STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case Nos. 15-2888PL
15-2889PL
JOHN L. LENTZ, JR., M.D., 15-2890PL

Respondent.
_____/

RECOMMENDED ORDER

On January 26 through 29, 2016, Administrative Law Judge Lisa Shearer Nelson of the Florida Division of Administrative Hearings (DOAH) conducted a duly-noticed hearing pursuant to section 120.57(1), Florida Statutes (2015), in Destin, Florida.

APPEARANCES

For Petitioner: Chad Wayne Dunn, Esquire
John B. Fricke, Esquire
Prosecution Services Unit
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399

For Respondent: Jacques G. Simon, Esquire
488 Madison Avenue, Suite 1100
New York, New York 10022

STATEMENT OF THE ISSUES

The issues to be determined in this proceeding are whether Respondent, John L. Lentz, Jr., M.D., committed the disciplinary violations charged with respect to seven patients in three

Administrative Complaints that have been consolidated for the purpose of hearing. If the facts demonstrate that any of the charged violations have been committed, then the appropriate penalty to be imposed for such violations must be recommended.

PRELIMINARY STATEMENT

On August 19, 2013, Petitioner, Department of Health (DOH or the Department), filed a one-count Administrative Complaint in DOH Case No. 2011-15106, charging Respondent with violating section 458.331(1)(t), Florida Statutes (2010-2011), by his diagnosis and treatment of patient C.C. with Lyme disease and Babesiosis. On September 16, 2013, Respondent executed an Election of Rights form disputing the allegations in the Administrative Complaint and requesting a hearing pursuant to section 120.57(1).

On November 13, 2013, the Department filed a second Administrative Complaint against Respondent in DOH Case No. 2011-18613. In this 11-count Administrative Complaint, the Department charged Respondent with violating section 458.331(1)(g), (m), and (t), with respect to his diagnosis of and treatment for Lyme disease, Bartonella, and Babesiosis with respect to patients D.H., J.L., W.L., D.D., and S.L., and the alleged failure to report the suspicion of or diagnosis of Lyme disease. On December 2, 2013, Respondent filed

an Election of Rights disputing the allegations in this Administrative Complaint, and requesting a disputed-fact hearing.

On November 13, 2013, the Department also filed an Administrative Complaint in DOH Case No. 2012-01987. In this third case, the Department charged Respondent with violating section 458.331(1)(g), (m), and (t), with respect to his diagnosis and treatment of patient C.H. with Lyme disease and Babesiosis, as well as failure to report the suspicion or diagnosis of Lyme disease. On December 2, 2013, Respondent filed an Election of Rights disputing the allegations of the Administrative Complaint and requesting a hearing pursuant to section 120.57(1).

On May 22, 2015, all three cases were referred to the Division of Administrative Hearings for assignment of an administrative law judge, and were docketed as DOAH Case Nos. 15-2888, 15-2889, and 15-2890, respectively. Petitioner moved to consolidate the three proceedings, and the motion was granted by Order dated June 5, 2015. Jacques G. Simon, an attorney licensed in the State of New York, requested acceptance as a qualified representative for Respondent, and his request was granted also by Order dated June 5, 2015.

The consolidated proceeding was originally scheduled for hearing to take place September 29 through October 2, 2015. At the request of the parties, the hearing was continued twice and

rescheduled for January 26 through 29, 2016, at which time the hearing was commenced and concluded. At the hearing, Joint Exhibits 1 through 31 were admitted into evidence. Petitioner presented the testimony of Dr. John Lentz, Dr. Charles Powers, Dr. William J. Robbins, Dr. Janelle Robertson, Dr. Patrick Anastasio, Ashley Rendon, J.H. (wife of patient D.H.), patient J.L., patient W.L., and patient S.L. Included in the Joint Exhibits were the depositions of Dr. Joel Rosenstock, patient C.H., and S.H. (mother of patient C.H.) in lieu of live testimony, as well as the depositions of Dr. Anastasio, Dr. Robertson, patient C.C., C.T.,[1/] Dr. Powers, and Dr. Robbins. Petitioner's Exhibits 1 through 4 were also admitted. Respondent testified on his own behalf and presented the testimony of Kerry L. Clark, Ph.D.; Michael Cichon, M.D.; patient C.C.; and M.C. (wife of patient C.C.).

On January 9, 2016, the parties filed a Joint Pre-hearing Stipulation in which they stipulated to certain facts which, where relevant, have been incorporated into the Findings of Fact below. The seven-volume Transcript of the proceedings was filed with DOAH on February 25, 2016. Three requests for extensions of time to file the parties' proposed recommended orders were filed. The first two were granted and the third granted in part, ultimately extending the deadline for post-hearing submissions to May 10, 2016. The page limit for the proposed recommended orders

also was extended to no more than 85 pages. Both Proposed Recommended Orders were timely filed and have been carefully considered in the preparation of this Recommended Order. Respondent's proposed recommended order includes an "Attachment A," which purports to be Petitioner's reporting requirements for the reporting criteria for Lyme disease and requests the undersigned to take "judicial notice" of the untitled document. The document was not identified as part of any of the exhibits submitted in this case, and section 120.569(2)(i), Florida Statutes, requires that when "official recognition is requested, the parties shall be notified and given an opportunity to examine and contest the material." Given that no request for official recognition was filed, the undersigned has not considered the attachment to Respondent's proposed recommended order.

All references to Florida Statutes are to the ones in effect at the time of the alleged violations, unless otherwise indicated.

FINDINGS OF FACT

Based upon the testimony and documentary evidence presented at hearing, the demeanor and credibility of the witnesses, and on the entire record of this proceeding, the following findings of fact are made:

1. Petitioner is the state agency charged with the licensing and regulation of the practice of medicine pursuant to section 20.43 and chapters 456 and 458, Florida Statutes.

2. At all times material to these proceedings, Respondent was a licensed physician in the State of Florida, having been issued license number ME 82437.

3. Respondent's address of record is 15200 Emerald Coast Parkway, St. Marten Unit 506, Destin, Florida 32541.

4. Respondent was board-certified by the Academy of Family Physicians until 2009. He currently holds no board certification in any specialty area, and did not complete any residency other than his residency in family medicine. Respondent went to medical school at the University of South Carolina and initially practiced in that state. He moved to Florida in 2001 and since that time, has worked in a variety of practice settings, including working as an emergency room physician in several hospitals in areas such as Phenix City, Alabama; Panama City, Florida; and Defuniak Springs, Florida.

5. At some point, Respondent became interested in the diagnosis and treatment of Lyme disease, and in approximately 2007, he opened a clinic in Destin named the Lentz Lyme Clinic. Respondent attended four continuing medical education courses that focused on the diagnosis and treatment of Lyme disease. Each of the courses he attended was three to four days long.

Diagnosis and Treatment of Lyme Disease

6. Lyme disease is an infectious disease caused by the bacteria Borrelia burgdorferi. Lyme disease is typically transmitted by a tick bite from what is often referred to as a deer tick, more formally known as the Ixodes scapularis tick. The tick is usually very small, and must remain on the person's skin for approximately 36 hours or more in order for the disease to be transmitted. Lyme disease is generally considered to be endemic to the Northeastern United States, in states such as the New England states, Pennsylvania, upstate New York, Delaware, and northern Virginia. While it is not impossible to contract Lyme disease in Florida, the more persuasive evidence established that it is not prevalent in this state. The most credible, compelling evidence presented established that most people who are diagnosed in Florida with Lyme disease were most likely infected while traveling in a part of the country that is endemic for the disease, and that states in the Southeastern United States are in a low-risk area for Lyme disease.

7. There was some conflict in the testimony concerning the stages and symptoms of Lyme disease, and what factors should be considered in diagnosing the disease at the various stages. The more credible and persuasive descriptions of Lyme disease and its stages describe the disease as having three stages: early localized Lyme disease; early disseminated Lyme disease; and late

Lyme disease. The probable stage of the disease at the time a patient presents for diagnosis and treatment determines what is necessary for a diagnosis.

8. Early localized Lyme disease is the disease as it typically presents within the first four weeks of the tick bite. The patient often, but not always, presents with a rash called an erythema migrans, which is generally over five centimeters wide (and can be as large as 19 centimeters) and is sometimes clear in the center, leading to the term "bull's-eye rash" to describe it. In addition to the erythema migrans, a patient may present with virus-like symptoms, such as fatigue, malaise, fever, chills, myalgia (muscle aches), and/or headache. Often the symptoms at this stage, or any stage, for that matter, are non-specific symptoms that are common to a variety of conditions, including ALS and MS. According to Respondent's expert, Dr. Cichon, these are conditions that a physician should also consider when diagnosing Lyme disease, Babesiosis, or Bartonellosis. In other words, when a patient presents with symptoms that do not include the erythema migrans, but are vague and non-specific, Lyme disease and co-infections related to Lyme disease should not be the only diagnoses considered.

9. In order to diagnose Lyme disease a thorough history is required, including information on a patient's travel locations, whether travel included states that are typically endemic for

Lyme disease; the time of year the travel occurred; whether the patient engaged in the type of activity (such as hunting, fishing, hiking, or other outdoor activities) that would expose him or her to the possibility of a tick bite; any history of rashes; and whether the patient remembers a tick bite. The history should also include any symptoms the patient is experiencing and when the symptoms began.

10. If the patient reports travel to an endemic area, and presents with an erythema migrans that the physician can examine, a diagnosis of early Lyme disease can be made without confirmatory laboratory tests. At that early stage, laboratory tests would not be particularly useful because they detect antibodies to the Borrelia burgdorferi, as opposed to detecting the bacteria itself. At that early stage of the disease, there is not sufficient time for the body to develop the antibodies necessary for detection through laboratory testing.

11. The second stage of Lyme disease is called early disseminated Lyme disease, which may be characterized by multiple erythema migrans lesions; cardiac symptoms, such as atrioventricular block; arthralgia (joint pain); myalgia; or neurologic involvement, such as lymphocytic meningitis, facial nerve Palsy (Bell's palsy), or encephalitis. If a patient presents with some combination of these symptoms, along with a history indicating travel to an endemic area and activities in

that area consistent with tick exposure, a reasonable prudent physician would seek confirmatory laboratory tests to reach a diagnosis of Lyme disease, assuming the patient presents four weeks or more after possible exposure to a tick bite. The type of test to use is discussed below.

12. Late Lyme disease is characterized by neurological symptoms, such as encephalomyelitis, peripheral neuropathy; and arthritis and arthralgia, usually in a single joint, such as a knee. As with early disseminated Lyme disease, a thorough history and physical is required for a diagnosis, as well as a confirmatory laboratory test.

13. There was a great deal of testimony presented regarding the type of testing that is appropriate for the diagnosis of Lyme disease. Petitioner advocated the use of the ELISA test, followed by the Western blot test, commonly referred to as the two-tiered approach. ELISA and Western blot will be discussed in more detail below. Respondent contends that this two-tiered approach is inaccurate and that other tests are more definitive. His argument regarding the testing to use is consistent with his claim that there are two "standards of care," one recognized by the Infectious Disease Society of America (IDSA), and one recognized by the International Lyme and Associated Diseases Society (ILADS).

14. The tests recognized as standard for diagnosis of Lyme disease by Drs. Robbins, Anastasio, Robertson, Rosenstock, and Powers, are the two-tiered approach ELISA and Western blot tests. The ELISA is an enzyme-linked immunosorbent assay screening test. If the screening test is positive or equivocal for enzymes indicative of Lyme disease, a Lyme Western blot test is performed to confirm the presence of antibodies to Borrelia burgdorferi.

15. For patients with early Lyme disease, the two-tier testing process may produce false negatives because the patient has not had sufficient time to develop antibodies in response to the bacteria. For those with late Lyme disease, the test is highly sensitive and specific because late Lyme disease patients have ample time to develop antibodies.

16. The two-step approach is recommended by the Centers for Disease Control (CDC) because it provides for both sensitivity and specificity. Usually lab tests are either sensitive or specific, but not both. For a test to be considered "sensitive," there are no false negatives. ELISA is considered a sensitive test. Specificity refers to the specific antibody bands being evaluated. With Western blot, there is an examination of different specific antibody bands. A Western blot IgM test looks for antibodies that are created initially from white blood cells that specifically attach to the infectious organism. A Western blot IgG looks for a different set of antibodies that continue to

persist long after the infection is gone. A Western blot IgG is considered positive if five of the ten antibody bands are positive, while an IgM is considered positive if two of three bands are positive.

17. The ILADS guidelines criticize use of the ELISA and Western blot tests because in the organization's view, the two-tiered testing lacks sensitivity. The guidelines state that several studies "showed that sensitivity and specificity for both the IgM and IgG western blot range from 92 to 96% when only two [as opposed to five] specific bands are positive."[2/] While the ILADS guidelines criticize the two-tiered approach represented by ELISA and Western blot and indicate that other testing has been evaluated, "each has advantages and disadvantages in terms of convenience, cost, assay standardization, availability and reliability." The ILADS guidelines do not expressly advocate not using the ELISA and Western blot, and note that while other tests remain an option to identify people "at high risk for persistent, recurrent, and refractory Lyme disease," the tests have not been standardized.

18. Dr. Michael Cichon, testifying for Respondent, opined that the ELISA and Western blot tests had little value and that Respondent's failure to use them was not a departure from the standard of care. However, while at hearing he denied that he would order either test, in his deposition he indicated that he

would order both tests, as a guide to diagnosis. His testimony that the ELISA and Western blot tests are not useful in the diagnosis of Lyme disease is rejected as not credible.

19. Clear and convincing evidence at hearing established that a reasonable, prudent physician who is presented with a patient having possible exposure to Lyme disease occurring four weeks or more before seeing the physician would order the two-tier testing of ELISA and Western blot if it was appropriate to test for Lyme disease. While performing other tests in conjunction with the two-tier tests is not per se a departure, the standard of care requires either ordering the ELISA and where necessary, the Western blot, or reviewing any test results for these tests previously obtained by the patient.

20. Treatment of Lyme disease also depends on the stage at which the condition is diagnosed. If a patient is diagnosed with early localized Lyme disease, a single course of doxycycline for 14 to 28 days is generally appropriate. Early disseminated Lyme disease and late Lyme disease may be treated with IV antibiotics, for a similar period of time.

21. In summary, the standard of care in the diagnosis and treatment of Lyme disease requires a physician to take an appropriate medical history, perform a physical examination, obtain objective laboratory test results in the absence of an erythema migrans rash, and refer patients who do not improve

after an initial course of antibiotic treatment to an infectious disease specialist for further evaluation. An appropriate history must include the information described in paragraph nine, and the testing to be ordered should include an ELISA and, where positive or equivocal, a Western blot test.

Diagnosis and Treatment of Babesiosis

22. Babesiosis is a parasitic disease of the blood caused by infection with Babesia. Babesiosis, like Lyme disease, is typically transmitted by a tick bite, and can be transmitted by the same tick that carries Lyme disease. There are occasions when a patient properly diagnosed with Lyme disease also will have Babesiosis as a co-infection. It is, however, not a common diagnosis, and even infectious disease specialists may go an entire career without diagnosing it.

23. If a family practice physician suspects Babesiosis, the better approach would be to refer the patient to an infectious disease specialist. However, failure to refer a patient to a specialist, assuming that the family physician performs the appropriate testing and treatment, is not necessarily a departure from the standard of care.

24. At all times material to the allegations in the Administrative Complaints, the standard of care for the diagnosis and treatment of Babesiosis included the physician taking an appropriate medical history, performing a physical examination of

the patient, and obtaining objective laboratory test results in order to make an evidence-based diagnosis.

25. As with Lyme disease, the patient's medical history should contain information regarding the patient's travel; whether they had exposure to a tick bite; whether they recall being bitten by a tick; as well as what symptoms the patient is experiencing. Babesiosis typically presents with virus-like symptoms, fever, sweats, and the identification of Babesia parasites in the patient's blood.

26. The tests that a reasonably prudent similar physician would order to determine whether a patient had Babesiosis are either a blood smear to identify Babesial parasites or a polymerase chain reaction (PCR) amplification of Babesial DNA.

27. Should a patient be diagnosed with Babesiosis, the normal and customary treatment is a ten-day course of clindamycin and atovaquone.

Diagnosis and Treatment of Bartonellosis

28. Bartonellosis is an infectious disease caused by bacteria of the genus Bartonella. It is generally transmitted by lice or fleas on a person's body, coming off of other animals, such as rats. It also can be transmitted through a cat scratch, as the cat gets fleas under its claws by scratching itself.

29. As is the case with Babesiosis, a family practice physician is unlikely to diagnose Bartonellosis. It is not a

common diagnosis, and even infectious disease specialists may go an entire career without diagnosing it.

30. If a family practice physician suspects Bartonellosis, the better approach would be to refer the patient to an infectious disease specialist. However, failure to refer a patient to a specialist, assuming that the family physician performs the appropriate testing and treatment, is not necessarily a departure from the standard of care.

31. In order to make a diagnosis, a thorough history and physical is required, along with objective laboratory test results. A physician should inquire about exposure to animals that could carry fleas, ticks, or lice, and whether there had been any recent instances where the patient has been scratched by a cat. The symptoms of Bartonellosis are nonspecific and include fever, headaches, myalgia, and arthralgia. The generally accepted test used to confirm a diagnosis of Bartonellosis would be a PCR amplification of Bartonella DNA, or paired blood serologies.

DOAH Case No. 15-2888PL; DOH Case No. 2011-15106 (Patient C.C.)

32. From approximately September 28, 2010, through approximately February 28, 2012, Respondent provided medical care and treatment to patient C.C. At the time of her original presentation to Respondent, C.C. was 27 years old.

33. Prior to seeing Dr. Lentz, C.C. had a series of orthopedic injuries. For example, in 1998, C.C. was involved in a serious car accident, resulting in multiple broken bones and internal injuries requiring a two-week stay in the hospital. C.C. joined the Air Force in 2006, where she served as an aircraft mechanic. During basic training she suffered an injury to her shoulder, which caused problems with her neck, back, and shoulder. While in the military, C.C. was involved in two additional accidents: she broke her wrist in a motorcycle accident at some point, and on March 31, 2009, she had a second accident where the car she was driving was struck by another vehicle. While C.C. denied any injuries as a result of this second accident, shortly thereafter in July 2009, she had neck surgery because of discs impinging on the nerves in her neck.

34. C.C.'s work as an aircraft mechanic required her to work in the fuel tanks of an airplane, which is a very confined space. C.C. is approximately 5'10" tall, and the work she performed required her to become contorted in a very small space for approximately 13 hours at a time. After her neck surgery, she started having increasing amounts of pain in her back and hips, to the point where she could no longer perform her job duties and in August of 2010, resorted to a wheelchair because of her inability to walk. Although she consulted multiple doctors

both in the military and through referrals to outside physicians, she did not discover the cause of her pain.

35. On or about September 28, 2010, Respondent evaluated C.C. for complaints of severe back, buttock, and right leg pain. When she presented for her first office visit, Dr. Lentz's review of symptoms indicated that C.C. had a frontal headache with pain at a level of 10 out of 10; sensitivity to light and sound; loss of hearing and buzzing; nausea but no vomiting; withdrawal symptoms described as sweats when she did not take Ultram or Lortab; and feelings of hopelessness and emotional lability. His physical examination reported that C.C. was in a wheelchair, and documented "soles of feet painful, SKIN: rashes, soles of feet red, NEURO: paresthesia, pain, tender extremity." At that time, Respondent diagnosed C.C. as having chronic fatigue syndrome and chronic pain syndrome.

36. In C.C.'s history, Respondent noted that she "grew up in Texas/Arkansas-hunting, forests, etc. There is no notation of recent travel on this first visit. Dr. Lentz asked her about any flu-like symptoms, which she denied having.

37. Many of the symptoms listed by C.C. are general symptoms that are common to a variety of ailments. Respondent, however, focused only on chronic fatigue, chronic pain, Lyme disease, Babesiosis, and lupus. On this first office visit, Respondent prescribed CD57, C3a, C4a, and eosinophilic cationic

protein (ECP) laboratory tests of C.C.'s blood. With respect to the order for CD57, Respondent listed Lyme disease as a diagnosis. For the C4a and C3a, he listed Lyme disease and Lupus as the diagnoses, and for the ECP he listed a diagnosis of Babesia infection.

38. Respondent did not prescribe an immunoassay (ELISA) test or Western blot test for Borrelia burgdorferi for C.C.

39. The ECP test result for C.C. collected on October 6, 2010, was 20.8. The reference range for a normal test result is 1-10. The notation for the test on the lab result states:

> This test uses a kit/reagent designated by the manufacturer as for research use, not for clinical use. The performance characteristics of this test have been validated by Advanced Diagnostic Laboratories at National Jewish Health. It has not been cleared or approved by the US Food and Drug Administration. The results are not intended to be used as the sole means for clinical diagnosis or patient management decisions.

40. On or about October 15, 2010, Respondent diagnosed C.C. with Lyme disease. He based his diagnosis of Lyme disease on the results of the CD57 blood test.

41. The CD57 test is a cluster designation test that measures a marker found on lymphocytes, which are a type of white blood cell that are sometimes referred to as natural killer cells. Although Respondent claimed at hearing that he did not consider the test to be definitive, in his deposition he

indicated that he believed that it was in fact definitive. Dr. Cichon, on the other hand, testified that the CD57 test used by Dr. Lentz is not a definitive test for Lyme disease, but is useful for measuring the progress of treatment. At least one test result for C.C. reflecting the results for a CD57 panel has the following notation from the laboratory:

> This test was developed and its performance characteristics determined by Labcorp. It has not been cleared or approved by the Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. Results of this test are for investigational purposes only. The result should not be used as a diagnostic procedure without confirmation of the diagnosis by another medically established diagnostic product or procedure.

42. On or about October 15, 2010, Respondent also diagnosed C.C. with Babesiosis. Respondent did not prescribe a blood smear examination for Babesial parasites or PCR amplification for Babesial DNA for C.C. He based his diagnosis on the ECP test.

43. On October 15, 2010, Dr. Lentz received an e-mail from C.C.'s roommate, M.B., informing him that C.C. had visited the emergency room over the weekend because of the level of her pain. The e-mail asked whether C.C. could begin with her treatment before her next appointment. In response, Dr. Lentz called in prescriptions for doxycycline and Cleocin, both of which are oral antibiotics.

44. On or about October 18, 2010, Respondent described C.C. as being in no acute distress, with a gait that is within normal limits. He also noted some wheezing, pain all over, tears, and cramps in her muscles. Respondent prescribed long-term IV antibiotic therapy and referred C.C. to a specialist for venous port placement for the administration of intravenous (IV) antibiotic therapy. The specific medications prescribed at this visit are acetaminophen-oxycodone 300 mg - 7.5 mg oral tablets to be taken three times daily; Cymbalta 30 mg oral, once a day; Flagyl 500 mg oral tablets, to be taken three weeks on, one week off; heparin 5000 units/ml injectable solution, once a day; Omnicef 300 mg oral capsules, once a day; Interfase Plus Prothera, a supplement; and boluoke lumbrokinase, also a supplement. At the October 18, 2010, visit, he also ordered a Fry test for Bartonellosis and prescribed intravenous vancomycin, with weekly vancomycin trough levels. Dr. Lentz testified at hearing that the prescription for vancomycin was to treat Bartonellosis.[3/] However, at this juncture, no diagnosis for Bartonellosis had been made.

45. Heparin is an anticoagulant that is used for a variety of issues, such as blood clots, pulmonary emboli, and Berko emboli. It is also used in coronary heart disease if a patient has a myocardial infarction. The more persuasive and credible testimony established that it was below the standard of care to

use heparin in the treatment of Lyme disease, Babesiosis, or Bartonellosis. Not only did heparin have no efficacy, it had the potential to be very dangerous for C.C., or any other patient.

46. On October 28, 2010, Respondent noted that the vancomycin was at 1.5 grams and still not therapeutic, and ordered that the medication be changed to Primaxin and that the Omnicef and vancomycin troughs be stopped.

47. On November 10, 2010, Respondent noted that C.C. was experiencing flu-like symptoms, but was now resting fewer hours each day. For the first time, he noted "past 4 years in military=Virginia, Canada, Honduras, as sites for exposure to Lyme." He also noted "no wheelchair, but slow to move, pain to rt LS-hip-leg." He continued to list her diagnoses as Lyme disease, Babesiosis, chronic pain syndrome, and chronic fatigue syndrome.

48. Respondent also saw C.C. in the office on December 8, 2010, and January 10, 2011. At the December 8, 2010, visit, he discontinued the use of Flagyl because of her nausea and switched to Tindamax (one tablet daily for three weeks, then off one week) instead. On January 19, 2011, Dr. Lentz received an e-mail from C.C.'s roommate regarding a fall C.C. had over the weekend. As a result, he wrote an e-mail to C.C. and told her to stop the Tindamax and "add the neurotoxins to remove the neurologic toxins that are being created by the antibiotics." He also directed her

to stop the heparin injections, as she needed to be off of heparin before having some hand surgery to remove a cyst.

49. C.C. returned for an office visit on February 9, 2011. At that time, Respondent's notes indicate that she was ambulatory but still significantly fatigued and still falling. He noted, "rt hip. sciatic nerve still #1 symptom, can not stand or walk for long periods of time, not sure if neurologic/Lyme or degenerative nerve dis." In his assessment, he stated she "needs CT lumbar sacrum to r/o orthopedic issue with back pain."

50. During the course of treatment, Respondent was consistently prescribing OxyContin at 10 mg, three times daily. On March 16, 2011, he referred C.C. to Dr. Beach at Andrews Institute to detox off the OxyContin. He also noted that she had been given 100 percent disability through the military, and would take approximately four months to process out of the military. He also noted "electrical ablation at T9, T10 for chronic back pain per Dr. Nyguen."

51. Dr. Lentz continued to see C.C. on April 12, 2011; May 4, 2011; and May 13, 2011. Throughout her treatment with IV antibiotics, C.C. experienced problems with nausea, rashes, and diarrhea, but claims that over time, her symptoms began to improve so that she could walk and eventually was able to hold down part-time employment.

52. Toward the end of her military tenure, C.C. needed a referral in order to continue to see Dr. Lentz. To that end, on June 8, 2011, she saw Dr. Janelle Robertson, M.D., a board certified infectious disease specialist at Eglin Air Force Base. Dr. Robertson evaluated C.C. for Lyme disease, and documented her history, including travel history and history of tick bites. She reviewed prior records from Eglin Air Force base that indicated C.C. had an ELISA screening on June 10, 2010 (approximately two and a half months before seeing Dr. Lentz), that was negative. The ELISA test was not only performed before C.C. saw Dr. Lentz, but well after C.C. began suffering the symptoms that led her to seek out Dr. Lentz. Accordingly, the ELISA test was administered at a time at which C.C. would have developed sufficient antibodies for the test to be useful. Dr. Robertson also noted that while C.C. had a history of tick bites in Florida, Texas, and Alabama, she did not report any rashes or illness at or near the time of the tick bites. She also had no history of migratory arthralgia or Bell's palsy.

53. Dr. Robertson testified credibly that C.C. was having no night sweats, weight loss, changes in vision, palpitations, difficulty breathing, or gastrointestinal problems, and that her primary complaint was back and hip pain. C.C.'s pain remained in the same locations and persisted without resolution since 2009.

54. Dr. Robertson concluded that C.C. did not have Lyme disease, and that her prior negative ELISA test conclusively established that she did not have the disease. She opined that, given that C.C.'s symptoms had persisted since 2009, if she had actually had Lyme disease, she would have developed antibodies that would have been detected with the ELISA test. She also determined that Respondent did not have Babesiosis and recommended to C.C. that she immediately stop the therapy prescribed by Dr. Lentz, because in Dr. Robertson's view, the therapy was unsafe.

55. C.C. has since transitioned out of the military into civilian life. Although she believes that the treatment by Dr. Lentz was effective in treating her condition, the events since she stopped treatment for Lyme disease suggest otherwise. For example, C.C. testified in her deposition that her treatment ended in mid-May 2011 because Dr. Lentz determined that she did not need more treatment, yet it appears that the military would no longer authorize treatment by Dr. Lentz once C.C. saw Dr. Robertson.

56. Moreover, she continues to have some of the same pain that led her to treatment with Dr. Lentz. In approximately October 2014, she had hip surgery because her "hips are pretty much shot." She has had three surgeries for kidney stones, steroid injections for temporary relief from her back pain, and

acupuncture treatments for her back pain. At least one physician attributed her problem to the kind of work she performed as an aircraft mechanic, and at deposition she indicated that a recent MRI indicated that she has some lumbar narrowing. In short, it appears that the months-long IV antibiotic therapy she endured has provided no lasting solution to her pain.

57. Respondent's care and treatment of C.C. was a departure from the standard of care in that he diagnosed Lyme disease based upon an inadequate history and no objective laboratory test results from an ELISA test and Western blot. Specifically, Respondent failed to obtain C.C.'s travel history or any history of rashes, possible tick bites, including the size of the tick, and in fact obtained a history devoid of any flu-like symptoms characteristic of Lyme disease. C.C.'s primary symptoms were related to her back pain. Respondent's own expert, Dr. Cichon, testified that the key to a diagnosis of Lyme disease is the patient's history.[4/]

58. With this inadequate history in mind, Respondent did not obtain an ELISA test or Western blot, but instead relied on a test that, on its face, indicates that it is for investigational use only and should not be used as a diagnostic procedure without confirmation of the diagnosis by another medically-established diagnostic product or procedure. The more persuasive and compelling testimony established that the failure to obtain

objective laboratory confirmation of Lyme disease through the use of the ELISA and Western blot tests is a departure from the standard of care recognized by a reasonably prudent similar physician. The more persuasive and compelling evidence also established that C.C. did not actually have Lyme disease, despite Respondent's diagnosis of the disease.

59. Respondent also departed from the appropriate standard of care by his failure to use the appropriate tests for the diagnoses of Babesiosis and Bartonellosis. His test of preference, the ECP test, is by its own terms, not intended to be used as the sole means for clinical diagnosis or patient management decisions. As stated by Dr. Robbins, it has no clinical relevance and is diagnostic of nothing. Likewise, his credible testimony indicated that use of the Fry test was not appropriate, as it is a proprietary test of the laboratory and not FDA approved.[5/]

60. Respondent's care and treatment of C.C. also departed from the applicable standard of care by prescribing surgery for placement of a venous port for administration of intravenous medication, and by prescribing both intravenous and oral antibiotic therapy in inappropriate and excessive amounts. The more credible and persuasive testimony demonstrated that C.C. did not have Lyme disease, Babesiosis, or Bartonellosis, and therefore did not need any of the antibiotic therapy prescribed.

Even had C.C. received a correct diagnosis, the more persuasive evidence demonstrated that the amounts and duration of the antibiotics prescribed were not only unwarranted, but potentially dangerous for the patient. C.C. had the possibility of negative reactions from the many antibiotics prescribed, but also the very real possibility that she has built up a resistance to the antibiotics such that they will be ineffective should she actually need them in the future.

61. Finally, Respondent's care and treatment of C.C. departed from the applicable standard of care by the prescription of heparin. There was no medical justification for the prescription of an anticoagulant for the treatment of Lyme disease, even if appropriately diagnosed (which did not happen here), and as with the prescription of multiple long-term antibiotics, was potentially dangerous and harmful to the patient.

DOAH Case No. 15-2889PL; DOH Case No. 2011-18613 (Patients D.H., S.L., J.L., W.L., and D.D.)

Patient D.H.

62. Respondent provided care and treatment to patient D.H. from approximately November 24, 2010, to approximately October 14, 2011. D.H. was previously seen by a physician's assistant, Thomas Gregory Roberts, who at various times worked under Respondent's supervision, including the period from

April 29, 2009, to May 26, 2010, and again from September 21, 2010, through December 18, 2010.[6/] Mr. Roberts had ordered a previous CD57 test for D.H., and had prescribed doxycycline for him on a long-term basis. Mr. Roberts' office was closing and his records were no longer available, so on November 24, 2010, D.H.'s wife, J.H., e-mailed Dr. Lentz to request laboratory tests and to schedule an appointment for D.H. She stated in part:

> Dear Dr. Lentz:
>
> Both my husband and I have been to you before, but not at your current office. [D.H.] went to Tom Roberts at Village Health Assoc. and was sent for blood work. His CD57 counts were off, so he put him on Doxycycline [sic] and was on it for several months. His last blood work was done in July and by the sound of it showed some improvement, but he told him to stay on the antibiotics. Tom Roberts gave him an order for follow up bloodwork which reads CD57 + NK Cells Dx2793. Since he is currently not practicing that we know of, we are requesting that you please write an order so that [D.H.] can have blood work done and come to you for the results.

63. Based upon this e-mail, Respondent ordered a CD57 test, using the diagnostic code for and reference to Lyme infection, and an ECP test using the diagnostic code for and reference to Babesia infection. He did so without actually seeing D.H., taking a history, or performing a physical examination.

64. Respondent diagnosed D.H. as having Lyme disease and Babesiosis. He communicated the diagnoses to D.H. on

December 25, 2010, via e-mail, stating, "CD57 is positive for Lyme and ECP positive for Babesia. Call Amy at 424-6841 for an appointment. Dr. Lentz." It does not appear from the record that he considered or ruled out any other condition for D.H.'s complaints.

65. Respondent did not prescribe or order for D.H. an ELISA or Western blot test, PCR amplification of Bartonella or Babesial DNA, or blood smear tests at any time during D.H.'s care and treatment.

66. Respondent did not refer D.H. to a specialist in the diagnosis and treatment of infectious diseases, such as Lyme disease, Bartonellosis, and Babesiosis at any time during Respondent's treatment and care of D.H.

67. D.H.'s first office visit was January 17, 2011. At that time, J.H., D.H.'s wife, who attended the majority of his doctor's visits with him, testified that his only complaint at that point was fatigue, and ongoing diarrhea she attributed to the lengthy time he had already been on antibiotics. She acknowledged that he checked off those items on a form at the doctor's office, but was not going to see Dr. Lentz complaining about those: he went simply because of his fatigue. He had no rash at that point, and never complained of a tick bite. Dr. Lentz's records, however, indicate that he complained about exhaustion; face-neck, jaw, and orbital pain; diarrhea; cramping;

stiff and painful joints; mood swings; irritability; explosive [sic]; and poor concentration.

68. From what J.H. could remember, the physical examination Respondent performed on D.H. was very brief. Respondent took D.H.'s blood pressure, possibly looked in his mouth, palpated his abdomen, and did a knee reflex test. She did not remember him doing anything else, except having D.H. fill out a long form. Dr. Lentz's medical records for this visit contain no prior medical history, no pulse, and no respiration rate.

69. Respondent diagnosed D.H. with Lyme disease. When J.H. asked him if he was sure, Respondent said, absolutely. J.H. had done some research and knew that Respondent had only ordered a CD57 for D.H. She asked him about ordering the Western blot, but he did not order it. She could not remember Respondent's exact response, but was led to believe that he did not think that the Western blot test was as accurate in diagnosing Lyme disease.

70. At this first visit, Respondent also ordered the Fry test. Results from the Fry test are dated January 25, 2011, and indicate:

> Based on the accompanying test results for the sample for listed patient and accession number is suggested for follow up confirmation of the putative organism(s).
>
> Protozoan: The Special Stains (100x magnification) or the Advanced Stains (magnification listed) for this sample is suggestive of a protozoan. PCR testing for

> putative FL1953 is suggested for follow-up confirmation.
>
> EPierythrozoan/Hemorbartonella: The Special Stains (100x magnification) or the Advanced Stains (magnification listed) for this sample is suggestive of epierythrozoan/ hemobartonella. PCR or serology testing for the putative epierythrozoan/hemobartonella (Bartonella spp.) is suggested for follow up confirmation and speciation. (emphasis added).

71. The records do not indicate that Respondent ordered any of the follow-up testing recommended by the Fry laboratory which, ironically, is the very testing for Bartonellosis that a reasonably prudent similar physician should order for this condition. His records also do not indicate that he ever added Bartonellosis as a diagnosis for D.H.

72. During the course of his treatment, Respondent prescribed for D.H. the antibiotics Omnicef, azithromycin, and Cleocin, as well as Interface Plus Prothera (an enzyme supplement formulation), boluoke lumbrokinase (a fibrinolytic supplement), atenolol (a beta blocker used primarily in cardiovascular disease, added March 7, 2011), heparin injections (an anticoagulant, also added March 7), artemisinin (an antimalarial, added June 14), Mepron (an antiparasitic, added June 14), Tindamax (added June 14), Plaquenil (an antimalarial), and Vermox (an anthelmintic)(both added August 21).

73. J.H. understood that, based upon Respondent's explanations, the heparin was prescribed to help other medicines be absorbed into the cells, or something along those lines. She was concerned about D.H. being on the heparin, in part because as a result of him injecting the heparin in his abdomen, D.H. had a lot of bruising and knots all over his belly. She was also concerned because D.H. worked as a boat captain on the Mississippi River, which required him to be away from home for weeks at a time. She was concerned about the ramifications should he have an accident at work when he had no access to medical care. Her concerns were warranted.

74. The couple also had concerns about the number of medications D.H. was taking while under Respondent's care. He developed blurred vision, did not sleep well, and had chronic diarrhea. When D.H. came home from his last visit, which J.H. apparently did not attend, he reported that Dr. Lentz had said something about having a port placed for the administration of more antibiotics. That shocked her, so before he would go through with port placement, they sought a second opinion.

75. Dr. Patrick Anastasio is an osteopathic physician who is a board-certified infectious disease specialist. During all times relevant to these proceedings, he was a solo practitioner in private practice at Emerald Coast Infectious Diseases in Fort Walton Beach, Florida. He has worked in the area for

approximately 12 years. D.H. sought a second opinion from Dr. Anastasio regarding his Lyme disease and Babesiosis diagnoses. To that end, he saw Dr. Anastasio for the first time on September 29, 2011.

76. Dr. Anastasio did not believe that D.H. had the symptoms initially to place him in a high risk group for Lyme disease. During his examination, he looked for signs that would be consistent with Lyme disease, such as arthritis, cognitive problems, or neurological problems, but did not discover any. Dr. Anastasio did not believe that D.H. had either Lyme disease or Babesiosis, but ordered a blood smear, and a Western blot and a Babesia PCR test to rule out the conditions. All tests came back negative.[7/]

77. Dr. Anastasio recommended to D.H. that he stop taking all of the medications prescribed by Dr. Lentz, and D.H. did so. It still took months for the diarrhea, most likely caused by the long-term antibiotic therapy, to subside. However, D.H. began to feel better once he stopped taking the antibiotics.

78. Dr. Charles Powers, M.D., testified that Dr. Lentz's medical records for D.H. were not adequate for the evaluation of whether D.H. had Lyme disease. He also believed that it was below the standard of care to use the CD57 for the diagnosis of Lyme disease as opposed to the ELISA and Western blot tests, and that it was below the standard of care not to order the ELISA and

Western blot tests in the absence of an erythema migrans rash that Dr. Lentz could physically observe. Dr. Powers believed that there was no basis upon which to diagnose D.H. with Lyme disease, and therefore any treatment based on this faulty diagnosis would be below the standard of care.

79. Even assuming the diagnosis was correct, Dr. Powers opined that the treatment ordered also was below the standard of care. According to Dr. Powers, a reasonably prudent family practitioner would usually prescribe doxycycline for the majority of cases, as opposed to the regimen of medications used by Dr. Lentz. Prescribing antibiotics the way they were prescribed would include adverse side effects, such as nausea and/or diarrhea with resistance to bacteria; development of C. difficile infection, which can be difficult to treat; and potential for allergic reactions, which can be fatal. Dr. Powers testified that when a combination of antibiotics is being used, with each additional antibiotic prescribed, the risk for complications increases exponentially. His testimony is credited.

80. Dr. Powers also opined that the use of heparin in the treatment of Lyme disease, Babesiosis, or Bartonellosis was a departure from the standard of care, and was a dangerous choice for this or any other patient who did not have a need for a blood thinner.

81. Dr. Robbins also believed that Respondent's care and treatment of D.H. was below the standard of care. He testified that Respondent breached the standard of care by diagnosing D.H. with Babesiosis using the ECP test and the Fry testing for the purpose of diagnosing Bartonellosis. He also testified, consistent with Dr. Powers, that using heparin in the treatment of any of these three diseases was an egregious departure from the standard of care. The testimony of Drs. Robbins and Powers is credited.

82. Dr. Cichon expressed concerns about the amount of medications prescribed by Dr. Lentz to D.H., specifically singling out the prescriptions for Plaquenil and Vermox. While his testimony fell far short of declaring that prescribing these medications represented a departure from the standard of care, his testimony was certainly not a ringing endorsement. It seemed as if he was trying to convince himself that Respondent's care and treatment of this patient fell within the standard of care. His testimony to that effect is rejected as not credible.

83. D.H. did not have a medical condition that justified the prescription of any of the medications and supplements that Dr. Lentz prescribed, much less for the duration taken. The prescription of any of these medications without a valid diagnosis was a departure from the standard of care attributed to a reasonably prudent similar physician.

Patient S.L.

84. Respondent provided care and treatment to patient S.L. from on or about August 17, 2010, to on or about January 7, 2011.

85. On or about August 17, 2010, at her first office visit with Dr. Lentz, S.L. presented with and reported to Respondent a history of heavy rectal bleeding, which occurred every four to five days.

86. At that visit, S.L. informed Respondent that in June, she had been advised to get a colonoscopy. Because of economic constraints, S.L. did not obtain the requested colonoscopy. There is no indication in the patient records for S.L.'s first office visit (or any later visit) that the reason for S.L.'s bleeding prior to his treatment of her had been determined or that it had resolved.

87. S.L. first went to see Dr. Lentz at Hope Medical Clinic[8/] because she believed that she had a urinary tract infection. She also had severe back pain, with pins and needles down both legs. Her back pain had started in 2005, following a car accident.

88. S.L. does not recall Respondent ever performing a physical examination, although the patient records indicate that at least a minimal examination was performed. She does recall him talking to her about being from Pennsylvania, but does not

recall him asking her about any travel history, whether she had been exposed to ticks, or had ever been bitten by a tick.

89. Dr. Lentz's medical records for this first visit make no mention of a travel history; no mention of tick exposure; and no mention of any type of rash. Much of the history related to other issues, such as S.L.'s history of bleeding, as opposed to any symptoms that could be said to be indicative of Lyme disease. The symptoms documented are "paresthesis to both legs due to lumbar path. Recent hematochezia. No melena. No upper abd. Pain. No diarrhea. Mostly awake sxs, not hs." Yet in his assessment/plan notes, he lists diagnoses of lumbago, displacement of lumbar intervertebral disc without myelopathy, and chronic pain syndrome. He prescribed Lyrica, Elavil, Lortab, and ordered a CD57, listing the Lyme disease diagnostic code. There was no medical basis, based on the history presented, to suspect or test for Lyme disease.

90. On September 21, 2010, S.L. presented to Dr. Lentz for a follow-up appointment. At this appointment, Respondent diagnosed S.L. as having Lyme disease. He ordered a Fry Bartonella test as well as an ECP test, and prescribed doxycycline, Omnicef, and Flagyl.

91. On September 30, 2010, S.L. called Respondent and reported throwing up all of her antibiotics, and asked about medication for her nausea. Dr. Lentz added the diagnosis of

Bartonellosis without seeing S.L. or performing any further physical examination. The results of the Fry test in the patient records state: "rare (1-4 organisms per total fields observed) coccobacilli adherent to erythrocytes – indicated by yellow arrow(s). This is suggestive of Hemobartonella(1) or Hemoplasma(2)." The notes also state, "[t]his stain is not FDA approved and is for research only."

92. At S.L.'s next appointment on October 5, 2010, Dr. Lentz prescribed rifampin and Cleocin, as well as Lovenox injections. Lovenox is a low molecular weight heparin that can be given subcutaneously. At the time Dr. Lentz prescribed it, there was no determination regarding the cause of her heavy rectal bleeding just a few months before.

93. On October 19, 2010, just two weeks after starting the Lovenox injections, S.L. presented to the emergency room at Sacred Heart Hospital with complaints of blood in her urine.[9/] Physicians in the emergency room attributed the blood in her urine to the Lovenox injections, and discharged her with a diagnosis of hematuria.

94. That same day, she presented to Dr. Lentz and told him about her emergency room visit. Dr. Lentz lowered the dose for Lovenox, but did not discontinue its use. His notes for this visit indicate that she had left flank pain, slight liver tenderness, no masses, and a "light liver test elevated, <2X

normal."[10/] He added a diagnosis for Babesiosis, but did not appear to explore what was causing the liver tenderness and elevated tests. Under his assessment and plan, it states: "1. Cut Lovenox BID to QAM. 2. Add Culturelle/probiotics to GI tract due to antibiotics being used, if urine lightens up and less blood on dipstick, then improvement."

95. Respondent did not prescribe S.L. a PCR amplification or Bartonella or Babesial DNA, or Western blot immunoassay tests at any time during Respondent's care and treatment of S.L.

96. Respondent did not refer patient S.L. to a specialist in the diagnosis and treatment of infectious diseases, such as Lyme disease, Bartonellosis, and Babesiosis, at any time during Respondent's care and treatment of S.L.

97. S.L. testified that the physicians at Sacred Heart Hospital informed her that there was no reason for her to be on the antibiotics or blood thinner prescribed by Dr. Lentz, and based upon their advice, she stopped the medication regimen he prescribed. The medical records from Sacred Heart do not mention this advice, and she saw Dr. Lentz at least twice after her emergency room visit: October 19 and November 2, 2010. After that, the only communications in Dr. Lentz's medical records for S.L. appear to be requests for medication related to urinary tract infections as opposed to treatment for Lyme disease, Babesiosis, or Bartonellosis. In any event, she quit seeing

Dr. Lentz for Lyme disease, Babesiosis, and Bartonellosis at least as of November 2, and testified credibly that she feels fine.

98. Based on the credible testimony of Drs. Powers and Robbins, Dr. Lentz's diagnosis and treatment of S.L. violated the applicable standard of care in that he failed to obtain an appropriate history to diagnose Lyme disease, Babesiosis or Bartonellosis in the first place. He failed to obtain a travel history, any information regarding possible tick bites, and if there was such a bite, the size of the tick and duration of the bite. He also failed to document symptoms that would suggest the possibility of Lyme disease to justify any objective laboratory testing. S.L.'s symptoms were related to back pain and a history of heavy bleeding. Her symptoms simply did not justify testing for Lyme disease.

99. The evidence was not clear and convincing that Respondent failed to perform an adequate examination. As noted above, while S.L. does not remember one, the medical records reflect notations indicating that one was in fact performed. The problem is that the history and physical examination do not support further investigation for Lyme disease.

100. Respondent also departed from the applicable standard of care by relying on tests that were not appropriate for the diagnosis of Lyme disease, Babesiosis, or Bartonellosis. As

stated above, there was no basis to test for these conditions at all, but if testing was going to be performed, then the appropriate tests were not the CD57, ECP, and Fry tests, but rather the ELISA, Western blot, PCR, and serologies discussed above.

101. Respondent's prescription of multiple antibiotics of lengthy duration also violated the standard of care, for reasons discussed above at paragraphs 60 and 79.

102. Likewise, Respondent's prescription of Lovenox fell below the standard of care. The use of Lovenox for Lyme disease, Babesiosis, and Bartonellosis is not warranted at all, but is especially egregious here, where S.L. had excessive bleeding problems of which Respondent was aware just months before Lovenox was prescribed, with no documentation that the cause of the bleeding had been identified and addressed, and no indication that Respondent did anything to investigate the cause of the bleeding. That he continued to prescribe the Lovenox, albeit at a lower dose, after her visit to the emergency room with hematuria, just compounds the problem.

103. Dr. Cichon testified that Respondent met the standard of care in diagnosing and treating S.L., saying that she had unexplained pain that could be due to Lyme disease. He struggled to identify any symptoms that are commonly associated with Lyme disease. His testimony seemed to indicate anytime there is

unexplained pain, Lyme disease is a possibility. His testimony on this issue is not credible.

104. The same can be said for his support of the diagnosis of Babesiosis. Dr. Cichon identified the primary symptoms of Babesiosis as headaches, sweating, and air hunger. S.L. did not have these symptoms, leaving only the ECP test as a basis for diagnosis. Relying on the ECP (which is only slightly elevated) is contrary to Dr. Cichon's own testimony regarding the primary importance of a thorough history to support such a diagnosis. Similarly, Dr. Cichon acknowledged in his testimony that he could not tell from Respondent's medical records whether S.L. had any symptoms to support a diagnosis for Bartonellosis, and stated that her symptoms could be due to her lumbar pathology. Given these inconsistencies, his opinion that Dr. Lentz did not depart from the applicable standard of care in the diagnosis of each of these diseases is not credible and is rejected.

105. Medical records must justify the course of treatment for a patient. Dr. Lentz's medical records for S.L. do not justify the diagnosis or treatment of Lyme disease, Babesiosis, or Bartonellosis. The medical records do not document symptoms that are consistent with the diagnoses of any of these diseases, and fail to provide a complete medical history.

Patients J.L., W.L., and D.D.

106. J.L. is the mother of S.L. W.L. is J.L.'s husband and S.L.'s father, and D.D. is S.L.'s son and J.L. and W.L.'s grandson.

107. On September 22, 2010, approximately one month after S.L. began treatment with Dr. Lentz, J.L. wrote him the following e-mail:

> Dr. Lentz:
>
> Thank you for talking with me on the phone today. We are really concerned about S.L. and we can not [sic] express to you how much you are appreciated for all you have done for her. You are a true blessing to our family. My husband was bitten by a tick over the July 4th weekend in MO. He developed the bulleye [sic] rash and went to our family doctor. Dr. Calvin Blount. He was give [sic] 10 days of antibiotics, but no follow up or blood test were ever ordered. We would like to be tested for Lyme. We believe that S.L. might have contracted Lyme before she became pregnant with D.D. and would like him tested also. Here is our information. Please let me know if you need any additional information. Thank you again for all you have done.

108. As noted above, there was an insufficient basis to justify the ordering of any tests related to Lyme disease for S.L. The only basis for ordering tests for D.D. is the suspicion that S.L. may have been infected prior to giving birth to D.D. If there is no basis for suspecting S.L. has Lyme disease, there is no basis for suspecting D.D. has Lyme disease.

109. Respondent did not make an appointment for, take a history from, or perform a physical examination of J.L., W.L., or D.D. Based upon this e-mail alone, he ordered CD57 and ECP tests for all three of them, as well as C4a and C3a tests for J.L. and W.L. To justify ordering the tests, he listed "Lyme Disease (088.81)" under his assessment/plan for each patient. Although he never saw any of these patients, he coded each encounter as "high complexity."

110. On October 14, 2010, Dr. Lentz sent an e-mail to J.L. stating that "D.D. is positive for Lyme and negative for Babesia."

111. On October 24, 2010, Dr. Lentz sent an e-mail to J.L. stating, "W.L. C4A is back=20,000+ indicative of active Lyme."

112. On October 25, 2010, Dr. Lentz sent an e-mail to J.L. which stated, "[t]he CD57 is 50=positive, and the ECP is 11.5=positive for Babesia. My initial charge is $400 and $200 for return visits. Since I will be seeing both you and [W.L.], I will drop that to $300 initial visits. Call Amy for the schedule."

113. Dr. Lentz testified that he did not diagnose J.L., W.L., or D.D. with any condition, and did not really consider them to be patients. In his view, he was simply doing a favor for the family members of a patient. However, he created records that referred to each patient as being new patients needing tests

for Lyme disease, and included diagnostic codes for the lab tests. With respect to each of them, he made an interpretation of the tests that he ordered. At least with respect to D.D., he admitted in his deposition that he diagnosed D.D. with Lyme disease based on the laboratory tests.

114. Both S.L. and W.L. testified credibly that, based on the communications received from Dr. Lentz, they each believed that he had diagnosed them with Lyme disease, and that he had diagnosed J.L. with Babesia. It is found that he did, in fact, provide diagnoses to J.L., W.L., and D.D., without the benefit of a personal history, or a physical examination.

115. Respondent did not refer J.L., W.L., or D.D. to a specialist in the diagnosis and treatment of infectious diseases such as Lyme disease, Bartonellosis, or Babesiosis.

116. Respondent did not order for J.L., W.L., or D.D. an ELISA or Western blot test, PCR amplification of Bartonella or Babesial DNA, or blood smear tests.

117. J.L. and W.L. decided to get a second opinion regarding the Lyme disease and Babesiosis diagnoses, and went to see Dr. Anastasio. Dr. Anastasio testified that J.L. did not have the required exposure to or symptoms for Lyme disease. Because she came to him with a Lyme disease diagnosis, he ordered a Lyme Western blot, a PCR for Babesiosis, and a PCR for Bartonellosis. J.L.'s Western blot IgM was negative, with two of

the three antibody bands tested returning as absent. The Western blot IgG was negative, with all ten antibody bands returning as absent. J.L.'s PCRs for both Babesiosis and Bartonellosis were negative.

118. Dr. Anastasio testified that he did not believe that J.L. had either Lyme disease or Babesia. His testimony was persuasive, and is credited.

119. Dr. Anastasio testified that, given W.L.'s history of a tick bite followed by a rash, there was at least a basis to believe his symptoms could be an indication of Lyme disease. The tick bite and rash were approximately six months prior to W.L. presenting to Dr. Anastasio, and almost three months prior to Dr. Lentz ordering tests for him. Given these time frames, there was plenty of time for W.L. to develop antibodies to Lyme disease if he was in fact infected with the disease. Dr. Anastasio testified that at the time he saw W.L., W.L.'s symptoms were not consistent with late Lyme disease.

120. Dr. Anastasio ordered several tests for W.L., including a Lyme Western blot, a PCR for Babesiosis, a blood smear for Babesiosis, and a PCR for Bartonellosis. The Western blot test was negative, with zero out of ten antibodies present. Both PCR tests and the blood smear were also negative. Dr. Anastasio concluded that W.L. did not have Lyme disease,

Babesiosis, or Bartonellosis, and his testimony to that effect is credited.[11/]

121. Respondent failed to meet the applicable standard of care with respect to the care and treatment of patients W.L., J.L., and D.D. Based on the credible testimony of Drs. Powers and Robbins, Dr. Lentz departed from the standard of care in ordering tests for all three patients when he did so without seeing them, taking a history with respect to any of them, or conducting a physical examination of any of them to determine whether any of the requested tests were warranted or even justified.

122. Respondent also departed from the applicable standard of care when he ordered tests that would not even assist in diagnosing Lyme disease, Babesiosis, or Bartonellosis had testing for those conditions been appropriate.

123. Moreover, Dr. Powers testified credibly that the appropriate way to order tests for a suspected condition is to use the symptoms that are being investigated by the physician ordering the test, as opposed to the suspected disease being considered. For example, one ordering a mammogram would list "screening" or "diagnostic," not "breast cancer," because at that point, breast cancer has not been, and might never be, diagnosed. Documenting the symptom as opposed to the disease is important in terms of continuing care, so that there is no confusion by a

subsequent health care provider reading the records about a premature diagnosis. Dr. Powers' testimony is credited.

124. Dr. Lentz also claimed that because J.L., W.L., and D.D. were not his patients, he did not need to have medical records for them that complied with section 458.331(1)(n). However, Dr. Lentz created patient records for all three in order to order the laboratory tests for them. He coded the action taken as having high complexity. The definition of medicine includes "diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition." § 458.305(3), Fla. Stat. Respondent clearly engaged in the practice of medicine when he wrote prescriptions for tests for the purpose of diagnosing disease. By ordering these tests, creating medical charts for them (however limited they may be), interpreting the test results and communicating those results, he established a physician-patient relationship with J.L., W.L., and D.D. Accordingly, he was required to have patient records that justified the course of treatment (here, the diagnosis of Lyme disease, Babesiosis, and Bartonella). The records presented do not meet that requirement.

DOAH Case No. 15-2890PL; DOH Case No. 2012-01987 (Patient C.H.)

125. At the time of the events giving rise to this case, C.H. was a 23-year-old woman. She was married and attending her final year of chiropractic school in Kennesaw, Georgia.

126. C.H. testified that in December 2010, she had experienced a bout with the flu, including an episode where she passed out in the shower, for which she was prescribed a Z-pack, and recovered. She then had gum surgery during the Christmas break, requiring anesthesia, after which she visited her husband's family in Missouri over the Christmas holiday.

127. After C.H. returned to Georgia, she returned to class for the spring semester. In early February of 2011, she had an episode in class where her heart started beating very rapidly, and upon a physician's advice, went to the emergency room. Tests given there were normal. Follow-up tests also did not reveal the basis for her symptoms, and in March 2011, her mother contacted Dr. Lentz based upon the suggestion of a family friend who had treated with him.

128. On or about March 20, S.H. contacted Respondent by e-mail regarding her 23-year-old daughter, C.H. S.H. had been referred to Respondent by a family friend. S.H. reported that she had found a checklist for Lyme disease symptoms online, which included some of the symptoms her daughter was experiencing, such as fatigue, rapid heartbeat, chest pain, headaches, blurry vision, and difficulty concentrating. She also related that C.H. was in her final year of chiropractic school and had recently completed her national boards, and thought that some of the symptoms might be related to stress and anxiety from her studies.

129. In that e-mail, S.H. reported to Respondent that C.H. had tested negative for Lyme disease the previous week. Respondent received a copy of C.H.'s negative Lyme disease test report from blood collected on or about March 16, 2011.

130. On or about March 22, 2011, Respondent documented his assessment of C.H. as Lyme disease and chronic fatigue syndrome. He ordered CD57, C3a, C4a, and ECP laboratory tests of C.H.'s blood. At the time these tests were ordered, Respondent had not seen or talked to C.H., taken her history, or performed a physical examination.

131. Respondent did not at any time prescribe an ELISA test or Western blot test for C.H.

132. On April 14, 2011, S.H. e-mailed Dr. Lentz to see if any test results had been received for C.H. Dr. Lentz replied, "CD57 51+ positive for Lyme. Babesia is negative at this time." When asked how to proceed, he told her she needed to start treatment until the CD57 is over 120.[12/]

133. S.H. asked via e-mail whether C.H. should get treatment from Dr. Lentz or her family doctor, saying they would prefer to work through him, as this is his specialty. Dr. Lentz responded, "This is more than a good family physician can handle. I have 35 years of family practice and know first hand. Lyme is a multi-faceted problem and requires extra time and effort to educate and direct this complex problem."

134. On or about April 18, 2011, Respondent prescribed the antibiotics Omnicef (cefdinir) and azithromycin to C.H. At the time he prescribed these medications, Respondent had not seen C.H., and there is no documentation in the patient records that Respondent made any inquiry regarding potential allergies before prescribing these antibiotics.

135. On or about April 25, 2011, C.H. presented to Respondent for the first, and only, office visit. The medical records for that date contain symptoms that C.H. credibly denies having reported to him, such as double vision, twitching, tremors and shakes, explosive (behavior), and shortness of breath. C.H. does not recall being weighed at that visit, although the record contains a weight for her. It does not however, indicate her temperature, pulse, or respiration rate. She recalls a minimum examination for which she remained clothed in shorts and a t-shirt. During the examination, Respondent asked if she had ever been bitten by a tick or had a rash, and checked some areas of her body for a tick bite/rash, which she denied ever having. Dr. Lentz did not inquire about her travel history. Despite the fact that one of her symptoms was the inability to take a deep breath and had suffered from heart palpitations, his patients do not reflect a temperature, pulse, or respiration rate.

136. At that visit, Respondent added the antibiotic Flagyl (metronidazole) and Interfase Plus Prothera, an enzyme

formulation, to C.H.'s medications. C.H. testified that at that visit, Dr. Lentz told her that he was a specialist with numerous years of experience, and that he was the only one certified to be able to treat this, and she would have to be under his constant care. C.H. also testified that he told her she would need to be medicated for the rest of her life, because Lyme disease lives forever in your body, and that she would probably never be able to get pregnant or have children. C.H. was devastated by this information. The entire visit with Dr. Lentz, including both the taking of her history and the physical examination, lasted approximately ten minutes. C.H.'s testimony is credited.

137. On or about June 10, 2011, Respondent prescribed CD57, C3a, C4a, and ECP tests for C.H. On or about July 2, 2011, Respondent prescribed C.H. with Babesiosis. He made this diagnosis completely on the basis of test results, as C.H. had not returned to his office after her first and only visit.

138. On or about July 9, 2011, Respondent added artemisinin (an antimalarial), Hepapro (a nutritional supplement); Mepron (atovaquone, an antiparasitic), heparin injections (an anticoagulant), magnesium oxide (antacid, laxative, dietary supplement), and omega-3 fatty acids to C.H.'s treatment.

139. Respondent did not prescribe a blood smear examination for Babesial parasites or PCR amplification for Babesial DNA for C.H.

140. At no time during her treatment did Dr. Lentz refer C.H. to a specialist. Indeed, he represented to her and to her mother that he was a specialist in Lyme disease and that he was better equipped to treat these conditions than a normal family practitioner would be.

141. C.H.'s condition worsened rather than improved under the medication regimen Dr. Lentz prescribed. She suffered diarrhea and blurred vision and her other symptoms did not improve.

142. Dr. Joel Rosenstock is a medical doctor licensed to practice medicine in the State of Georgia. He is board certified in internal medicine with a subspecialty in infectious disease, and has practiced infectious disease medicine for over 30 years. During the time related to this proceeding, Dr. Rosenstock was practicing in Atlanta, Georgia, at the AbsoluteCARE Medical Center and Pharmacy.

143. C.H. first presented to Dr. Rosenstock on July 12, 2011, at which time she reported Dr. Lentz's diagnoses of Lyme disease and Babesiosis. In contrast to her brief visit with Dr. Lentz, her consultation with Dr. Rosenstock lasted two to three hours.

144. Dr. Rosenstock immediately ordered a Western blot test for C.H., which was negative. He conducted a thorough history and physical for her, and asked C.H. questions about her travel

history, her dogs and where they slept, her hobbies, etc. He advised her that he did not believe that she had Lyme disease or Babesiosis, and recommended that she stop all of the antibiotics and other medications that Dr. Lentz had prescribed. He warned her that it could take several months before the drugs were out of her system, so relief from the side effects would not be immediate. Within a few weeks of stopping the medications, C.H. was feeling much better and was on her way to feeling back to her old self.

145. Dr. Rosenstock did not believe that any of the tests that Dr. Lentz ordered for C.H. were useful in diagnosing Lyme disease or Babesiosis, and did not believe that heparin served any purpose in treating C.H.

146. Based on the credible opinions of Drs. Powers and Robbins, and the testimony of Dr. Rosenstock as a subsequent treating provider, it is found that Dr. Lentz departed from the applicable standard of care in the care and treatment of C.H. in several respects.

147. First, Respondent departed from the applicable standard of care by ordering blood tests and prescribing antibiotic treatment for C.H. (as well as other medications) when he had never actually seen her. At the time he ordered the blood tests, and at the time he first ordered medications for C.H., he had not obtained a history for her, much less a history that was

suggestive of Lyme disease, and had not conducted a physical examination of any kind. All he had as a basis for ordering tests was the e-mail from her mother. This e-mail was an insufficient basis upon which to determine that testing for Lyme disease was warranted.

148. When he did actually see C.H., he failed to perform an adequate physical examination and failed to take an adequate history that included travel history, possible exposure to ticks, how long any tick bite may have lasted, and the size and appearance of the tick.

149. Respondent failed to use the generally accepted tests for the diagnosis of Lyme disease and Babesiosis, instead relying on tests that are meant for investigational purposes and indicate on their face that they are not meant for diagnostic purposes. Moreover, as noted above, at the time he ordered the tests, he had no basis upon which to believe C.H. had Lyme disease. Although even his own expert witness consistently stated that a diagnosis of Lyme disease is based in large part upon a thorough history, here, Dr. Lentz had no history. Dr. Cichon's testimony that it was appropriate to rely on the information in S.H.'s e-mail about her daughter's symptoms (keeping in mind that her daughter is an adult, not a child) is rejected as not credible.

150. Respondent also departed from the applicable standard of care by prescribing Omnicef, azithromycin, artemisinin,

Hepapro, Mepron, heparin injections, magnesium oxide, and omega-3 fatty acids for a condition that she did not have. Given that C.H. had no condition justifying the prescription of these drugs, the prescriptions were both inappropriate and excessive. They also were prescribed for a duration that was not justified, and exposed C.H. to complications that were unnecessary.

151. Respondent was required to keep medical records that justified the course of treatment. His medical records for C.H. fell well short of this requirement. He failed to document a complete history, an adequate physical examination, or why he did not refer her case to a specialist. He also departed from the applicable standards when he used a diagnosis of Lyme disease as the basis for blood tests at a time when he had never seen the patient.

Failure to Timely Report Diagnoses or Suspicion of Lyme Disease to the Department of Health (DOAH Case Nos. 15-2889 and 15-2890)

152. Finally, in DOAH Case Nos. 15-2889 and 15-2890, the Department alleged that Respondent failed to report his diagnoses of Lyme disease or suspicions of Lyme disease for patients D.H., J.L., W.L., S.L., D.D., and C.H. to the Department of Health.

153. Section 381.0031, Florida Statutes (2010-2011), requires certain licensed health care practitioners and facilities in Florida to report the diagnosis or suspicion of the existence of diseases of public health significance to the

Department of Health. Lyme disease is one of the diseases identified by rule that meets the definition of a disease that is "a threat of public health and therefore of significance to public health." § 381.0031(2), Fla. Stat.; Fla. Admin. Code R. 64D-3.029. There are forms that are identified by rule for use in reporting these cases. Fla. Admin. Code R. 64D-3.030(3).

154. Ashley Rendon is a biological scientist for the Department of Health in Okaloosa County. Ms. Rendon is an epidemiologist whose duties include investigating reportable disease conditions and outbreaks of public health significance in Okaloosa County.

155. According to Ms. Rendon, whose testimony is consistent with the Department's rules on this subject, all diagnosed or suspected cases of Lyme disease must be reported to the Department. Once reported, the county health office will conduct an analysis of the reported diagnosis or suspicion, based on a "guidance to surveillance" document, to determine whether the reported case meets the definition for Lyme disease such that the case needs to be reported to the statewide system and to the CDC. Ms. Rendon testified that whether a suspected case or a diagnosis meets the case definition is not for the practitioner to decide. Ms. Rendon's testimony is credited.

156. According to Ms. Rendon, the Department maintains records both for those reported cases that met the case

definition and those reported cases that did not. For 2010, there was one case of Lyme disease that was confirmed, probable, or suspect. None were reported for 2011. There were seven to eight additional cases that were reviewed, but not reported as probable, confirmed, or suspect.

157. Not all reported results are confirmed by ELISA or Western blot.

158. Ms. Rendon reviewed the records of the Department to determine whether Dr. Lentz had reported any cases of Lyme disease, whether suspected or diagnosed, to the Department. There was one instance where a patient of Dr. Lentz's apparently called in and asked questions, but there was no record of Dr. Lentz or anyone in his office reporting Lyme disease.

159. Dr. Lentz claimed that he had at least on one occasion attempted to report in the past, but that he could not say if he had reported any of the patients named in the Administrative Complaints. He claimed that the Department would not accept reports that are not supported by two-tier testing results, so he stopped trying to report. His claim is rejected as not credible.

160. There is clear and convincing evidence to establish that Respondent failed to report his diagnoses of Lyme disease for patients D.H., J.L., W.L., D.D., S.L., and C.H.

General Observations

161. Of the seven patients presented in this proceeding, Dr. Lentz saw only two before ordering tests for Lyme disease and in some cases, Babesiosis or Bartonellosis. With respect to C.H., not only did he fail to see her before ordering testing, but he ordered medications for her without ever obtaining a medical history or performing a physical examination.

162. Some of the patients specifically requested testing for Lyme disease. However, it is the physician's responsibility to determine whether there is any realistic reason to believe that a patient has a need for such tests. Moreover, in several instances, the general, non-specific symptoms related by the patients suggest several other alternative conditions that could cause the patients' problems. Even Respondent's expert opined that Lyme disease, Bartonellosis and Babesiosis share a lot of general, non-specific symptoms with other illnesses, including serious diagnoses such as ALS, MS, and rheumatoid diseases. These are all, according to Dr. Cichon, differential diagnoses that a physician should sometimes consider when trying to find a diagnosis.

163. Yet with all of these patients, Dr. Lentz went straight to Lyme disease every time. He did not consider much of anything else when even to a lay person, the records cry out for a more thoughtful and measured approach. In short, it seems that

Dr. Lentz wanted to find Lyme disease regardless of the symptoms presented, and so he did. By doing so, he cost these patients not only the money used for testing and, with respect to C.C., W.L., S.L., and C.H., subjecting them to treatments they did not need and, in at least with respect to S.L., could not afford, but he subjected them to a treatment regimen that made them miserable, was of questionable benefit, and exposed them to unnecessary risks.

164. Petitioner presented the expert testimony of Dr. Charles Powers, a general family practitioner, and Dr. William Robbins, an infectious disease specialist. It also presented the testimony of subsequent treating physicians: Dr. Janelle Robertson, Dr. Patrick Anastasio, and Dr. Joel Rosenstock. Each subsequent treating physician testified credibly that the symptoms presented simply did not justify a diagnosis of Lyme disease, and the testing they either conducted or reviewed did not indicate a basis for such a diagnosis. Their testimony was consistent with that of both expert witnesses presented by the Department, and the testimony of these subsequent treating physicians and expert witnesses have been accorded great weight.

165. Respondent presented the testimony of Dr. Michael Cichon, a retired infectious disease specialist. Dr. Cichon's testimony was in many respects inconsistent, and at times he

seemed to be struggling to actually support the care and treatment that Respondent performed in these cases. While he championed Respondent's use of the CD57, the ECP, and the Fry test, he also admitted that he seldom, if ever, used some of these tests, and that there were problems with standardization of the tests. Moreover, the tests themselves indicated on their face that they were for investigational, as opposed to diagnostic, use, and should not be used as the sole basis for diagnosis of patients. Because of the significant inconsistencies with his testimony and the contrasts between what he advocated and what Dr. Lentz sometimes did, his testimony is given little weight.

CONCLUSIONS OF LAW

166. DOAH has jurisdiction of the subject matter and the parties to this action pursuant to sections 120.569 and 120.57(1), Florida Statutes (2015).

167. This is a proceeding whereby the Department seeks to revoke Respondent's license to practice medicine. The Department has the burden to prove the allegations in the three Administrative Complaints by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 595 So. 2d 292 (Fla. 1987). As stated by the Supreme Court of Florida:

> Clear 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 testimony must be precise and lacking in confusion as to the facts at 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.

In re Henson, 913 So. 2d 579, 590 (Fla. 2005) (quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)). This burden of proof may be met where the evidence is in conflict; however, "it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., 590 So. 2d 986, 988 (Fla. 1st DCA 1991).

Case No. 15-2888

168. DOAH Case No. 15-2888 deals only with patient C.C., and contains one count, charging Respondent with violating section 458.331(1)(t). Section 458.331(1)(t) provides:

> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (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.
> 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.
>
> 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.

169. Section 456.50(1)(g), Florida Statutes (2011), defined medical malpractice as follows:

> (g) "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. Only for the purpose of finding repeated medical malpractice pursuant to this section, any similar wrongful act, neglect, or default committed in another state or country which, if committed in this state, would have been considered medical malpractice as defined in this paragraph, shall be considered medical malpractice if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.

170. Section 766.102, Florida Statutes (2010-2011), provided in pertinent part:

> **Medical negligence; standards of recovery; expert witness.**—

> (1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 766.202(4), the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. 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.
>
> * * *
>
> (4) The Legislature is cognizant of the changing trends and techniques for the delivery of health care in this state and the discretion that is inherent in the diagnosis, care, and treatment of patients by different health care providers. The failure of a health care provider to order, perform, or administer supplemental diagnostic tests shall not be actionable if the health care provider acted in good faith and with due regard for the prevailing professional standard of care. (emphasis added).

171. With these standards in mind, the Administrative Complaint alleges that Respondent violated section 458.331(1)(t) in the following ways:

> a. By diagnosing Lyme disease without objective laboratory test results from immunoassay test and a Western blot test;
> b. By diagnosing Babesiosis without objective laboratory test results from a blood smear examination for Babesial

parasites or PCR amplification for Babesial DNA;
c. By prescribing surgery for placement of a venous port for administration of intravenous medication;
d. By prescribing inappropriate and excessive intravenous antibiotic therapy without medical justification;
e. By prescribing inappropriate and excessive oral antibiotic therapy without medical justification; and
f. By prescribing the anticoagulant heparin without medical justification.

172. The Department has proven the allegations in the Administrative Complaint in Case No. 15-2888 by clear and convincing evidence. The undersigned has considered the specific language in section 766.102(4) with respect to the allegations regarding the ordering of objective laboratory tests. Respondent contends that he did order testing to support his diagnoses, and that the testing he ordered was sufficient. However, the more compelling and persuasive testimony presented indicates that the standard of care required that Respondent order the ELISA and Western blot for Lyme disease, blood smear, or PCR amplification for Babesial DNA. The tests upon which Respondent relied may or may not have been useful in conjunction with ELISA and Western blot or PCR amplification. However, the tests themselves indicate that they are not intended as the sole means for clinical diagnosis, and Respondent departed from the standard of care by his reliance on these tests.

Case No. 15-2889

173. The Administrative Complaint in DOAH Case No. 15-2889 contains 11 counts, and addresses the care and treatment provided to patients D.H., J.L., W.L., D.D., and S.L.

174. Count I charges Respondent with violating section 458.331(1)(t), quoted above, with respect to the care and treatment of D.H. in the following ways:

> 82.a. By diagnosing Lyme disease without objective laboratory test results from ELISA or Western blot immunoassay tests;
> b. By diagnosing Babesiosis without a pathologist's report of a positive blood smear examination for Babesial parasites or PCR amplification for Babesial DNA;
> c. By prescribing inappropriate and excessive antibiotic therapy without medical justification;
> d. By prescribing the anticoagulant heparin without medical justification;
> e. By prescribing antimalarial medication without medical justification;
> f. By prescribing antiparasitic medication without medical justification;
> g. By prescribing anthelmintic medication without medical justification;
> h. By prescribing supplements without medical justification;
> i. By prescribing a beta blocker without medical justification;
> j. By failing to obtain a complete history;
> k. By failing to perform adequate physical examinations;
> l. By failing to order appropriate tests for the diagnosis of Lyme disease;
> m. By failure to order appropriate tests for the diagnosis of Babesiosis; and/or
> n. By failing to refer to a specialist in infectious disease.

175. The undersigned notes that the bases identified in paragraphs 82.a. and l., and b. and m., of the Administrative Complaint are somewhat duplicative. That being said, the Department has demonstrated all of the bases listed above with the exception of paragraphs 82.i. and n.

176. With respect to paragraph 82.i., the only testimony related to prescription of a beta blocker indicated that Dr. Lentz prescribed a beta blocker for D.H. in order to continue a prescription he was already taking, and Dr. Lentz gave him a refill because D.H.'s job would prevent him from seeing his prescribing doctor before his prescription ran out. With respect to paragraph 82.n., the Department did not establish that doing so here was a departure from the standard of care. Similarly, the evidence was not clear and convincing that a primary care physician could not diagnose Lyme disease or Babesiosis, assuming that he or she took an appropriate history, conducted a thorough physical examination, and, where warranted, ordered the appropriate objective laboratory tests.

177. Count II of the Administrative Complaint charged Respondent with violating section 458.331(1)(m), with respect to the care and treatment of D.H., which provided as a basis for discipline:

> (m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the

> licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

178. The Department charged Respondent with violating section 458.331(1)(m) by failing to document a complete history, by failing to document adequate physical examinations, and failure to document referrals to specialists. The Department proved a violation with respect to the first two bases listed by clear and convincing evidence. While Dr. Lentz did not refer D.H. to a specialist, the evidence did not establish that he necessarily had to, provided he conducted the appropriate history and physical and ordered the appropriate tests. Inasmuch as a referral was not required, the failure to document a referral is not, under the facts of this case, a basis for discipline.

179. Counts III and IV address the care and treatment provided to J.L. Count III charges Respondent with violating section 458.331(1)(t), quoted above, in the following ways:

> 90.a. By diagnosing Lyme disease without objective laboratory test results from ELISA or Western blot immunoassay tests;
> b. By failing to obtain a complete medical history;

c. By failing to perform a physical examination;
d. By failing to order appropriate tests for the diagnosis or Lyme disease; and/or
e. By failing to refer to a specialist in infectious disease.

180. As with patient D.H., paragraphs 90.a. and d. of the Administrative Complaint are somewhat duplicative, and the Department did not establish the basis articulated in paragraph 90.e. by clear and convincing evidence. The Department did establish a violation of section 458.331(1)(t) with respect to J.L. in all other respects.

181. Count IV charged Respondent with a violation of section 458.331(1)(m), quoted above, with respect by a. failing to document a complete medical history of J.L.; b. failing to document adequate physical examinations of J.L.; and c. failing to document referrals to specialists for J.L. The Department has proven a violation of section 458.331(1)(m) with respect to J.L. as alleged in paragraphs 94.a. and b. by clear and convincing evidence. A violation for the reason articulated in paragraph 94.c. was not established.

182. Counts V and VI address violations with respect to patient D.L. Count V charges a violation of section 458.331(1)(t) with respect to D.L. for the following departures from the standard of care:

> 98.a. By diagnosing Lyme disease without objective laboratory test results from ELISA or Western blot immunoassay tests;
> b. By failing to obtain a complete medical history;
> c. By failing to perform a physical examination;
> d. By failing to order appropriate tests for the diagnosis or Lyme disease; and/or
> e. By failing to refer to a specialist in infectious disease.

183. For the same reasons stated with respect to Count I and III, the Department has established a violation with respect to paragraphs 98.a. through d. of the Administrative Complaint, but not with respect to paragraph 98.e., by clear and convincing evidence.

184. Count VI charges Respondent with a violation of section 458.331(1)(m) with respect to W.L. by failing to document a complete medical history, by failing to document adequate physical examinations, and/or by failing to document referrals to specialists. For the reasons stated with respect to Count II and IV, the Department established a violation of section 458.331(1)(m) with respect to W.L. based on the first two grounds, but not the third.

185. Counts VII and VIII allege violations of section 458.331(1)(t) and (m), respectively, with respect to the care and treatment of D.D. The grounds upon which the violations are predicated are identical. For the same reasons already articulated, the Department has proven a violation of

section 458.331(1)(t), as charged in Count VII, for the reasons articulated in paragraphs 106.a. through d. of the Administrative Complaint, but not 106.e., by clear and convincing evidence. Similarly, the Department has proven a violation of section 458.331(1)(m) as charged in Count VIII, for the reasons articulated in paragraphs 110.a. and b., but not paragraph 110.c. of the Administrative Complaint, by clear and convincing evidence.

186. Counts IX and X of the Administrative Complaint identify charges with respect to the care and treatment of S.L. Count IX charges Respondent with violating section 458.331(1)(t) in the following ways:

> 114.a. By diagnosing Lyme disease without objective laboratory test results from ELISA or Western blot immunoassay tests;
> b. By diagnosing Babesiosis without a pathologist's report of a positive blood smear examination for Babesial parasites or PCR amplification for Babesial DNA;
> c. By prescribing inappropriate and excessive antibiotic therapy without medical justification;
> d. By prescribing the anticoagulant heparin without medical justification.
> e. By failing to obtain a complete history;
> f. By failing to perform adequate physical examinations;
> g. By failing to order appropriate tests for the diagnosis of Lyme disease;
> h. By failing to order appropriate tests for the diagnosis of Bartonellosis;
> i. By failing to order appropriate tests for the diagnosis of Babesiosis; and/or
> j. By failing to refer to a specialist in infectious disease.

187. The Department proved the allegations as listed in paragraphs 114.a. through e., and g. through i., by clear and convincing evidence. As with other patients, paragraphs 114.a. and g., and b. and i., are somewhat duplicative. The undersigned notes that with respect to paragraph 114.d. for patient S.L., Respondent prescribed Lovenox as opposed to traditional heparin. However, the evidence established that Lovenox is a low-molecule form of heparin, and is still considered an anticoagulant. Given that evidence, paragraph 114.d. is established by clear and convincing evidence. Paragraphs 114.e. and j. were not established.

188. Count X charged Respondent with violating section 458.331(1)(m) by failing to document a complete medical history, by failing to document adequate physical examinations, and by failing to document referrals to specialists. This violation is established by the failure to document a complete medical history. The other two bases were not established by clear and convincing evidence.

189. Count XI charges Respondent with failing to perform a statutory or legal obligation, in violation of section 458.331(1)(g), with respect to all five patients, by failing to comply with the reporting requirements contained in section 381.0031(1),[13/] Florida Statutes (2010-2011).

190. Section 381.0031(1) provides:

> Report of diseases of public health significance to department.—
> (1) Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; . . . that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health.

191. Rule 64D-3.029 identifies Lyme disease as a disease of public significance that must be reported the next day. Similarly, rule 64D-3.030 identified the type of information to be reported and the form practitioners may use to meet this reporting requirement.

192. Respondent argued that this requirement only applied to those cases that are diagnosed through the use of Western blot and ELISA, because those are the tests that the CDC and Department of Health recognize with respect to Lyme disease, and that reporting is simply a surveillance mechanism. While the reference to Western blot and ELISA underscores the fact that Respondent should have ordered these tests, the statute states an affirmative requirement to report, regardless of what type of test the practitioner uses, or what he or she believes the Department will do with the information once it is reported. The Department has established a violation of section 458.331(1)(g), by failing to report suspicion or diagnosis of Lyme disease as required by section 381.0031, by clear and convincing evidence.

Case No. 15-2890

193. The Administrative Complaint in DOAH Case No. 15-2890 deals with Respondent's care and treatment of C.H.

194. Count I of the Administrative Complaint charges Respondent with violating section 458.331(1)(t) in the following ways:

> 39.a. By diagnosing Lyme disease without objective laboratory test results from immunoassay test and/or a Western blot test;
> b. By diagnosing Babesiosis without objective laboratory test results from a blood smear examination for Babesial parasites or PCR amplification for Babesial DNA;
> c. By prescribing inappropriate and excessive antibiotic therapy without medical justification;
> d. By prescribing the anticoagulant heparin without medical justification.
> e. By prescribing antimalarial medication without medical justification;
> f. By prescribing antiparasitic medication without medical justification;
> g. By prescribing antacids, laxatives, enzyme formulations, and supplements without medical justification;
> h. By failing to obtain a complete medical history;
> i. By failing to perform adequate physical examinations; and/or
> j. By failing to refer patient C.H. to specialists.

195. The Department established the above-referenced allegations by clear and convincing evidence, with the exception of paragraph 39.j. While it would have been more prudent (and humane), to refer C.H. to a doctor who was closer geographically

to her home in upstate Georgia, no testimony was presented to establish that a physician must refer a patient to a physician in the area of his or her residence.

196. Count II of the Administrative Complaint charges Respondent with a violation of section 458.331(1)(m), by failing to document a complete medical history, failing to document adequate physical examinations, and/or failing to document referrals to specialists. The Department has established a violation of section 458.331(1)(m), with respect to the first two reasons articulated, by clear and convincing evidence.

197. Finally, Count III charges Respondent with failing to perform a statutory or legal obligation placed on a licensed physician in violation of section 458.331(1)(g), by failing to report his diagnosis or suspicion of Lyme disease with respect to C.H. It could be argued that section 381.0031 does not apply in this instance because C.H. was not a Florida resident. However, section 381.0031 contains no such residency requirement, and the undersigned declines to add language to the statute that the Legislature has not seen fit to include. Accordingly, the Department has established a violation of section 458.331(1)(g) with respect to C.H. by clear and convincing evidence.

198. The Department has alleged, and the undersigned has found a basis for, violations of section 458.331(1)(t) with respect to seven separate patients. Accordingly, pursuant to the

terms of sections 458.331(1)(t)3. and 456.50(1)(h), Respondent is guilty of repeated malpractice.

199. The Board of Medicine has established disciplinary guidelines in accordance with the requirements of section 456.079, which provide notice of the ranges of penalties typically imposed for violations of chapters 456 and 458, and the rules of the Board of Medicine. Fla. Admin. Code R. 64B8-8.001. The rule also identifies aggravating and mitigating factors for consideration should a penalty outside the guideline ranges be recommended. In this case, there is no need to resort to the mitigating and aggravating factors identified by the rule, because the recommended penalty fits within the guideline range.

200. Under the version of rule 64B8-8.001 in effect at the time the acts alleged in the Administrative Complaints were committed, the penalty for a violation of section 458.331(1)(t) classified as repeated malpractice was revocation or denial of licensure and an administrative fine of $1,000 to $10,000.

201. For a violation of section 458.331(1)(m), the guideline ranged from a reprimand to denial of licensure or two years' suspension followed by probation, 50-100 hours of community service, and an administrative fine from $1,000 to $10,000.

202. There is no specific penalty listed for a violation of section 381.0031. However, for violations of section

458.331(1)(g), for those offenses not specifically listed, the penalty is based on the severity of the offense, and the potential for patient harm, and ranged from a letter of concern to revocation or denial, 100 hours of community service, and an administrative fine from $1,000 to $10,000.

203. The Department recommends a penalty for each Administrative Complaint. For Case No. 15-2888, it recommends revocation of Respondent's license and an administrative fine of $5,000. For Case No. 15-2889, the recommendation is revocation of Respondent's license and an administrative fine of $20,000. For Case No. 15-2890, the Department recommends revocation and an administrative fine of $5,000.

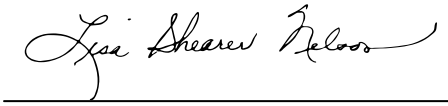
RECOMMENDATION

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

RECOMMENDED that the Board of Medicine enter a final order finding that Respondent has violated section 458.331(1)(g), (m), and (t), as alleged in the three Administrative Complaints at issue in this proceeding; and by the findings that Respondent violated section 458.331(1)(t) with respect to all seven patients, Respondent is guilty of repeated malpractice. It is further recommended that the Board of Medicine revoke his license to practice medicine in the State of Florida, impose an

administrative fine in the amount of $30,000, and impose costs pursuant to section 456.072.

DONE AND ENTERED this 8th day of July, 2016, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of July, 2016.

ENDNOTES

[1/] C.T.'s testimony also was offered at hearing for the purpose of establishing Dr. Anastasio's reaction regarding Dr. Lentz when one of the patients in this case visited Dr. Anastasio's office. Given that any statement attributed to Dr. Anastasio would be hearsay, and given that Dr. Anastasio was available at hearing to testify and Respondent had ample opportunity to impeach his credibility and explore any bias he may have, the testimony was excluded. C.T.'s deposition was submitted for the same purpose and has not been considered. The fact that Dr. Anastasio thought that Dr. Lentz was not practicing sound medicine and held that view consistently, was abundantly clear at hearing.

[2/] The ILADS guidelines, dated 2004, cite to three articles dated from 1992 to 1998 for this premise.

[3/] The terms Bartonella and Bartonellosis are used interchangeably in testimony, although the initial description of the condition indicated that the disease is Bartonellosis and the bacteria from which it is derived is Bartonella. To avoid

confusion, the term Bartonellosis is used consistently in this Order to refer to the disease.

[4/] Dr. Cichon's math was a little off: he testified that history is 79 percent of the diagnosis, the physical examination is 19 percent, and the laboratory results about 12 percent. The combination would equal 110 percent. The point, however, remains the same: an adequate history is essential, and one did not exist here. The undersigned notes that the Administrative Complaint does not specifically allege that Respondent violated section 458.331(1)(t) by taking an inadequate history in order to diagnose Lyme disease. The failure to do so is not a separate basis upon which to discipline Dr. Lentz, but highlights the failure to obtain objective laboratory testing that is appropriate to make the diagnosis.

[5/] Dr. Cichon testified that it was not a departure from the standard of care to base a diagnosis of Babesiosis or Bartonellosis on the Fry test results. However, he also testified that it was a test that he did not use in his own practice. His support of the test was not very credible, and his testimony is rejected.

[6/] Although Respondent acknowledged that Mr. Roberts was not licensed as a physician in Florida, he, D.H., and J.H. (D.H.'s wife) consistently referred to Mr. Roberts as Dr. Roberts.

[7/] The records in evidence for Dr. Anastasio's office included a preliminary negative report for Western blot, but not the final report. Dr. Anastasio felt sure that he had gotten the results, either in writing or over the phone, despite their absence from the records. While clearly a paper copy should have been in the records, his testimony that the test result was negative is credited.

[8/] Hope Medical Clinic was a medical clinical in the Destin area providing services donated by various healthcare providers for patients who could not afford to pay for medical care. It is unclear whether Hope Medical Clinic is still operating, but it was a facility where Respondent donated his time.

[9/] Hospital records from Sacred Heart also indicate that she was in the emergency room on October 14, 2010, as well, complaining of nausea and left flank pain. Neither party presented testimony regarding this visit.

[10/] The Administrative Complaint does not charge Respondent with any violations for failure to follow up on these test results related to S.L.'s liver, or the noted tenderness. It may well be that there is nothing wrong here. It is mentioned because it is yet another illustration of the fact that Respondent seems so focused on Lyme disease and its possible co-infections that he seems to pay no attention to other symptoms or complaints the patient may have.

[11/] Respondent attempted to undermine Dr. Anastasio's credibility by arguing that Dr. Anastasio was somehow out to get him because he would be a competitor for treatment of Lyme disease. This might have some traction if Dr. Anastasio was claiming that Dr. Lentz was treating patients who were legitimately diagnosed with Lyme disease incorrectly. However, Dr. Anastasio testified that none of the patients he had seen should have been diagnosed with Lyme disease in the first place. In other words, neither physician would, in his view be in the position of treating these patients because they had no infectious disease to treat.

[12/] The lab report for an Abs. CD8-CD57 + Lymphs actually lists the reference range for a normal test as 60-360.

[13/] The Administrative Complaint cited section 381.031 as opposed to section 381.0031. The reference was corrected by an Amended Notice of Scrivener's Error filed October 6, 2015.

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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.