STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 16-1595PL

ROBERT B. DEHGAN, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

On June 20 and 21, 2016, Administrative Law Judge Lisa Shearer Nelson conducted a disputed-fact hearing pursuant to section 120.57(1), Florida Statutes (2015), in St. Augustine, Florida.

APPEARANCES

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

For Respondent: Thomas R. Brown, Esquire
The Brown Law Firm
6277 Dupont Station Court East, Suite 3
Jacksonville, Florida 32217

STATEMENT OF THE ISSUES

The issues to be resolved are whether Respondent, Robert B. Dehgan, M.D. (Dr. Dehgan or Respondent), committed sexual

misconduct in violation of sections 456.072(1)(v) and 458.331(1)(j), Florida Statutes (2014), with respect to patients A.S., S.M., and C.T.; and if so, what penalty should be imposed.

PRELIMINARY STATEMENT

On February 24, 2016, Petitioner, Department of Health (the Department or Petitioner), filed a six-count Amended Administrative Complaint against Respondent, alleging that he committed sexual misconduct in the course of his treatment of patients A.S., S.M., and C.T. On March 10, 2016, Respondent filed an Answer to Amended Administrative Complaint and Demand for Formal Hearing. On March 18, 2016, the Department referred the case to the Division of Administrative Hearings (DOAH) for assignment of an administrative law judge.

After receipt of the parties' Joint Response to Initial Order, on April 5, 2016, a Notice of Hearing was issued scheduling the case to be heard on June 20 through 24, 2016. Petitioner and Respondent filed Unilateral Pre-hearing Statements on June 13 and June 14, 2016, respectively. Respondent also filed a Motion to Declare Florida Statutes Sections 456.072(1)(v), 456.331(1)(j), and 458.329 to be Unconstitutional, as well as a Notice of Hearing on the motion. On June 15, 2016, an Order was issued stating that, inasmuch as administrative law judges do not have the authority to address the constitutionality of a statute, there would be no ruling on Respondent's motion,

but that he would be afforded an opportunity to argue the motion at the beginning of the hearing in order to preserve the issue for appeal.

Although the parties had requested five days for the hearing, only two days were necessary for the presentation of evidence, and the hearing began June 20 and concluded June 21, 2016. Joint Exhibits 1 through 4 were admitted into evidence. Petitioner presented the testimony of patients A.S., S.M., and C.T.; Andrea Pratt; and Bruce Goldberger, M.D. Petitioner's Exhibits 1 through 3, which include the depositions of Jonathan Waldbaum, M.D., and of Respondent, also were admitted into evidence. Respondent testified on his own behalf and presented the testimony of Thomas Pulzone; Edward Risch, M.D.; and Diana Cordero, M.D., and Respondent's Exhibit 1 was admitted into evidence. Petitioner was given an opportunity to late-file a copy of Respondent's prior discipline, which was officially recognized.

The three-volume Transcript of the proceedings was filed with DOAH on July 6, 2016. At the request of the parties additional time was allotted for filing proposed recommended orders, and Respondent and Petitioner filed their Proposed Recommended Orders on July 20 and 21, 2016, respectively.

Unless otherwise specified, all statutory references are to the version of the statute in effect at the time of the alleged conduct.

FINDINGS OF FACT

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

1. Petitioner is the state agency charged with regulating 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 medical doctor within the State of Florida, having been issued license number ME16903. Respondent's address of record is 220 Paseo Terraza, No. 307, St. Augustine, Florida 32095.

3. Respondent originally practiced as an orthopedic surgeon. However, Respondent experienced some professional difficulties in the mid-80s that resulted in his seeking and completing retraining in the area of physical medicine and rehabilitation.[1/] He is board certified in physical medicine and rehabilitation.

4. At the time of the allegations giving rise to this case, Respondent was practicing pain management with a practice

entitled "Jacksonville Multispecialty Group, LLC" (JMG), and held the necessary certification from the United States Drug Enforcement Agency to prescribe Suboxone and Subutex.

5. Suboxone is a brand name for buprenorphine, a synthetic opioid, which is a controlled substance and is generally used to treat opioid addiction. Subutex is also a brand name for buprenorphine. Unlike Suboxone, Subutex does not contain naloxone, an additive used in Suboxone to prevent overdosing. Subutex is prescribed for pregnant patients and those patients who cannot tolerate Suboxone.

6. The office policy for pain management patients at JMG, consistent with most similar health care providers, was to obtain a urine sample for a 12-panel test at each visit. The purpose of the drug testing was to insure that pain management patients were abiding by the contract that they sign, and taking only the medicine prescribed to them. If a patient is compliant, the test results should show the existence of the drugs prescribed in his or her system, and none others. If a patient is not compliant, it is a basis for dismissing the patient from the physician's practice.

7. The urine sample given at each visit is used for a test performed in the office, and tests for 12 drug classes. The results from the 12-panel test are presumptive only. If any results are positive that should not be, the sample is sent to a

laboratory that does complex testing for confirmation. The confirming laboratory then performs a liquid chromatography mass spectrometry (LCMS). The LCMS is a very specific test that provides confirmation for drug use and drug classes, and rules out the possibility of false positives that may occur with a point-of-care test.

8. According to Dr. Bruce Goldberger, M.D., a professor and the director of toxicology at the University of Florida College of Medicine, LCMS is the more accurate test and is considered the gold standard in drug testing. Dr. Goldberger's testimony is credited.

Patient S.M.

9. Patient S.M. received medical care from Respondent from March 12, 2014, through August 27, 2014. S.M. saw Dr. Dehgan or an Advanced Registered Nurse Practitioner (ARNP) under his supervision approximately every four weeks during this time period.

10. At the time of her initial presentation to JMG, S.M. was 44 years old. S.M. had been prescribed opiates in response to a badly sprained ankle and some dental surgery, and as a consequence, became addicted to them. She testified candidly and credibly at hearing that as a result of her addiction, she sought both prescription and illegal street drugs, including heroin, methadone, oxycodone, and hydrocodone. S.M. was frightened by

her behavior, and sought treatment in order to get clean and to be a better role model for her daughter.

11. Respondent treated S.M. with Subutex,[2/] and she responded well to the treatment and has managed to refrain from using opiates and other illegal drugs. She had no complaints regarding Respondent's treatment plan for her and felt she benefited significantly from his treatment plan.

12. When a patient would come to the office at JMG for a follow-up visit while on Suboxone or Subutex treatment, the patient would fill out a therapy progress report. The therapy progress report asked the patient a series of questions, such as "please describe any life changes, triggers, or stressors that have occurred since your last visit," "list your ideas and plan to cope with these life changes, triggers, or stressors," and "what is your next short-term goal?" S.M. routinely completed these therapy progress reports and recorded in the early reports how much better she was feeling, and that she was not experiencing any cravings. Dr. Dehgan ordinarily reviewed the therapy progress report at the time of a patient's visit if it was available.

13. S.M. saw Dr. Dehgan approximately every four weeks. The first three visits were routine and uneventful. However, at her visit on May 30, 2014, S.M. remarked on her therapy progress report that she was anxious because her daughter was getting

ready to leave for Canada for the summer, and she had been fighting with her ex-husband regarding finances. She talked to Dr. Dehgan about her anxiety, and mentioned that she had taken a second job working on the weekends at the beaches in St. Augustine and the Palm Coast area.

14. Dr. Dehgan told her that he lived on the beach and asked if he could give her his cell phone number, and maybe he could take her to lunch.

15. S.M. said okay, because she did not know what else to do. He handed her a slip of paper with the phone number on it, and she put it in her purse. When she stood up to leave, Respondent hugged her and attempted to kiss her, ultimately kissing the side of her face near her ear because she turned her head away from him.

16. The door of the examination room was closed, and there was no attendant or ancillary personnel in the room at the time Dr. Dehgan hugged and attempted to kiss S.M.

17. S.M. was shocked by Dr. Dehgan's actions, as nothing like this had ever happened to her before. She left the office without saying anything to anyone about it, and confided only to the one person outside of JMG who knew that she was taking Subutex.

18. Despite the incident described above, S.M. returned to JMG for her next scheduled appointment with Dr. Dehgan, because

she could not find another provider who could prescribe Subutex and who would take her health insurance. Most providers that she could find would only take cash, and she could not afford to pay for treatment without using her insurance.

19. S.M.'s next scheduled appointment was June 27, 2014. Initially, Respondent did not mention or acknowledge his actions at the May 30 appointment, and S.M. was relieved. At the end of the appointment, however, Respondent remarked, "hey, I gave you my phone number. You didn't call me." S.M. made up an excuse that she had lost the phone number. As he left, Respondent hugged her again.

20. S.M. interpreted Respondent's actions as romantic in nature. As she stated, she did not know if Respondent wanted to have sex with her, "but I know when someone is asking me on a date."

21. S.M. also saw Respondent on August 1, 2014, and August 27, 2014. On August 27, 2014, there was a female staff member in the room for her appointment. Respondent had been presented with and signed an acknowledgment form on August 22, 2014, just five days before, which stated:

> I understand the office policy that a female member of our staff must be present during my female patient's office visits. I understand that I will not conduct the office visit without ensuring that a member of our staff is present.

22. Andrea Pratt, vice president of operations for JMG, testified that the acknowledgement form was put in place to protect both the doctor and the patient, and was put in place after receiving a complaint from another patient. Only Dr. Dehgan was required to sign an acknowledgement form. Dr. Dehgan's testimony in his deposition that he requested the change in policy because he was being propositioned by female patients is rejected as not being credible, and Ms. Pratt's testimony regarding the reason for the policy is accepted.

23. On September 15, 2014, Respondent was terminated from his employment with JMG. While Respondent contends that it was for having ten unsigned patient charts, the termination letter indicates that he was terminated without cause. As a result of his dismissal from JMG, at her next scheduled appointment, S.M. saw Dr. Hernan Chang, M.D. When she checked in for the appointment, she asked if Dr. Dehgan was no longer there because he kisses his patients.

24. S.M. continued to be treated at JMG and seen by Dr. Chang, until she received a letter from the practice in 2015 indicating that Dr. Chang would no longer be seeing patients at that location.

25. Respondent testified that he has no recollection of S.M. He attempted to impeach S.M.'s credibility on the basis of

a positive urine drug screen result received from a point-of-care test at JMG.

26. S.M.'s 12-panel test for her appointment on September 25, 2014, was negative for opiates. However, the confirmatory LCMS was positive for morphine, with a value of 85, compared to a reference range of less than 50 nanograms per milliliter. S.M. denied taking morphine or any other opiates after starting Subutex.

27. S.M.'s drug results were reviewed by Dr. Goldberger, who testified that a concentration of 85 nanograms per milliliter of morphine can be attributed to ingestion of morphine, ingestion of codeine, or ingestion of poppy seeds. These possible attributions also are listed on the report itself. He opined that it would be difficult to attribute the exact source of morphine resulting in this test result for S.M. His testimony is persuasive, and is credited.

28. S.M. did not know any other patients who treated with Dr. Dehgan, and does not know any of the patients who were witnesses in this case. Her testimony was consistent and persuasive: she was candid about the scope of her drug dependence, including her resort to illegal drugs. Her explanation as to why she continued to see Dr. Dehgan after the May 30 incident is believable, considering her desire to remain off illicit drugs and opiates, and the continued references to

financial difficulties in her therapy reports. Indeed, the note for her second visit indicates that a stressor for her was the difficulty getting her medications approved by her insurer. It is understandable that she would be reluctant to change physicians if she could not find one that would take her insurance.

29. Moreover, even assuming that S.M. was noncompliant leading up to her visit on September 25, 2014, and the evidence does not support such a finding, any noncompliance would not necessarily lead to a conclusion that she was not telling the truth regarding her encounters with Respondent.

Patient A.S.

30. Patient A.S. initially presented to Dr. Dehgan for treatment of opiate dependence when Dr. Dehgan worked at Orthopedic Associates, prior to his employment at JMG.

31. When she first presented for treatment at JMG, A.S. was 50 years old. She had a lengthy history of multiple abdominal surgeries dating back to her mid-twenties, including bowel resections, multiple hernia repairs, a tubal ligation, hysterectomy, endometriosis treatment, tubal pregnancy, and appendectomy. As a result of her lengthy use of legitimately-prescribed opioid medications, A.S. became dependent on them.

32. A.S. began treating with Dr. Dehgan at JMG beginning June 10, 2013, and continued treatment at JMG until September 16,

2014, receiving Suboxone for her opioid addiction. Like S.M., A.S. was satisfied with Respondent's treatment plan. She had no complaints about Dr. Dehgan until the summer of 2014. During that summer, there were three separate incidents where A.S. contends that Respondent touched her inappropriately. While A.S. did not recall the exact dates of these incidents, she was consistent in her testimony of what happened and in her belief that these incidents occurred on three different, consecutive appointments with Dr. Dehgan leading up to the Respondent's termination from JMG.[3/]

33. At A.S.'s first appointment at JMG, she filled out a patient questionnaire that asked a variety of questions related to past medical history, current complaint, and medications taken. The questionnaire included a diagram, showing the front and back of a person's body, on which a patient was directed to identify areas and types of pain. A.S. identified pain both in the abdominal area, and the corresponding area on her lower back. She described the pain for both areas as being sharp and aching. She did not indicate that she had any pain radiating down either leg. Respondent made no assessment regarding back pain in his notes, but prescribed Suboxone for her chronic pain and recommended follow-up in two months.

34. At all subsequent visits but one, A.S. continued to complete some sort of questionnaire or a therapy progress report.

For the visits on August 13, 2013, and September 13, 2013, there is no mention of back pain by either Respondent or A.S.

35. There does not appear to be a questionnaire for the appointment on November 22, 2013, but Respondent's notes for this visit mention low back pain for the first time.[4/] Respondent's records for the November 22 appointment identify constant low back pain under the "History of Present Illness" category. The note states in part:

> 50-year-old female is seen in the office today for followup evaluation and management of chronic opioid dependency. She takes Suboxone 8 mg twice daily. She is not taking any other medications and maintaining well on Suboxone twice daily There [sic] has been no interval change in the location, quality, increasing/decreasing factors, associated signs and symptoms as previously described.
> Lumbar Spine/Lower Back:
> Low back pain bilaterally, **lumbar, that is constant**, Nature: aching, Aggravated by: any physical activity, Aggravated by: bending, Severity: moderate to severe. Previous trials offered little or short durations of relief. Some relief from medications. Low back pain midline, paraspinal, Nature: aching, Nature: shooting, **lumbar, that is constant**, aggravated with movement, walking, lifting the legs.
>
> Radiates down the leg with associated numbness that is has [sic] severity: moderate to severe.

36. Despite this lengthy note describing what appears to be a new complaint, Respondent's notes for the back under the "General Examination" section of the patient record is exactly the

same as it was for the previous visit and contains no positive findings:

> BACK: Cervical, thoracic and lumbar spines, full range of motion, no kyphosis, no scoliosis, spine nontender to palpation, No muscle spasms noted, no paraspinal muscle tenderness nor trigger points identified.

Respondent did not sign this patient record: it reflects an electronic signature of January 6, 2015, well after his departure, and the sign-off status is listed as "pending."

37. A.S.'s next appointment at JMG was December 20, 2013. Her questionnaire for the visit indicated that she was depressed, had a stomach ache, and that it was not a good time of year for her. She was simply seeking to get through things and hope the next year was better. There is no mention of back pain. Respondent's notes, however, under "History of Present Illness" are identical to the November 22 visit with respect to back pain. The physical examination is also identical, with no real findings related to her back. This patient note also is listed as "pending," and is electronically signed in January 2015, after Respondent's departure.

38. Similarly, A.S.'s notes on her questionnaire for her January 17, 2014, visit mention depression, loneliness, and an asthma flare-up, but make no mention of back pain. Respondent's notes, which are electronically signed well after his termination, reference low back pain, but make the same negative

findings with respect to his examination. A.S.'s notes for the visit on February 19, 2014, mention problems with her car as a stressor, but again mention nothing about back pain or abdominal pain. Respondent's notes reference ongoing abdominal pain, but make no mention of back pain in the "History of Present Illness." References to the back under "General Examination" are the same negative findings listed for prior visits, yet lumbago and sciatica are listed as diagnoses under "Assessments." The same can be said for Respondent's notes for the visit on March 21, 2014, for which A.S.'s questionnaire makes no mention of back pain.

39. It was during this visit that the first incident of what A.S. alleged was inappropriate behavior by Respondent most likely occurred. A.S. had been telling Dr. Dehgan about how she was feeling, and A.S. testified that as she was getting ready to leave the examining room, Respondent said, "I think you need a hug," and reached over and hugged her. The embrace lasted about 30 seconds and made her feel strange. A.S. testified that the hug was initiated by Dr. Dehgan at a time when the door to the examining room was closed and there was no one else in the room. She was astonished because no doctor had ever done that to her before. She continued to see him, however, because she thought this first incident was a "fluke" and finding a pain management physician was difficult.

40. At A.S.'s visit on April 18, 2014, she wrote that she was very depressed and was experiencing chronic pain with respect to her abdomen and lower back, and that her allergies had been terrible. Respondent's notes, which he signed on April 28, 2014, indicate that she complained of persistent abdominal pain, hernia, and low back pain radiating to her buttocks. Under his "General Examination" for this visit, Respondent noted that her abdomen was soft and tender to the touch; that there was "presence of hernia and right lower side." With respect to her back, he notes for the first time that there is tenderness on the lumbar paraspinals, sacrum, and buttocks; that there is forward flexion, associated with moderate pain; that A.S. "stands and toes and heels with some discomfort"; and that her "[s]traight leg rising is mildly positive." Respondent lists lumbago and sciatica among her diagnoses, with lumbago as the primary diagnosis.

41. A.S. testified that she talked to Respondent about her fear that she had another hernia that might need repair, and he offered to check it for her. She consented to his doing so. He did not ask her to take her clothes off, and the examining room door was closed, with no one else in the room. During his purported examination related to her hernia, Respondent did not examine the four quadrants of her abdomen. He simply touched her

abdomen and reached up and squeezed A.S.'s right breast with one hand.

42. A.S. has suffered from hernias and has been examined in connection with hernia repairs since her early thirties. She had seen two prior physicians for this condition before seeing Respondent. No other doctor had ever touched her breast in the examination of her hernia.

43. Dr. Jonathan Waldbaum, M.D., testified as an expert on behalf of the Department. Dr. Waldbaum testified that a breast examination should never be part of an abdominal examination, and while it was possible for there to be incidental touching of a patient's breast, depending on the location of the hernia and the physique of the patient, any such contact would be limited to the back of the physician's hand coming into contact with the breast. Even Respondent testified that there would be no reason for him to touch A.S.'s breast.

44. A.S. testified that she backed away from Respondent, but did not say anything to him.

45. A.S.'s next appointment at JMG was June 19, 2014, at which time she saw an ARNP, Ashley Schinner. While her questionnaire does not mention back pain, the patient record notes back pain and abdominal pain related to her hernia in the "History of Present Illness" section, but no positive findings

regarding her back under the "General Examination." Lumbago and sciatica remain under the "Assessments" section.

46. A.S. saw Dr. Dehgan at her next appointment, July 17, 2014. A.S. continued to see Dr. Dehgan because she needed the medication he prescribed. Again, her questionnaire mentions some mild depression, but not back pain. Respondent's notes, on the other hand, indicate under "History of Present Illness" that she complains of low back pain radiating to the hips, lower limbs, feet and ankles. It also notes abdominal pain, and references the history of 13 abdominal surgeries. With respect to his examination, Respondent notes tenderness and lumbar paraspinals, sacroiliac and buttocks, that her range of motion of the lumbar spine is associated with pain, and that her "[s]traight leg raising is positive on both sides." Respondent's notes continue to list lumbago as her primary complaint, as well as listing sciatica and chronic pain syndrome along with her opioid dependence.

47. A.S. testified that at the July 17 visit, she told Dr. Dehgan that her back was hurting, not because of a problem originating with her back, but because the pain in her abdomen caused her to hunch over and to be unable to stand up straight. A.S. testified that Respondent felt her back and ran his hand down her buttock on the right side, not in the manner one would expect as part of a physical examination, but more like a caress.

When asked to specify what part of her body he touched, A.S. testified that he went "low," low enough for it to be inappropriate in that it was nowhere near her back, and Respondent used only one hand.

48. A.S. testified that she had never had another doctor examine her back before, but did not believe this examination to be appropriate. She told her sister that she would never go into Respondent's office alone again. Assuming that the incident occurred in July 2014, she did, however, return for one more visit where Dr. Dehgan was present. It is unclear whether her sister went with her for this visit, but the medical records by Respondent are consistent with those for the prior visit.

49. A.S.'s final visit occurred September 16, 2014, after Dr. Dehgan's termination from the practice. At that time, she was accompanied by her sister and saw Dr. Chang as opposed to Dr. Dehgan. When she was told that Dr. Dehgan had been let go, she asked whether his termination was due to sexual harassment.

50. A.S. is no longer going to JMG. She also is no longer a Suboxone patient, and has resumed taking opiates because her pain is too intense to do without it. While she reported needing additional surgery, she has been advised that she must stop smoking before surgery can be performed. She continues to suffer from depression, and will no longer see a male doctor because of trust issues created by Respondent's actions. Following her

treatment with Respondent, A.S. experienced further depression leading to a suicide attempt and involuntary hospitalization, which was, in part, attributable to the events described in this proceeding.

51. Respondent testified that he has no recollection of A.S., yet also testified that he remembers A.S. asking that he examine her for a hernia, and that she had a long scar from her sternum to her pubis.[5/] He attempted to discredit A.S.'s testimony by demonstrating the differences between her recollection of the visits and what is written in Respondent's notes. Specifically, A.S. was adamant that she only complained about back pain on one occasion, at her July 2014 visit. Respondent's notes, however, indicate multiple claims of back pain.

52. A.S.'s handwritten questionnaire clearly reference back pain on at least three occasions. They do not, however, include any reference to pain radiating down her legs or into her feet. Even the diagram on which A.S. marked the areas of pain in her back for her initial visit indicated that the pain was more at the hip level than her buttocks. In each instance where A.S. did reference back pain in her questionnaires, the reference is in connection with abdominal pain. Clearly, the pain caused by her adhesions and recurrent hernia was her primary complaint. In her

view, any back pain was ancillary to the abdominal pain that she had lived with for years.

53. It also appears that many of the notes in Respondent's medical records appear to be canned, or part of a template. Andrea Pratt testified that the electronic medical records system JMG used included templates that physicians could use, but were not required to be used. While Respondent denied using the templates, given the grammar (or lack thereof) and identical nature of some of the entries, use of the templates would explain some of the medical entries. Further, while several of the visits contain diagnoses of lumbago and sciatica, the record is clear that the primary purpose for A.S.'s treatment with Respondent always remained her treatment for opioid dependence.

54. Respondent also attempted to impeach A.S.'s testimony because of her drug use,[6/] and a positive drug test at her August 13, 2014, appointment, which reflected a positive result for oxycodone. However, the toxicology confirmation report from Essential Testing indicated a negative result for opiates. Dr. Goldberger testified credibly that A.S. did not have oxycodone in her system on August 13, 2014, and his testimony is accepted.

55. Finally, Respondent attempted to explain the July visit by stating that the touching A.S. contended was inappropriate was actually part of a physical examination related to her back pain.

However, A.S.'s description of Respondent's actions does not remotely match the description by any doctor who testified of what constitutes an appropriate examination for back pain.

56. Dr. Waldbaum testified that a good examination of the low back would start with seeing how the patient walks and observing the patient standing up. A physician would look at the patient's posture, check for scoliosis or curvature of the spine, and would check the patient's range of motion. The physician would perform a neurologic examination to check for things like strength in the patient's legs and reflexes. He or she would then palpate the back, including palpating down the middle, along the bones of the spine, the paraspinal muscles, and the hips. The physician would evaluate the structures going below the belt line in the back, the muscles in the gluteal area. He or she would push gently to palpate the area. Respondent proffered the testimony of Drs. Risch and Cordera on the same issue. While their testimony was not considered because neither doctor had been noticed as an expert in this proceeding, their testimony was similar to Dr. Waldbaum's with respect to a proper examination. Had their testimony been considered, it would only serve to reinforce the testimony of Dr. Waldbaum. What A.S. credibly described was not an examination of her back consistent with this testimony.

57. The more persuasive and compelling testimony establishes that on three separate occasions, Respondent touched A.S. inappropriately by hugging her, by squeezing her breast, and by caressing her buttocks.

58. Hugging a patient is not within the scope of the professional practice of medicine. Squeezing a female patient's breast outside the context of a breast examination is likewise not within the scope of the professional practice of medicine. Caressing a patient's buttocks is not part of an examination of a patient's back for pain, and is not within the scope of the professional practice of medicine.

Patient C.T.

59. Patient C.T. saw Respondent on one occasion. She went to JMG and Dr. Dehgan for pain management related to her history of avascular necrosis, a condition in which the bone marrow in the joints deteriorates, causing pain. C.T. suffers with pain primarily in the hips, knees, shoulders, and ankles. When she presented to Dr. Dehgan, she was 46 years old.

60. During C.T.'s visit, Respondent examined her back. While it was reasonable for Respondent to examine her back given her physical condition, he lifted her shirt to check her spine without letting her know that he was going to do so, which caught her by surprise. What is more troubling is that at the end of the appointment, a medical assistant came in and left some

paperwork on Respondent's desk, and then left the room. Respondent and C.T. were standing face to face. When she went to leave, he bent down, placed his hand at the small of her back, and kissed her in her ear, with his tongue going into her right ear.

61. C.T. was stunned, and did not know what to do, so she patted him on the back. No one else was in the room, and the door was closed. Her focus at this point was to leave as quickly as possible, so she took her appointment card and exited the room. At the front desk, she told whoever could hear her that she would not be returning, and went to her car to call her adoptive mother. She called the office to speak to a supervisor, but none was available.

62. C.T. did not know any of the other patients who testified in this proceeding. She filed a complaint with the Department of Health because she believes that what Respondent did was wrong. She interpreted his actions as sexual and is no longer trustful of male physicians.

63. C.T.'s testimony was clear, consistent, direct, and compelling. Respondent tried to undermine her credibility by dredging up a variety of painful episodes in her distant past, and emphasizing her mental health diagnoses. In his Proposed Recommended Order, he states:

> What C.T. did not tell Dr. Dehgan is interesting. She did not tell Dr. Dehgan that she had been raped. She did not tell him that six days prior to seeing him she was treated at Flagler Hospital in St. Augustine, for vertigo, right shoulder and right arm pain, subsequent to a slip and fall accident occurring August 3, 2014. She did not tell Dr. Dehgan that she has post traumatic stress disorder. She did not tell Dr. Dehgan that she had Attention Deficit Hyperactivity Disorder. She did not tell Dr. Dehgan that she had asthma. She did not tell Dr. Dehgan that she had anxiety, anxiety with panic attacks, and depression. She did not tell Dr. Dehgan that she was, and that she had been, a patient for many years under the care of psychiatrist Dr. Emmanuel Martinez. She did not tell Dr. Dehgan that she lost 75 pounds in a period of 18 months. She did not tell Dr. Dehgan that on numerous occasions, she had tried to commit suicide.

64. First, with respect to some of the history Respondent claims that C.T. omitted, there is not necessarily a question on the patient history form that she completed that would have required the information to be provided. The form was focused on the reason a patient presented to JMG, and, for the most part, included questions regarding prior treatment that a patient has received for the pain that caused him or her to seek treatment for pain management. It did not, for example, ask about prior hospitalizations in general, but rather, only asked about prior surgeries. Second, Respondent's statements about C.T.'s purported non-disclosures in many respects are false. Consultation with a psychiatrist or psychologist related to the

pain was disclosed on page 4 of the patient form, at Joint Exhibit 3, page 16. Asthma was checked on the same form at page 5, as was C.T.'s disclosure of anorexia, now recovered. At page 7 of the same form, C.T. disclosed that she has received treatment for depression and anxiety, provided Dr. Emmanuel Martinez's name and telephone number, and further indicated that she saw him every two months. The form made no inquiry regarding suicide attempts, and had no question for which an answer disclosing them would be responsive.

65. Respondent seemed to think that anyone with a history of mental illness is automatically a suspect witness who cannot be believed. There is no support for such a contention in this record. C.T.'s mental health history from ten years prior to this incident simply has no relevance to her testimony in this case. C.T.'s only memory difficulties at hearing were listing which medications she had taken over the years, as she did not have her medication list with her. Her reluctance to discuss issues related to her mental health, especially issues related to events over ten years old, did not impugn her credibility as a witness. Her memory of the events giving rise to this case was clear and credible, and is accepted.

66. It is never within the scope of professional practice for a physician to place his tongue in the ear of a patient.

67. Respondent presented the testimony of three individuals with whom he has worked who all testified concerning his character and his general demeanor with patients. Thomas Pulzone worked at Orthopedic Associates of St. Augustine, and knew Dr. Dehgan through his association with that practice prior to working with JMG. Mr. Pulzone thinks highly of Respondent. However, he never directly observed Respondent conduct an examination of any patient, and his contact with Respondent since Respondent left Orthopedic Associates has been limited to a few telephone calls.

68. Dr. Edward Risch is an orthopedic surgeon from whom Respondent rented office space for approximately ten years. Dr. Risch has not worked with Respondent since 2010 and never directly observed Respondent's examination of female patients.

69. Dr. Diana Cordero worked with Dr. Dehgan for approximately six months of the time he was at JMG, and shares space at his current practice location. Her work with Respondent at JMG was limited, and she never saw him examine a patient. There is no evidence that she, like Respondent's other witnesses, was present when any of the events giving rise to this case took place.

70. Respondent tried to impeach the testimony of each patient based on inconsistencies between her recollection of her treatment by Dr. Dehgan and what was contained in his medical

records for each of them. It was never established that any of the patients had reviewed her medical records. More importantly, it was never established that what was written in those records was an accurate statement of the care and treatment actually given.

71. For example, Respondent testified that he would perform a comprehensive examination for a first visit, but not for follow-up visits. The medical records seem to indicate a comprehensive visit was performed every time, and all three patients did not recall much of an examination at all. Respondent testified that he would not generally perform a Babinski test (a test of a patient's reflexes by scratching the bottom of his or her foot) for a follow-up Suboxone appointment, yet this test was routinely referenced as completed in Respondent's medical records. Given the marked disparities between all three patients' memories of their appointments and the contents of the medical records, as well as the internal inconsistencies noted in A.S.'s records, Respondent's medical records appear to be less than reliable. Accordingly, they do not provide a basis for discounting the testimony of the three patients whose testimony was clear, consistent, and compelling.

CONCLUSIONS OF LAW

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

73. 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 Amended Administrative Complaint 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).

74. Counts I, II, and III of the Amended Administrative Complaint charge Respondent with violating section 456.072(1)(v) with respect to his care and treatment of patients A.S., S.M., and C.T., respectively. Counts IV, V, and VI charge Respondent with violating section 458.331(1)(j), for the same three patients based on the same conduct.

75. Section 456.072(1)(v) provides in pertinent part:

> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
>
> * * *
>
> (v) Engaging or attempting to engage in sexual misconduct as defined and prohibited in s. 456.063(1).

76. Section 456.063 provides in pertinent part:

> (1) Sexual misconduct in the practice of a health care profession means violation of the professional relationship through which the health care practitioner uses such relationship to engage or attempt to engage the patient or client, or an immediate family member, guardian, or representative of the patient or client in, or to induce or attempt to induce such person to engage in, verbal or physical sexual activity outside the scope of the professional practice of such health care profession. Sexual misconduct in the practice of a health care profession is prohibited.

77. Section 458.331(1)(j) provides:

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

* * *

> (j) Exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity. A patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his or her physician.

78. Section 458.329, also cited in the Amended Administrative Complaint, provides:

> The physician-patient relationship is founded on mutual trust. Sexual misconduct in the practice of medicine means violation of the physician-patient relationship through which the physician uses said relationship to induce or attempt to induce the patient to engage, or to engage or attempt to engage the patient, in sexual activity outside the scope of the practice or the scope of generally accepted examination or treatment of the patient.

79. The Board of Medicine has adopted a rule implementing sections 458.329 and 458.331(1)(j). Florida Administrative Code Rule 64B8-9.008 provides in pertinent part:

> (1) Sexual contact with a patient is sexual misconduct and is a violation of Sections 458.329 and 458.331(1)(j), F.S.
> (2) For purposes of this rule, sexual misconduct between a physician and a patient includes, but it is not limited to:
> (a) Sexual behavior or involvement with a patient including verbal or physical behavior which
> 1. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it;
> 2. May reasonably be interpreted as intended for the sexual arousal or

gratification of the physician, the patient or any third party; or
3. May reasonably be interpreted by the patient as being sexual.

80. The Department has proven all six counts in the Amended Administrative Complaint by clear and convincing evidence. S.M. testified credibly that she interpreted Respondent's hug, kiss, provision of his cell phone number, and offer to take her to lunch as romantic in nature, and the hug and kiss clearly constitute sexual contact. Respondent's hug, squeezing of A.S.'s breast, and caressing of A.S.'s buttocks beyond the appropriate bounds of a back examination are also sexual contact. Finally, kissing C.T., including placing his tongue in C.T.'s ear, is sexual contact. All of these actions are outside the boundaries of an appropriate physician-patient relationship and violate sections 456.072(1)(v) and 458.331(1)(j) as alleged in the Amended Administrative Complaint.

81. The Board of Medicine has adopted Disciplinary Guidelines to provide notice to the public and to licensees regarding the range of appropriate penalties to be imposed for violations of chapters 456 and 458. Fla. Admin. Code R. 64B8-8.001. For a violation of section 456.072(1)(v) or section 458.331(1)(j), the guideline penalty as it existed in 2013 and 2014, when these violations took place, is from a one-year suspension, followed by a period of probation and a

reprimand, and an administrative fine of $5,000, to revocation or denial of licensure and an administrative fine of $10,000.

82. Rule 64B8-8.001(3) also provides aggravating and mitigating factors for the Board to consider should a penalty outside the guidelines be considered. These factors are also helpful in determining where, within the range of permissible penalties, discipline should be imposed. Among those factors identified in the rule are the exposure of patient or public to injury or potential injury, the legal status of the licensee at the time of the offense(s), the number of counts or separate offenses established, and the licensee's disciplinary history. The rule also provides in pertinent part:

> (4) It is the intent of the Board to notify applicants and licensees whom it regulates under Chapter 458, F.S., of the seriousness with which the Board deals with sexual misconduct in or related to the practice of medicine. In particular, the Board has identified those situations in which the sexual misconduct is predatory in its character because of the particular powerlessness or vulnerability of the patient, or because of the licensee's history or manipulation of the physician/patient relationship. Therefore, it is the policy of the Board, where any one of the following aggravating conditions are present in a sexual misconduct case, to consider revocation as an appropriate penalty:
> (a) Where controlled substances have been prescribed, dispensed or administered inappropriately or excessively, or not in the course of the physician's professional practice, or not in the patient's best interests.

(b) Where the relationship between the licensee and the patient involved psychiatric or psychological diagnosis or treatment.
(c) Where the patient was under the influence of mind altering drugs or anesthesia at the time of any one incident of sexual misconduct.
(d) Where the licensee is under suspension or probation at the time of the incident.
(e) Where the licensee has any prior action taken against the authority to practice their profession by any authority, or a conviction in any jurisdiction, regardless of adjudication, relating to sexual misconduct, in appropriate relationships with patients, or sex-related crimes.
(f) Where the patient is physically or mentally handicapped at the time of the incident.
(g) Where the patient is a minor at the time of the incident.
(h) Where the patient is an alien, whether legal or illegal; or a recipient of federal or state health care benefits, or state family aid at the time of the incident.
(i) Where the patient has a history of child sexual abuse, domestic violence, or sexual dysfunction, which history is known to the licensee at the time of the sexual misconduct.

83. The facts in this case demonstrate that Respondent committed sexual misconduct with three different patients. The conduct has undermined each patient's trust in male physicians, thus limiting the patients' health care choices. With respect to all three patients, controlled substances were prescribed, but were done so appropriately. While C.T. had a history of sexual abuse, it is not clear how much of that history Respondent actually knew.

84. However, all three patients were seeing Respondent for pain management and were seeking treatment to recover from opiate dependency or avoid it, and were in a position where finding another treatment provider would be difficult. Respondent violated the trust all three patients placed in him. The undersigned is mindful of the significant investment Respondent has in his education and experience as a medical doctor, but the behavior demonstrated in this case cannot be condoned and cannot be allowed to continue.

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 violated sections 456.072(1)(v) and 458.331(1)(j), as alleged in the Amended Administrative Complaint. It is further recommended that the Board issue a letter of reprimand against Respondent's license; suspend his license for a period of three years, followed by five years of probation; impose a permanent restriction that Respondent may not examine or treat female patients without a licensed health care provider in attendance; require completion of a medical ethics course prior to reinstatement of his license; and impose an administrative fine of $30,000.

DONE AND ENTERED this 31st day of August, 2016, in Tallahassee, Leon County, Florida.

LISA SHEARER NELSON
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 31st day of August, 2016.

ENDNOTES

[1/] Dr. Dehgan testified that in 1985, he suffered a chemical burn on his hand that required surgery, and he could no longer operate. He also testified that he entered an agreement with the Board of Medicine wherein he agreed not to do invasive medicine, and has adhered to this agreement. Similarly, during his deposition, Respondent testified that charges were filed against his license by the Department of Professional Regulation (which at that time was the agency providing support services for the Board), and that he placed his license in inactive status, completed a residency in physical medicine rehabilitation, and then petitioned the Board to re-activate his license, after which he re-entered private practice.

The Final Order of the Board, however, is less than helpful. The Order has attached to it several Administrative Complaints that the parties apparently sought to resolve by stipulation. The proposed settlement does provide for Respondent to place his license in an inactive status until he can demonstrate his ability to practice medicine with reasonable skill and safety to patients, and further provides that this demonstration would include successful completion of a Board-approved residency program. However, the Final Order filed June 21, 1988, indicates that the Board rejected the proposed stipulation, and there is no

indication what, if anything, was considered as a counter-proposal. While it can be inferred that the final resolution involved something along similar lines, there is no indication in this record to establish the particulars of that final resolution. What is clear is that the charges against Respondent in the 1980s had nothing to do with allegations of sexual misconduct.

[2/] There is a discrepancy in Respondent's medical records for S.M. with respect to her initial prescription. The patient record for March 12, 2014, lists under "Treatment" to start Subutex, start Zoloft, start Xanax, and refer to Counseling and Recovery Breakthroughs. The sign-off status for the patient record for this initial meeting is listed as pending, and indicates that it was electronically signed on December 31, 2014, well after Dr. Dehgan's termination from the practice. At the next visit on March 26, 2014, under "History of Present Illness," Dr. Dehgan's notes stated that "[s]he was initially seen in 2 weeks ago [sic] given a prescription for Suboxone. She states that she had abdominal pain taken [sic] Suboxone. She tried Subutex and tolerated pretty well." This patient note sign-off status is listed as completed, and the patient note is electronically signed on March 28, 2014. S.M.'s testimony is consistent with the March 26 note.

[3/] Based on her testimony, as well as the other evidence presented, the undersigned has described each incident in the context of the appointment at which it is most likely to have occurred. While it is possible that the incidents and the appointment dates are not accurately paired, the more persuasive evidence makes this chronology the most likely. Regardless of the dates of the incidents, and whether they corresponded with the appointment identified for each incident, A.S.'s testimony was clear, consistent, and convincing about what happened and the relative time period for it.

[4/] Not all of the patient questionnaires are dated, but assuming that they are in chronological order, consistent with the rest of the patient records, given the ones that are dated, it is relatively easy to match them up with the different medical appointments.

[5/] In his deposition, Respondent testified that he does not remember any of the three patients, but that he had prepared notes from his review of the patient records related to this case. He then relayed an incident that he indicated occurred on September 10, 2014, in which his medical assistant was present.

He testified that A.S. asked the medical assistant to leave because she wanted to speak with Dr. Dehgan privately. When the medical assistant told her that it was against office policy for her to leave, A.S. got upset and left, and as she went through the waiting room, said that Dr. Dehgan makes out with his patients. The problem with Dr. Dehgan's story is that A.S. did not have an appointment on September 10, 2014. Dr. Dehgan also testified that he generally left the examination room door open six to 12 inches, and that while he never hugged patients they sometimes initiated a hug with him. With respect to A.S., his notes indicate that he never found that she had a hernia. As noted at paragraph 40, his medical records state that he did note the presence of a hernia during her visit on April 18, 2014. Dr. Dehgan's version of events varies significantly from the other witnesses in this case, and is rejected.

[6/] He stated in his deposition that all three complainants "had nothing to lose. All you have to do, look at their history, their background. They're all drug abusers. They're all divorced. They all have certain social issues." While Respondent clearly made these comparisons to cast aspersions on their credibility, these same descriptions could also be a basis for making them vulnerable to exploitation.

COPIES FURNISHED:

Thomas R. Brown, Esquire
The Brown Law Firm
6277 Dupont Station Court East, Suite 3
Jacksonville, Florida 32217
(eServed)

Chad Wayne Dunn, Esquire
Corynn C. Gasbarro, Esquire
Prosecution Services Unit
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399
(eServed)

Nichole C. Geary, General Counsel
Department of Health
4052 Bald Cypress Way, Bin A02
Tallahassee, Florida 32399-1701
(eServed)

Claudia Kemp, JD, Executive Director
Board of Medicine
Department of Health
4052 Bald Cypress Way, Bin C03
Tallahassee, Florida 32399-3253
(eServed)

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.