STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF NURSING,

Petitioner,

vs. Case No. 17-2458PL

NANCY JANE REED, R.N.,

Respondent.
_____/
DEPARTMENT OF HEALTH, BOARD OF MASSAGE THERAPY,

Petitioner,

vs. Case No. 17-2459PL

NANCY JANE REED, L.M.T.,

Respondent.
_____/

RECOMMENDED ORDER

On August 15, 2017, Administrative Law Judge J. Lawrence Johnston held the final hearing in these cases by video teleconference at locations in Tampa and Tallahassee.

APPEARANCES

For Petitioner: Susan K. Bodner, Esquire
Kristen M. Summers, Esquire
Department of Health
4052 Bald Cyprus Way, Bin C-65
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For Respondent: Suzanne Suarez Hurley, Esquire
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STATEMENT OF THE ISSUES

The issues are whether the Respondent should be prohibited or restricted from practicing as a licensed registered nurse and as a licensed massage therapist, or be otherwise disciplined, for allegedly being unable to practice nursing and massage therapy with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, or chemicals, or any other type of material, or as a result of any mental or physical condition, in violation of sections 464.018(1)(j) and 480.046(1)(h), Florida Statutes (2016).[1/]

PRELIMINARY STATEMENT

In 2016, the Petitioner, the Department of Health (DOH), filed two administrative complaints against the Respondent. One was against the Respondent's registered nursing license, which is regulated by the Board of Nursing, and the other was against her massage therapy license, which is regulated by the Board of Massage Therapy. Both complaints alleged that the Respondent had an opioid use disorder, a sedative/hypnotic use disorder, a cannabis use disorder, an alcohol use disorder, chronic pain syndrome, anxiety disorder and/or chronic insomnia. The Respondent disputed the allegations and asked for a disputed-fact hearing.

The hearing requests were referred to the Division of Administrative Hearings for assignment to an Administrative Law

Judge. The registered nursing license complaint was designated DOAH case 17-2458PL; the massage therapy license complaint was designated DOAH case 17-2459PL. The two cases were consolidated, and the parties engaged in discovery in preparation for the hearing.

On August 7, the Respondent moved to exclude all pre-employment application and drug screen information provided to DOH by the Moffit Cancer Center, which led directly to DOH's investigation and charges, on grounds that the information was confidential and exempt from disclosure under section 112.0455(11), Florida Statutes (2017). DOH filed a response. The motion was heard at the outset of the hearing and was denied.

On August 9, the Respondent gave notice that it had sent DOH a "21-day letter" as a condition precedent to the filing of a motion for sanctions under section 57.105, Florida Statutes (2017). DOH filed a response in opposition, which pointed out that it would be premature to rule on the motion prior to the final order.

The parties filed a Joint Pre-hearing Stipulation that facilitated the conduct of the hearing and included 28 undisputed facts. At the hearing, Joint Exhibits 1 through 11 and Petitioner's Exhibits 1 through 5 were received in evidence. The Petitioner called Lawrence S. Wilson, M.D., to testify as an expert in addiction medicine. The Respondent called John

Ault, R.N.,[2/] as a fact and character witness, and James R. Edgar, M.D., as an expert in addiction medicine. She also testified and had Respondent's Exhibits 7 b., c., e., f. and g., and 9 through 15 admitted in evidence.

After the hearing, a Transcript was filed, and the parties filed proposed recommended orders, which have been considered.

FINDINGS OF FACT

1. The Respondent is a Florida licensed registered nurse (RN 9295784) and licensed massage therapist (MA 46128). She has been working as an RN in Florida since 2009. Neither her nursing nor her massage therapist license had been disciplined before the charges filed in this case.

2. In January 2016, the Respondent was working three 12-hour night shifts as a nurse in a hospital that admitted mentally ill patients. After being assaulted by a violent patient, she decided to change specialties.

3. In May 2016, the Respondent applied for a job at Moffitt Cancer Center in Tampa. Moffitt made an offer, contingent on passing a health screening, which included a drug screening. During the screening on May 10, the Respondent appeared to be drowsy, which seemed odd and suspicious to the Moffitt staff who conducted the health screening. The Respondent's urine sample was corrupted, and she returned two days later to provide another sample. The second sample tested positive for butalbital,

oxazepam, morphine, codeine, temazepam, and alprazolam. The Respondent had prescriptions for all these drugs, but the one for butalbital was not current. Butalbital is a Schedule III controlled substance under section 893.03(3), Florida Statutes, and is found in Fiorinal and Fioricet, which are prescribed to treat migraine headaches. As a result of the pre-employment screening, Moffitt would not clear the Respondent to work there.

4. The Respondent testified that she appeared to be drowsy at the time of the Moffitt pre-employment screening because she was tired from working three consecutive 12-hour night shifts at Hospital Corporation of America's West Pasco Hospital in Trinity. In addition to working at the hospital, she was acting as a union delegate, plus going to school full-time to earn a bachelor's degree in nursing, and she was up late studying the night before her screening at Moffitt. The Respondent denied abusing or misusing her prescriptions and explained that she was taking the out-of-date prescription to save money on a prescription she used infrequently, as needed, for migraines.

5. In July 2016, the Respondent was recruited for a nursing job at Bayshore Health System's St. Joseph's Hospital in Tampa. She was hired and participated in a pre-employment screening there. Her drug screening tests were negative, and she was cleared to begin work starting on July 18.

6. At St. Joseph's, the Respondent passed her skills tests and worked three 12-hour shifts a week from 7:00 p.m. to 7:00 a.m. She took her new job seriously. Since she previously worked on a mental health unit, she was first assigned work with a preceptor in the neurological stroke unit to refresh general nursing skills.

7. In September 2016, the Respondent received a letter from Moffitt saying that "recent events" had come to Moffitt's attention that could constitute a violation of the Nurse Practice Act and advising that Moffitt would have to report the Respondent to DOH and the Board of Nursing if she did not consult with the Intervention Project for Nurses (IPN), within two days, as an alternative to disciplinary action for nurses who are in violation because of the use drugs or alcohol, or because of physical or psychological impairment. The Respondent did not think she was in violation and declined to consult IPN.

8. Moffitt filed a complaint with DOH, which began the process of compelling the Respondent to be evaluated by an expert in addiction medicine.

9. In October 2016, the Respondent's supervisor, Laura Robidoux, talked to her because she thought the Respondent failed to recognize a patient's subnormal temperature as a sign of sepsis. Seventeen hours after the Respondent's shift ended, the patient went into medical distress, and the hospital staff

recognized sepsis as the cause. Although several other nurses and doctors were involved in the patient's care both during and after the Respondent's shift, the Respondent was counseled about it.

10. St. Joseph's terminated the Respondent from her employment in early December 2016. The Respondent's supervisor believed the Respondent missed a shift on Saturday, December 3, because of excessive drinking. Actually, the Respondent reasonably believed that she was not scheduled to work the shift in question. She already had satisfied her 36 hours of work that week, between actual work and paid time off; she was not expecting to have to work a fourth shift on Saturday; and she was unaware that she had been scheduled to work. The Respondent had dinner and a glass of wine with her mother, who resided with her. After dinner, she took a shower. At about 6:30 p.m., the unit secretary at St. Joseph's called to say the Respondent was supposed to be at work. Her mother took the message and relayed it to the Respondent, who immediately called back to explain that she did not think she was scheduled to work and did not think she should go to work because she just had a glass of wine with dinner.

11. The Respondent's supervisor received a "zone report" on the supposed missed shift on Monday, December 5. She was very upset with the Respondent and did not accept her explanation of

what happened. She informed the Respondent that, as a probationary employee, she was going to be terminated from her employment. The Respondent chose to resign instead.

12. On the form used by Nurse Robidoux to document the reasons for terminating the Respondent, she added that the Respondent did not get the flu shot that was required by December 1, 2016. That ground for termination was false. Actually, as the Respondent tried to explain to her supervisor, she got her flu shot at CVS on November 28. Although the Respondent had proof, her supervisor maintained the alleged flu shot failure as a ground for termination.

13. The termination documentation did not mention the incident in October regarding the patient with sepsis. It also did not mention any other grounds for termination. In her deposition on July 31, 2017, Nurse Robidoux talked about another supposed patient care issue, which she thought was a medication error, but she was not sure and was unable to recall any details.

14. There was no evidence of any other patient care or attendance issues during the Respondent's employment at St. Joseph Hospital. There was no evidence of any other incidents that could raise any concern that the Respondent was impaired in any way while working as a nurse at St. Joseph's Hospital.

15. The addiction medicine expert retained by DOH to evaluate the Respondent was Dr. Lawrence Wilson. Dr. Wilson was a urologist until substance abuse impaired his ability to practice medicine, and he entered the Professional Resource Network (PRN) program. Instead of remaining in urology after successful completion of the program, he decided to pursue addiction medicine. He completed a two-year fellowship in addiction medicine at the Drug Abuse Comprehensive Coordinating Office (DACCO) at the University of Florida in Tampa from 2010 to 2012 and is board-certified in the field. After his fellowship, he went to work at DACCO in Tampa and eventually became its associate medical director. He also serves as medical director at a private treatment facility in Tampa called Seven Summit Pathways, which is a residential and outpatient medication-assisted treatment facility. He also is a certified medical review officer, meaning he is qualified to determine whether there are legal and valid reasons for substances detected by laboratories testing samples from a drug screening program.

16. Coincidentally, Dr. Wilson arranged to examine and interview the Respondent on December 14, 2016, shortly after her termination by St. Joseph's Hospital. His evaluation was based on the examination and interview, the reports on three drug tests he had done on the Respondent, the report from Moffitt, and a telephone interview with Laura Robidoux.

17. Dr. Wilson understood from Nurse Robidoux that the Respondent had "major performance issues" involving her failure to "pick up on clinical symptoms of her patients." In fact, only one patient was involved. The Respondent was in the process of been retrained under the supervision of a preceptor at the time, and it was not clear from the evidence who was responsible for not recognizing the patient's symptoms.

18. Dr. Wilson also understood from Nurse Robidoux that the Respondent missed her shift on December 3 "because she had been drinking with friends" and "didn't call that she was not coming to work and then didn't show up [a]nd called, 'after the fact' – according to Ms. Robidoux – after her shift already started." His understanding was incorrect. The Respondent's explanation of what actually happened is accepted.

19. The Moffitt drug screen was positive for several drugs. The Respondent had valid prescriptions for all of them except butalbital, which is a barbiturate and a Schedule III controlled substance under section 893.03(3). It can lead to moderate or low physical dependence or high psychological dependence. The Respondent's primary care physician had prescribed Fiorinal, which contains butalbital and codeine, to treat the Respondent's migraine headaches, which is a common use for it. However, the prescription was five years out-of-date. The Respondent conceded to Dr. Wilson that she should have asked her doctor to update the

prescription, but she tried to explain that she did not use the prescription much and was trying to save money.

20. The Moffitt drug screen also was positive for five other drugs, or their metabolites, for which the Respondent had valid, current prescriptions. These included alaprazam (generic for Xanax) and temazepam (generic for Restoril).

21. In her interview on December 14, the Respondent told Dr. Wilson she was taking: Lisinopril; Zyrtac (an antihistamine used for allergies); Tylenol with codeine; Fiorinal; metoprolol (a beta blocker for blood pressure); Zofran (an antiemetic for nausea); Protonix (for gastroesophageal reflux); Ativan (generic for lorazepam, a long-acting benzodiazepine sedative); and Vistaril (a sedating antihistamine, typically used for anxiety).

22. The Respondent told Dr. Wilson that she was "on and off" Xanax, a short-acting (two to four hours) benzodiazepine, for 20 years. She had been using it on an almost nightly basis for approximately five years, but stopped using it in approximately June 2016. She decided to stop taking it because she had to increase its dose to achieve the desired therapeutic effect (as her body habituated to the drug, and her tolerance for it increased). She had some withdrawal symptoms when she stopped taking it, including feeling sick, having trouble sleeping, and getting tremors or shakes for about three days. Dr. Wilson

opined that the Respondent had become dependent on benzodiazepines.

23. At some point in the year or so before Dr. Wilson evaluated her, the Respondent went to a second physician, who prescribed Restoril, a medium-acting benzodiazepine (temazepam). She was taking Restoril, 30 milligrams, "on and off" for about a year. Before she stopped the Xanax, there were times when the Respondent would take both Xanax and Restoril (which would explain the positive results from the Moffitt drug screening).

24. It was a concern to Dr. Wilson that the Respondent might have been taking Xanax and Restoril together because they would have a synergistic effect and produce a higher level of sedation. The concurrent use of multiple benzodiazepines can cause cognitive impairment, including slow reactions and difficulty with problem-solving, which are critical to the practice of nursing and, to some lesser extent, massage therapy. However, the evidence was not clear and convincing that the Respondent used multiple benzodiazepines concurrently or that she ever was impaired when practicing nursing or massage therapy.

25. As part of his evaluation on December 14, Dr. Wilson had the Respondent submit to a hair test and a urine test. A hair test typically records two to three months of substance or medication ingestion. A positive hair test indicates multiple, repeated uses of a substance or medication (at least four to five

uses) over a two or three week period. A one-time use would not show up on a hair test. The Respondent's hair test was positive for butalbital, codeine, hydrocodone (a metabolite of codeine), and Tramadol.

26. The Respondent had valid prescriptions for the Fiorinal, which would explain the positive results for butalbital and codeine. Hydrocodone is a metabolite of codeine, which probably explains its presence along with codeine.

27. The Respondent also had a prescription for Tylenol with codeine, which she was taking approximately three to five days a month for various musculoskeletal aches and pains in her hips, back and knees, and for premenstrual discomfort. The prescription was for one pill twice a day, but the Respondent admitted she would use between three and four tablets a day, which concerned Dr. Wilson.

28. In general, Dr. Wilson was concerned with the Respondent taking opiates and benzodiazepines together. Both cause significant depression or slowing of the central nervous system, and using them together can lead to cognitive impairments, including slow thought processes; and taking too much could cause the Respondent to fall asleep or pass out, which obviously would affect her ability to practice nursing and massage therapy with reasonable skill and safety. However, the evidence was not clear and convincing that the Respondent ever

was impaired when practicing nursing or massage therapy by the concurrent use of these two drugs.

29. The positive result for Tramadol was very significant to Dr. Wilson because the Respondent did not mention it or produce a prescription for it during her interview, and the test showed a high level, which correlated to a significant use.

30. Tramadol is a "non-opiate opiate," meaning it mimics the effect of an opiate but is not made from opium poppy seed and has a different chemical structure. It is a strong analgesic used for pain management and, depending on the dose, can cause significant central nervous system depression. However, the evidence was not clear and convincing that the Respondent ever was impaired when practicing nursing or massage therapy by the use of Tramadol, alone or in combination with any other drug.

31. Dr. Wilson did not think it likely that the Respondent had a plausible reason for not mentioning the Tramadol, and he believed she was trying to hide it from him. The Respondent's explanation was that she had been taking it for menstrual cramps for about three months instead of Tylenol with codeine because it gave her enough pain relief without promoting menstrual bleeding; that it allowed her to remain clear-headed; and that she did not consider it to be an opiate or non-opiate opiate. Similar to the Xanax detected by the Moffitt pre-employment screening, the

Respondent was using what remained from an out-of-date prescription.

32. During the interview on December 14, Dr. Wilson asked the Respondent about alcohol. She told him that she would drink weekly during college, about three to five drinks, until becoming fairly intoxicated; that she drank socially in her thirties, about twice a week, between three and five ounces; and that her drinking decreased during her thirties and forties; and that she currently drinks one or two alcoholic beverages about four to five times a year. She said her most recent drinks were a large Bailey's after dinner two days before the interview, and a large drink about ten days before that.

33. As part of her examination by Dr. Wilson on December 14, the Respondent submitted to a phosphatidyl ethanol (PEth) blood spot test. This test measures ethanol in the blood stream and is used to detect heavy, frequent use of alcohol and/or binge drinking on less request occasions, as opposed to social drinking. The standard cut-off of the PEth test is set at 20 nanograms per milliliter (ng/ml), which requires, at a minimum, approximately seven to eight ounces of alcohol in a week. The Respondent's PEth test was positive at 63 ng/ml, which was inconsistent with what she reported to Dr. Wilson.

34. Dr. Wilson diagnosed the Respondent with alcohol use disorder of mild to moderate severity because he thought she used

alcohol in larger amounts over a longer period of time than intended; her alcohol use resulted in a failure to fulfil a major obligation at work; and there was recurrent alcohol use in situations in which it was hazardous. He opined that her alcohol use put her at risk for being unable to practice with reasonable skill and safety to patients.

35. During the interview on December 14, Dr. Wilson also asked the Respondent about cannabis use. She told him she used it a lot during high school, decreased its use in her twenties to episodic, and that she had not used it in four years. Dr. Wilson conceded that it did not seem to be an issue anymore and was insignificant, but he still diagnosed cannabis use disorder, moderate severity, in remission, based on her use of large amounts over a long period of time (in high school) and a general presumption that she spent "a great deal of time . . . in activities under the influence or to use or obtain, or recover from its effects."

36. After completing the evaluation of the Respondent, Dr. Wilson diagnosed: opioid use disorder, moderate severity; sedative/hypnotic use disorder, moderate severity; cannabis use disorder, moderate severity, in remission; alcohol use disorder, mild to moderate severity; chronic pain syndrome related to degenerative joint disease and chronic migraine headaches; hypertension; anxiety disorder, NOS; and chronic insomnia, NOS.

Dr. Wilson opined that the Respondent was unable to continue her practice of nursing with the required skill and safety due to untreated substance use disorders and risk of impairment. He recommended that she enter treatment for substance abuse disorders, at a partial hospitalization level, at an IPN-approved treatment facility (which happens to be the kind of care provided for $5,000 a month at the substance abuse treatment facility operated by him in Tampa), and that she be monitored by IPN after completion of treatment. The Respondent disagreed, did not think referral to IPN was necessary, and declined IPN.

37. Based on Dr. Wilson's opinion and recommendation, DOH filed charges that the Respondent was unable to practice nursing or massage therapy with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, or chemicals, or any other type of material, or as a result of any mental or physical condition, in violation of sections 464.018(1)(j) and 480.046(1)(h). Emergency orders were entered restricting her practice of those professions pending disposition of the charges.

38. At the hearing, Dr. Wilson testified in support of his opinions. However, his ultimate opinions on whether the Respondent was "safe to practice nursing or massage therapy" were based on "suspicions" and the "possibility" or "risk" of impairment. In addition, they were based in part on factual

assumptions that were not proven by clear and convincing evidence at the hearing.

39. The Respondent called her own expert, Dr. James Edgar, to dispute Dr. Wilson's opinions. Dr. Edgar is a board-certified psychiatrist. He is not board-certified in addiction medicine or addiction psychiatry; does not complete continuing education or self-study related to substance use disorders; and does not hold the kinds of certifications Dr. Wilson has. However, he has performed evaluations of licensed health care providers for PRN and IPN, which are Florida's programs for impaired physicians and nurses, and for private attorneys who represented licensees, for over 42 years.

40. Dr. Edgar based his opinion on a review of Dr. Wilson's work, an interview of the Respondent, and psychological testing using the Minnesota Multiphasic Personality Inventory (MMPI-2), which is considered the "Gold Standard." He accepted the Respondent's explanations of her sleepiness during the Moffitt pre-employment screening interview and her use of her prescription drugs. As a result, he questioned some of the factual basis for Dr. Wilson's opinions. He did not concur with Dr. Wilson that taking Xanax and Restoril ("an anti-anxiety medication and sleeping medication") at the same time was necessarily dangerous, depending on the dose (which Dr. Wilson

did not know), the patient's age, the patient's weight, and other factors.

41. Dr. Edgar did not concur with any of Dr. Wilson's Axis I diagnoses (opioid use disorder, sedative/hypnotic use disorder, cannabis use disorder, or alcohol use disorder). He also did not think the Respondent had an Axis II personality disorder. He agreed with Dr. Wilson that the Respondent has Axis III medical illnesses and conditions and Axis IV stressors that made her level of anxiety and irritation understandable. On Axis V, Dr. Edgar rated the Respondent at a "global assessment of functioning" (GAF) of 85.

42. Dr. Edgar explained that a GAF of 90 represents:

> Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasionally argument with family members).

A GAF of 80 represents:

> If symptoms are present, they are transient and expectable reactions to psychological stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

43. Dr. Edgar explained that he does not think the Respondent has opioid use disorder because: (a) all opioids she took were prescribed by her doctor; (b) there is no indication

that she has increased the use of these medications; and (c) there is no indication that the use of these medications has impaired her ability to function as a nurse. He reviewed a note from the Respondent's physician stating that he thought she was safe to practice in nursing, and there was no history of any employer or fellow employee expressing concern about the Respondent's ability to function as a nurse as a result of her medications. Former co-worker, John Ault, R.N., testified that she was very capable, in his opinion.

44. Dr. Edgar explained that he does not think the Respondent has sedative/hypnotic use disorder because: (a) her medications were all prescribed by physicians; (b) she does not have what he would call a history of taking more of these medications than prescribed; and (c) she may have increased the dosage of Xanax, but that was "perfectly within the realm" because some people need more for the drug to be effective. He does not think her taking more of the medication is a sign or symptom of any substance use disorder. He also noted that, as a nurse, she is capable of making that kind of decision.

45. Dr. Edgar explained that he does not think the Respondent has cannabis use disorder because: (a) there is no history of cannabis affecting Respondent's behavior, her social situation, her schooling, or her work; and (b) her use of cannabis was more than 20 years ago. He also disagreed with

Dr. Wilson that the Respondent has a "lifetime [cannabis] disorder."

46. Dr. Edgar disagreed with Dr. Wilson's basing a diagnosis of alcohol use disorder on Respondent's PEth test result. He believes the test is unreliable and insufficient to support such a diagnosis by itself. He thought the other evidence of alcohol use was lacking and minimal.

47. Dr. Edgar said the "chronic pain syndrome" diagnosed by Dr. Wilson was unwarranted and was another example of his making more out of something than was warranted. Having pain and taking prescribed medication does not mean the Respondent has a syndrome. If she did, he says you would expect to see that diagnosis by her primary care physician. Instead, he says she has a history of migraine headaches, and as an older nurse has aches and pains from stooping and bending and picking up patients, and is appropriately treating both with physician-prescribed medications.

48. Dr. Edgar does not believe taking expired medications is an indication of a syndrome, of drug abuse, or of a disorder. It could well be related to the cost of the medicine.

49. Regarding Dr. Wilson's diagnosis of anxiety disorder, Dr. Edgar referred to the result of the Respondent's MMPI-2 testing and explained that it is perfectly reasonable for

somebody in the Respondent's very stressful situation to have anxiety.

50. Regarding Dr. Wilson's diagnosis of chronic insomnia, Dr. Edgar noted that nurses who have consecutive night shifts are more apt to have trouble sleeping. He did not believe there was enough information to call it chronic insomnia. He would leave any diagnosis regarding insomnia up to the Respondent's primary care physician. The Respondent tried different medications to deal with her insomnia, and Dr. Edgar did not think that was necessarily dangerous, even if she used Restoril and Xanax together.

51. Dr. Edgar's evaluation of the Respondent included the information that the IPN program requires. He ruled out substance abuse and other mental health problems that might interfere with the Respondent's ability to provide safe nursing care. He saw no pertinent chemical dependency history, no history of diversion of patient medications, and no history of misusing prescription medication. The question in his "IPN template" regarding "status and stability of recovery" was inapplicable because the Respondent had no history of drug abuse or dependency, was not in a recovery program, and was only taking medications prescribed by her doctor.

52. Dr. Edgar observed no impairment in the Respondent's problem-solving ability, cognitive functioning, judgment, ability

to cope with stressful situations, decision-making in a crisis, or mental status. He found no cravings on the part of the Respondent for drugs or alcohol.

53. Dr. Edgar concluded that the Respondent does not suffer from any kind of impairment or disease that has resulted in an inability to practice nursing with reasonable skill and safety. He does not believe she needs to be referred to IPN for a program like the one Dr. Wilson recommended.

54. According to the DSM-V, a diagnosis of substance use disorder is based on a "pathological pattern of behaviors" related to substance abuse. A person who has opioid use disorder, sedative/hypnotic use disorder, and/or alcohol use disorder will have behavioral issues and/or impairment that is obvious to other people. These typically would include a lack of motivation and a failure to meet school or work responsibilities. The Respondent has not demonstrated these behavioral patterns. Quite to the contrary, she was pursuing her bachelor's degree in nursing while working full-time when she applied for the job at Moffitt; and she started a computer systems technician program at Erwin Technical College when her licenses were suspended, and was maintaining a straight "A" average. Dr. Edgar did not think it was likely that an impaired person would be able to perform like that.

55. Dr. Edgar acknowledged that the Respondent had high scores on the addiction proneness indicator in her MMPI-2 psychological test results, but he explained that score is a mere indicator, and is insufficient to support a diagnosis. While it is possible that a problem could arise from being prescribed these medications, Dr. Edgar does not believe problems have arisen to date in the Respondent's case. He believes it is telling that there has never been a complaint or a concern about the Respondent's work as a nurse or her ability to practice nursing safely, except for those of Ms. Robidoux. As he observed, "that is usually where it starts."

56. Dr. Wilson's opinions appeared to be influenced by his honest and genuine belief as a physician that the Respondent would benefit from the care and treatment she could receive as a participant in IPN. He may well be correct. He also may be correct that there is some risk that problems might arise in the future. However, the evidence taken as a whole was not clear and convincing that the Respondent is now unable to practice nursing and massage therapy with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, or chemicals, or any other type of material, or as a result of any mental or physical condition.

CONCLUSIONS OF LAW

57. DOH licenses and regulates nurses and massage therapists in Florida and is authorized to investigate and file administrative complaints charging violations of the laws governing those professions in this state. §§ 464.018(1)(j) and 480.046(1)(h), Fla. Stat.

58. Because DOH seeks to impose license discipline, it has the burden to prove the allegations in the administrative complaints by clear and convincing evidence. See Dep't of Banking & Fin. v. Osborne Stern & Co., Inc., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987). This "entails both a qualitative and quantitative standard. The evidence must be credible; the memories of the witnesses must be clear and without confusion; and the sum total of the evidence must be of sufficient weight to convince the trier of fact without hesitancy." In re Davey, 645 So. 2d 398, 404 (Fla. 1994). See also Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983). "Although this standard of proof may be met where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991)(citations omitted).

59. Disciplinary statutes and rules "must be construed strictly, in favor of the one against whom the penalty would be imposed." Munch v. Dep't of Prof'l Reg., Div. of Real Estate,

592 So. 2d 1136, 1143 (Fla. 1st DCA 1992); see Camejo v. Dep't of Bus. & Prof'l Reg., 812 So. 2d 583, 583-84 (Fla. 3d DCA 2002); McClung v. Crim. Just. Stds. & Training Comm'n, 458 So. 2d 887, 888 (Fla. 5th DCA 1984)("[W]here a statute provides for revocation of a license the grounds must be strictly construed because the statute is penal in nature. No conduct is to be regarded as included within a penal statute that is not reasonably proscribed by it; if there are any ambiguities included, they must be construed in favor of the licensee." (citing State v. Pattishall, 126 So. 147 (Fla. 1930))).

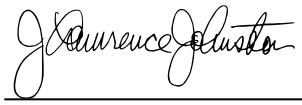
60. The grounds proven in support of DOH's assertion that the Respondent's licenses should be disciplined must be those specifically alleged in the administrative complaints. See e.g., Trevisani v. Dep't of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005); Cottrill v. Dep't of Ins., 685 So. 2d 1371 (Fla. 1st DCA 1996); Kinney v. Dep't of State, 501 So. 2d 129 (Fla. 5th DCA 1987); Hunter v. Dep't of Prof'l Reg., 458 So. 2d 842 (Fla. 2d DCA 1984). Due process prohibits DOH from taking disciplinary action against a licensee based on matters not specifically alleged in the charging instruments, unless those matters have been tried by consent. See Shore Vill. Prop. Owners' Ass'n, Inc. v. Dep't of Envtl. Prot., 824 So. 2d 208, 210 (Fla. 4th DCA 2002); Delk v. Dep't of Prof'l Reg., 595 So. 2d 966, 967 (Fla. 5th DCA 1992).

61. In order to sustain the charges in this case, DOH must prove, by clear and convincing evidence, that the Respondent is unable to practice nursing and massage therapy with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, or chemicals, or any other type of material, or as a result of any mental or physical condition. §§ 464.018(1)(j) and 480.046(1)(h), Fla. Stat. The burden of proof was not met in this case. The Board of Nursing should not mandate participation in IPN at this time.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that final orders be entered by the Board of Nursing and the Board of Massage Therapy dismissing the charges against the Respondent. If this recommendation is followed, jurisdiction is reserved for 30 days after the rendition of the final order to rule on the Respondent's Motion for Sanctions under section 57.105(1), if it is renewed within those 30 days.

DONE AND ENTERED this 3rd day of November, 2017, in Tallahassee, Leon County, Florida.



J. LAWRENCE JOHNSTON
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of November, 2017.

ENDNOTES

[1/] Unless otherwise noted, statutory references are to the 2016 codification of the Florida Statutes, which was in effect at the time of the alleged offenses.

[2/] In the Transcript, his name is misspelled "Alt."

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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.