.e., physician-induced overactive thyroid). Dr. Rodriguez reached this conclusion based upon L.V.'s low TSH level (.02 and .03 mIU/L on April 19 and 21, respectively), notwithstanding L.V.'s normal thyroid values[7/] and the absence of symptoms frequently associated with hyperthyroidism, such as rapid heartbeat,[8/] tremors, and hyperreflexia. Based upon her diagnosis——which, as discussed later in this Recommended Order, is rebutted by the credible testimony of Respondent's expert——Dr. Rodriguez instructed L.V. to discontinue the desiccated thyroid medication.

E. Expert Testimony

22. During the final hearing in this cause, Petitioner presented the testimony of Dr. Elton Shapiro, a board-certified endocrinologist, in support of its contention that Respondent's treatment of L.V. departed from the standard of care.

23. During his direct examination, Dr. Shapiro opined, first, that Respondent violated the standard of care by initiating treatment with desiccated thyroid medication where the patient's TSH did not fall outside the testing laboratory's reference range. In Dr. Shapiro's view, once it is determined that a patient's TSH level is within the upper limit of the reference range established by the laboratory (typically 4.5 mIU/L),[9/] it is improper for a physician to begin thyroid supplementation——irrespective of the patient's symptoms,[10/] thyroid hormone levels (i.e., T3 and T4), or the proximity of the TSH value to the upper end of the range. Thus, per Dr. Shapiro's conception of the standard of care, a physician would commit misconduct by prescribing, ab initio, thyroid medication to a patient with a TSH of 4.4 mIU/L (a value barely within the upper limit), even if the levels of T3 and T4 are low and the patient exhibits symptoms consistent with thyroid dysfunction.

24. Dr. Shapiro further opined that once thyroid medication is prescribed——which, per the witness, may only occur

if the TSH is greater than 4.5 mIU/L——a physician should endeavor to decrease the patient's TSH to a range of .3-3.0 mIU/L, with an optimum level of 2.0 mIU/L. Thus, Dr. Shapiro accepts as "normal," for initial diagnostic purposes, a TSH level that does not exceed the upper reference range of 4.5 mIU/L; upon the initiation of therapy, however, a TSH level previously regarded during the diagnostic phase as acceptable (e.g., 4.0 mIU/L) is less than ideal and worthy of downward movement. In other words, what is considered "normal" or optimal depends, in Dr. Shapiro's view, on whether the patient has already been placed on thyroid medication or has yet to begin such therapy.[11/]

25. With respect to Respondent's treatment of L.V. during the period of November 2008 through February 2009 (i.e., after the patient began taking thyroid medication), Dr. Shapiro testified that Respondent deviated from the standard of care by: ordering a refill of the thyroid medication in November 2008; increasing the dosage of thyroid medication in December 2008; continuing L.V. on the medication in January 2009; and increasing the dosage a second time in February 2009. As the sole basis for his opinion that continued treatment was not warranted, Dr. Shapiro noted that L.V.'s TSH levels in December 2008 and February 2009 (3.00 mIU/L and 1.78 mIU/L, respectively) did not exceed the upper end of the laboratory reference range

(4.5 mIU/L) and were therefore "normal." This testimony appears, however, to be inconsistent with the witness' own standard, as described in the previous paragraph of this Recommend Order: i.e., once thyroid supplementation has begun, the laboratory reference ranges are supplanted by a permissible range of .3-3.0 mIU/L and a target of 2.0 mIU/L.[12/]

26. Finally, Dr. Shapiro opined, based solely upon L.V.'s extremely low TSH levels upon her admission to the hospital, that Respondent's treatment resulted in the patient's development of iatrogenic hyperthyroidism.

27. On cross-examination, Dr. Shapiro was asked, on a number of occasions, to enumerate the sources upon which he relied in his articulation of the standard of care. In response, Dr. Shapiro repeatedly testified that his opinions were derived from guidelines promulgated by the American College of Endocrinology ("ACE guidelines"),[13/] which contemplate that thyroid supplementation is properly initiated only where a patient's TSH level is greater than the testing laboratory's reference range[14/]; once treatment is initiated, the guidelines call for a TSH range of .3-3.0 mIU/L and a target of 2.0 mIU/L.[15/]

28. Critically, however, Dr. Shapiro never testified that the ACE guidelines were intended by its drafters to establish a standard of care, nor, more importantly, did he testify that

Florida physicians adhere to these guidelines with such uniformity that they mark the standard of a minimally competent practitioner. Instead, Dr. Shapiro's testimony simply reflects that he regards the ACE guidelines as absolute and binding, which, as discussed later in this Recommended Order, is insufficient to establish the standard of care by clear and convincing evidence.

29. Even assuming that Dr. Shapiro' exclusive reliance on the ACE guidelines is a deficiency that can be brushed aside, the undersigned would nevertheless reject his opinions in favor of those articulated by Respondent's expert witness, Dr. Edwin Lee.[16/] Dr. Lee, a board-certified endocrinologist, credibly opined, first, that Respondent's initiation of treatment was consistent with the standard of care in light of L.V.'s symptoms, initial TSH value (which exceeded 2.5 mIU/L), as well as L.V.'s level of T3, Free, which was measured at the low end of the reference range. (Dr. Lee explained that 95% of normal patients have a TSH level of 2.5 mIU/L or less, and that a value in excess of 2.5 mIU/L is an indication of mild underactive thyroid.) Further, Dr. Lee testified, again credibly, that Respondent's continued treatment of L.V. with increasing levels[17/] of desiccated thyroid supplementation comported with the standard of care where the patient, who had demonstrated no adverse reactions to the medication, continued to present with

symptoms and sub-optimal laboratory values (i.e., levels of T3 below an ideal range of 300-350 pg/dL, and TSH values outside a target range of .3-1.0 mIU/L).

30. Finally, Dr. Lee credibly opined that that Respondent's treatment of L.V. with desiccated thyroid medication did not result in iatrogenic hyperthyroidism. In support of this opinion, Dr. Lee emphasized, among other factors, that L.V.'s T3 and T4 levels, as well as heart rate, were entirely normal upon the patient's admission to the hospital.[18/] Dr. Lee further observed, correctly in the undersigned's view, that L.V.'s persistent diarrhea——a condition from which the patient had suffered on multiple occasions over the years, long before she began treatment with Respondent——was more likely caused by medications (Flagyl and Levaquin) prescribed by another physician.

CONCLUSIONS OF LAW

A. Jurisdiction

31. DOAH has jurisdiction over the parties and subject matter of this cause, pursuant to section 120.57(1), Florida Statutes.

B. The Burden and Standard of Proof

32. This is a disciplinary proceeding in which Petitioner seeks to discipline Respondent's license to practice medicine. Accordingly, Petitioner must prove the allegations contained in

the Amended Administrative Complaint by clear and convincing evidence. Dep't of Banking & Fin., Div. of Secs. & Investor Prot. v. Osborne Sterne, Inc., 670 So. 2d 932, 935 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292, 294 (Fla. 1987).

33. Clear and convincing evidence:

> [R]equires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and lacking in confusion as to the facts in issue. The evidence must be of such a weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

C. Petitioner's Authority to Impose Discipline; The Charge Against Respondent

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

35. In Count I of the Amended Administrative Complaint, Petitioner charges Respondent with a violation of section 458.331(1)(t), which provides three grounds for disciplinary action:

> 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.
>
> 2. Committing gross medical malpractice.
>
> 3. Committing repeated medical malpractice as defined in s. 456.50. A person found by the board to have committed repeated medical malpractice based on s. 456.50 may not be licensed or continue to be licensed by this state to provide health care services as a medical doctor in this state.

(emphasis added).

36. Of the three forms of malpractice detailed above, Petitioner asserts only that Respondent is guilty of "medical malpractice," which is defined, in relevant part, 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), Fla. Stat. In turn, section 766.102(1), Florida Statutes, provides:

> 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.

(emphasis added).

37. In paragraph 33 of the Amended Administrative Complaint, Petitioner contends that Respondent failed to meet the standard of care in one or more of the following ways:

> a. by incorrectly diagnosing Patient L.V. with hypothyroidism;
>
> b. by prescribing a medication, desiccated thyroid, either Armour or Nature-throid, which was not medically indicated in Patient L.V.;
>
> c. by failing to prescribe an appropriate and/or correct dosage of desiccated thyroid, Armour or Nature-throid, if it was medically indicated in Patient L.V.;
>
> * * *
>
> f. by failing to correctly interpret and/or respond to Patient L.V.'s laboratory data results while continually treating her for hypothyroidism.

38. In light of the undersigned's finding that Respondent never diagnosed L.V. with hypothyroidism, Petitioner's first theory of guilt is rejected without further discussion.

39. With respect to the remaining theories, Petitioner attempts to prove Respondent's guilt through the testimony of its expert, Dr. Shapiro, that the treatment of L.V. deviated from the ACE guidelines——the provisions of which, in Dr. Shapiro's opinion, constitute the standard of care because he agrees with their content and believes that physicians are bound to follow them. As alluded to previously, however, and as discussed in greater detail below, such testimony lacks probative force and is substantively deficient.

40. First, it is well-settled that although an expert may rely upon information that has not been admitted into evidence

in forming an opinion, e.g., the ACE guidelines, it is improper for an expert to base an opinion entirely on hearsay. Linn v. Fossum, 946 So. 2d 1032, 1037-38 (Fla. 2006); Gerber v. Iyengar, 725 So. 2d 1181, 1185 (Fla. 3d DCA 1998).

41. Further, and on a more fundamental level, Dr. Shapiro's testimony is unpersuasive because it betrays a misunderstanding of the means by which a standard of care is properly formulated. In lieu of testimony that "a physician must do X, Y, and Z because certain guidelines require it," Petitioner must instead demonstrate through its expert that "X, Y, and Z represent the prevailing practices in the community because X, Y, and Z are what physicians actually do." See Sweet v. Sheehan, 932 So. 2d 365, 368 (Fla. 2d DCA 2006)(observing that a physician owes a duty to "use the ordinary skills, means and methods that are recognized as necessary and which are customarily followed in the particular type of case to the standard of those who are qualified by training and experience to perform similar services in the community or in a similar community")(emphasis added)(quoting Brooks v. Serrano, 209 So. 2d 279, 280 (Fla. 4th DCA 1968)); Dep't of Health v. Gaeta, Case No. 11-5793, 2012 Fla. Div. Adm. Hear. LEXIS 301, *17-18 (Fla. DOAH June 12, 2012; DOH Sept. 5, 2012)(emphasizing that the standard of care "must be based on generally prevailing peer

performance, that is, be recognized as necessary and customarily followed in the community.")

42. Dr. Shapiro's testimony that he considers the guidelines to be binding on himself (and others) falls well short of persuading the undersigned, by clear and convincing evidence, that the guidelines are customarily followed by Florida physicians and, therefore, represent the standard of care. See Diaz v. New York Downtown Hosp., 784 N.E.2d 68, 70 (N.Y. 2002)(holding expert testimony failed to create a triable issue of negligence in the absence evidence that guidelines of the American College of Radiology, upon which the expert relied, had been generally accepted and implemented by hospitals); see also LaFarge v. Kyker, 2011 U.S. Dist. LEXIS 143015, *11-12 (N.D. Miss. Dec. 12, 2011)(observing, in the context of a medical malpractice action, that guidelines published by American College of Cardiology and the American Heart Association "are indeed just 'guidelines'" and do not set forth the standard of care); Bettis v. Wade, 2011 Ill. App. Unpub. LEXIS 1337, *15 (Ill. App. Ct. May 6, 2011)("Since there was no showing that the guidelines were observed by others in the relevant chiropractic community, it was improper for Dr. Sash to rely on them to establish the standard of care applicable to defendant"); Dowling v. Deakins, 2009 Minn. Dist. LEXIS 27, *8 (Minn. Dist. Ct. Sept. 1, 2009)("Policies and guidelines do not

set the standard of care. Rather, in a medical negligence case . . . the standard of care is established through expert testimony regarding the prevailing standard of care in the community.").

43. Even assuming, arguendo, that Dr. Shapiro's testimony did not suffer from the defects outlined above, his views concerning the propriety of L.V.'s treatment are less persuasive than those of Dr. Lee's. This is so because Dr. Shapiro never cogently articulated, other than by reference to the ACE guidelines, why a TSH value, albeit the most sensitive means of evaluating thyroid function, should be relied upon exclusively in determining whether thyroid supplementation should be initiated or continued. In other words, Dr. Shapiro failed to explain why a physician, once in possession of a patient's laboratory results, must completely exclude the patient's physical symptoms and levels of T3 and T4——the hormones actually produced by the thyroid——from the decision-making process.

44. Dr. Lee's articulation of the standard of care, on the other hand, is far less mechanical in that it takes into account the patient's T3 and T4 levels,[19/] symptoms, as well as the TSH levels in the management of a patient's treatment. Dr. Lee's approach, in short, is more appealing in that it leaves greater room for the application of judgment and discretion——elements that must be at a physician's disposal if medicine is to be both

a science and an art. See Chandler v. Greenstone Ltd., 2011 U.S. Dist. LEXIS 90122 (W.D. Wash. Aug. 12, 2011)("[T]he evidentiary . . . reliability of a physician's testimony must be evaluated with an awareness that medicine is both an art and a science"); Nat'l Union of Hosp. & Health Care Emps. v. Cnty. of Cook, 692 N.E.2d 1253, 1263 (Ill. App. Ct. 1998)(distinguishing the practice of medicine from "mechanical and routinized" tasks and observing that modern medicine is both a science and an art).

45. For the reasons elucidated above, Petitioner has failed to adduce clear and convincing evidence that Respondent violated section 458.331(1)(t) in the manner alleged in the Amended Administrative Complaint.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that a final order be entered by the Board of Medicine dismissing Counts I and II of the Amended Administrative Complaint.

DONE AND ENTERED this 7th day of January, 2013, in Tallahassee, Leon County, Florida.

EDWARD T. BAUER
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 7th day of January, 2013.

ENDNOTES

[1/] The deposition transcript of Dr. Guy Zingaro (identified as Petitioner's Exhibit 10) has been received in lieu of the witness' live testimony.

[2/] Ms. Jimenez testified credibly that L.V. did not present with a rapid heartbeat during any office visit. The undersigned's finding in this regard does not conflict with the Joint Prehearing Stipulation, wherein the parties simply agreed that L.V. "complained" of heart palpitations.

[3/] The physical examination also included an EKG, which yielded unremarkable results.

[4/] See transcript of September 14, 2012, proceedings at p. 81, lines 23-25.

[5/] Although not relevant to the issues raised in the Amended Complaint, Respondent also prescribed Vitamin D and progesterone.

[6/] See Petitioner's Exhibit 12, p. 595 (Petitioner's exhibits are marked with two sets of page numbers; the undersigned's

references are to the "Bates numbering"); see also transcript of September 14, 2012, proceedings at pp. 85-86.

[7/] The April 21 testing revealed a T3 of 390 pg/dL, which was within the upper limit of 420 pg/dL, and a T4 level of 1.00, which likewise fell within the reference ranges.

[8/] L.V.'s hospital records reflect a normal heart rate upon her arrival at the emergency room (72 beats per minute) and during her subsequent period of hospitalization. See Pet Ex. 15, pp. 133-136 (references are to the "Bates numbering.")

[9/] See transcript of June 22, 2012, proceedings at p. 188, lines 9-11.

[10/] See transcript of September 14, 2012, proceedings at p. 8, lines 5-17.

[11/] See transcript of June 22, 2012, proceedings at p. 191, lines 24-25; p. 192, lines 1-3.

[12/] This discrepancy is likely explained by Dr. Shapiro's view that treatment should not have been initiated in the first instance.

[13/] See transcript of September 14, 2012, proceedings at p. 9, lines 12-14.

[14/] See transcript of September 14, 2012, proceedings at p. 8, lines 14-22; p. 9, lines 8-14.

[15/] See transcript of June 22, 2012, proceedings at p. 191, lines 24-25; transcript of September 14, 2012, proceedings at p. 58, lines 1-3.

[16/] The undersigned hereby accepts Dr. Lee (whose deposition has been received in lieu of live testimony) as an expert in the specialty of endocrinology.

[17/] In its Proposed Recommended Order, Petitioner highlights Dr. Lee's concession that a physician would violate the standard of care if the level of thyroid medication were increased in the absence of current laboratory values. That is true as far as it goes——but it does not advance Petitioner's cause. As detailed elsewhere in this order, Respondent ordered (and reviewed) blood tests prior to each dosage increase. See Petitioner's Exhibit 12, pp. 595 and 605 (references are to the "Bates numbering");

see also transcript of September 14, 2012, proceedings at p. 85, lines 11-25; p. 86, lines 1-17; p. 92, lines 1-11.

[18/] Although L.V.'s TSH was indeed low, the undersigned credits Dr. Lee's testimony that iatrogenic hyperthyroidism does not occur in the absence of abnormal T3 or T4 levels.

[19/] See Respondent's Exhibit 2, pp. 10; 17; 22; 70, lines 21-25; 71, line 1.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order must be filed with the agency that will issue the final order in this case.