STATE OF FLORIDA
DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION,

PETITIONER,

vs. CASE NO. 9311241

Richard Morales, M.D.

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Business and Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Richard Morales, M.D. hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.165, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0039846. Respondent's last known address is 1012 Druid Road, Clearwater, Florida 34616.

3. Respondent is board certified in psychiatry, and his specialty is pain and stress management.

4. On or about September 23, 1988, Patient #1, a 55 year old female, was referred to Respondent with a chief complaint of

chronic pain in the neck and low back resulting from an auto accident of August 19, 1988.

5. Patient #1 was noted to have a past history of head injury, back injury and whiplash injury, all within the last five years. She also had a history of unstable blood pressure which became elevated during stressful periods. A history of alcohol abuse which has been in remission for over two years, and chronic depression that goes back twenty years was further noted.

6. Respondent interviewed Patient #1 and determined that she was markedly depressed with no suicidal ideation or indications of psychosis. Respondent's diagnosis of Patient #1 was major depressive reaction, myofacial syndrome of neck and low back, and rule out right wrist sprain and left hand sprain.

7. Respondent's initial treatment plan for Patient #1 included physical therapy, neuromuscular therapy, range of motion exercises, hot and cold compresses, and biofeedback training. For treating Patient #1's depression, Respondent prescribed Limbitrol 5-12.5 milligrams, three tablets at bedtime.

8. During the period from on or about September 23, 1988, to on or about February 1, 1990, Respondent prescribed various anti-depressant and anti-anxiety medications including Limbitrol, Ludiomil, Prozac, Valium, Halcion and Tranxene to Patient #1.

9. Limbitrol is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains chlordiazepoxide and amitriptyline, Schedule IV controlled substances listed in Chapter 893, Florida Statutes. Limbitrol is indicated for the treatment of

patients with moderate to severe depression associated with moderate to severe anxiety.

10. Ludiomil is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains maprotiline hydrochloride. Ludiomil is indicated for the treatment of depressive illness and is also effective for the relief of anxiety associated with depression.

11. Prozac is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains fluoxetine hydrochloride. Prozac is indicated for the treatment of depression.

12. Valium is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains diazepam, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Valium is indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. Addiction prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving diazepam because of the predisposition of such patients to habituation and dependence.

13. Halcion is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains triazolam, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Triazolam, a hypnotic agent, is useful in the short-term management of insomnia. Addiction prone individuals (such as drug addicts and alcoholics) should be under careful surveillance when receiving triazolam because of the predisposition of such patients to habituation and dependence.

14. Tranxene is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains clorazepate dipotassium, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Tranxene is indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety.

15. The legend drugs noted in paragraphs nine (9) through fourteen (14) were inappropriately prescribed to Patient #1 by Respondent in that Respondent failed to adequately monitor Patient #1, a known alcoholic, for possible addiction and/or dependence.

16. Respondent failed to keep adequate written medical records for Patient #1 in that Respondent did not justify the liberal prescribing of anti-depressant and anti-anxiety medications to Patient #1, a known alcoholic, by sufficiently detailing the number of pills ordered, dosage size, refills, directions for use, or reasons for prescribing.

17. During the period from on or about November 3, 1988, to on or about April 3, 1989, Respondent prescribed Ritalin to Patient #1.

18. Ritalin is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains methylphenidate hydrochloride, a Schedule II controlled substance listed in Chapter 893, Florida Statutes. Ritalin is indicated for the treatment of attention deficit disorders for a stabilizing effect in patients with a behavioral syndrome characterized by moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity. Ritalin is contraindicated in patients

with marked anxiety, tension, and agitation since the drug may aggravate these symptoms. Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative.

19. Respondent inappropriately prescribed Ritalin to Patient #1 in that Respondent failed to adequately monitor Patient #1 for possible addiction and/or dependence and Ritalin was contra-indicated. Ritalin should not have been prescribed to Patient #1, who exhibited symptoms of anxiety and tension.

20. Respondent failed to keep adequate written medical records for Patient #1 in that Respondent did not justify the prescribing of Ritalin to Patient #1 by sufficiently detailing the reasons for prescribing a legend drug that was contraindicated for Patient #1.

21. During the period from on or about September 30, 1988, to on or about February 1, 1990, Respondent prescribed various opiate pain-killers to Patient #1 including Tylenol w/codeine, Percodan and Percocet.

22. Tylenol w/codeine is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains acetaminophen and codeine phosphate, a Schedule III controlled substance listed in Chapter 893, Florida Statutes. Tylenol w/codeine is indicated for the relief of mild to moderately severe pain. Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused.

23. Percodan is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains oxycodone, a Schedule II controlled substance listed in Chapter 893, Florida Statutes. Percodan is indicated for the relief of moderate to moderately severe pain. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused, and Percodan should be prescribed with the same degree of caution appropriate to the use of other oral narcotic-containing medications.

24. Percocet is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains oxycodone, a Schedule II controlled substance listed in Chapter 893, Florida Statutes. Percocet is indicated for the relief of moderate to moderately severe pain. Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused, and Percocet should be prescribed with the same degree of caution appropriate to the use of other oral narcotic-containing medications.

25. On or about September 17, 1989, Patient #1's daughter found Patient #1 passed out on her kitchen floor, and she was subsequently taken to the Emergency Room at HCA Largo Medical Center. Patient #1 was diagnosed with acute myocardial infarction, SIADH (syndrome of inappropriate antidiuretic hormone release), asthmatic bronchitis, narcotic addiction, chronic back pain, hypothyroidism, and hypertension. Because of the diagnosis of SIADH and narcotic addiction, the Percodan and Percocet was

discontinued and Patient #1 was placed on Methadone. Patient #1 was eventually discharged on or about September 28, 1989.

26. On or about October 10, 1989, Patient #1 was again admitted to HCA Largo Medical Center because of intractable nausea and vomiting, intractable headache, and hypertension. Patient #1 was again diagnosed with SIADH and an addiction to Percocet and Percodan, and was discharged on or about October 20, 1989.

27. On or about November 16, 1989, Respondent prescribed Percocet to Patient #1 to be taken at a rate of two (2) tablets every six (6) hours. The usual adult dosage of Percocet is one (1) tablet every six (6) hours.

28. On or about December 6, 1989, Respondent again prescribed Percocet to Patient #1.

29. Respondent inappropriately prescribed Percocet and Percodan to Patient #1 by failing to adequately monitor Patient #1 for possible addiction and/or dependence, and by prescribing Percocet to Patient #1 on two occasions following a diagnosis of narcotic addiction and/or dependence.

30. Respondent failed to keep adequate written medical records for Patient #1 in that Respondent did not justify the continued prescribing of Percocet and Percodan to Patient #1, a known alcoholic and narcotic addict, by sufficiently detailing the number of pills ordered, dosage size, refills, directions for use, or reasons for prescribing.

31. On or about January 31, 1991, Patient #1 was admitted to Morton Plant Hospital and was diagnosed with cancer of the lung

with brain metastases. Patient #1 was subsequently discharged home with Hospice care and she died on or about March 7, 1991.

COUNT ONE

32. Petitioner realleges and incorporates paragraphs one (1) through thirty-one (31) as if fully set forth herein this Count One.

33. Respondent failed to keep adequate written medical records in that Respondent: did not document justification for the liberal prescribing of anti-depressant and anti-anxiety medications to Patient #1, a known alcoholic, by sufficiently detailing the number of pills ordered, dosage size, refills, directions for use, or reasons for prescribing; did not document justification for the prescribing of Ritalin to Patient #1 by sufficiently detailing the reasons for prescribing a legend drug that was contraindicated for Patient #1; and did not document justification for the continued prescribing of Percocet and Percodan to Patient #1, a known alcoholic and narcotic addict, by sufficiently detailing the number of pills ordered, dosage size, refills, directions for use, or reasons for prescribing.

34. Based on the preceding allegations, Respondent has violated Section 458.331(1)(m), Florida Statutes, by failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

COUNT TWO

35. Petitioner realleges and incorporates paragraphs one (1) through thirty-one (31) and paragraph thirty-three (33) as if fully set forth herein this Count Two.

36. Respondent inappropriately prescribed legend drugs in that Respondent: failed to adequately monitor Patient #1, a known alcoholic, for possible addiction and/or dependence while prescribing various Schedule IV anti-depressant and anti-anxiety medications to Patient #1; failed to adequately monitor Patient #1 for possible addiction and/or dependence while prescribing Ritalin, a Schedule II controlled substance, to Patient #1; prescribed a legend drug, Ritalin, to Patient #1 while she exhibited symptoms of anxiety and tension, which are contraindications for Ritalin; failed to adequately monitor Patient #1 for possible addiction and/or dependence while prescribing Percodan and Percocet, Schedule II controlled substances, to Patient #1; and prescribed Percocet to Patient #1 on two occasions following a diagnosis of narcotic addiction and/or dependence.

37. Based on the preceding allegations, Respondent has violated Section 458.331(1)(q), Florida Statutes, by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in

excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his intent.

COUNT THREE

38. Petitioner realleges and incorporates paragraphs one (1) through thirty-one (31), paragraph thirty-three (33) and paragraph thirty-six (36) as if fully set forth herein this Count Three.

39. Respondent practiced medicine below the acceptable standard of care in that Respondent: prescribed Schedule IV anti-depressant and anti-anxiety medications to Patient #1, a known alcoholic, without documenting adequate justification for such prescribing; prescribed Ritalin, a Schedule II controlled substance, to Patient #1 while she exhibited symptoms of anxiety and tension, which are contraindications for Ritalin; prescribed Percodan and Percocet, Schedule II controlled substances, to Patient #1, a known alcoholic, without documenting adequate justification for such prescribing; and prescribed Percocet to Patient #1 after she had been diagnosed as a narcotic addict.

40. Based on the preceding allegations, Respondent has violated Section 458.331(1)(t), Florida Statutes, through gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: permanent revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 23 day of April, 1994.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

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FILED
Department of Business and Professional Regulation
AGENCY CLERK

CLERK Sarah L. Workman
DATE 4-26-94

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF MEDICINE

Final Order No. AHCA-95-01207 Date 9-1-95
FILED
Agency for Health Care Administration
AGENCY CLERK
R.S. Power, Agency Clerk
By: Brandon L. Moore
Deputy Agency Clerk

AGENCY FOR HEALTH CARE ADMINISTRATION, BOARD OF MEDICINE,

Petitioner,

v.

AHCA CASE NO: 93-11241
DOAH CASE NO: 94-3408
LICENSE NO: ME 0039846

RICHARD MORALES, M.D.,

Respondent.
_____/

FINAL ORDER

THIS MATTER was heard by the Board of Medicine (hereinafter Board) pursuant to Section 120.57(1)(b)10., Florida Statutes, on August 4, 1995, in Palm Beach Gardens, Florida, for consideration of the Hearing Officer's Recommended Order (Attached as App. A) in the case of Agency for Health Care Administration, Board of Medicine v. Richard Morales, M.D. At the hearing before the Board, Petitioner was represented by Steve Rothenburg, Medical Attorney. Respondent was present and represented by Grover C. Freeman, Esquire. Upon consideration of the Hearing Officer's Recommended Order after review of the complete record and having been otherwise fully advised in its premises, the Board makes the following findings and conclusions:

FINDINGS OF FACT

1. The Hearing Officer's Recommended Findings of Fact are approved and adopted and are incorporated herein by reference as the Findings of Fact of the Board in this cause.

2. There is competent, substantial evidence to support the Board's findings herein.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over the parties and subject matter of this case pursuant to Section 120.57 and Chapter 458, Florida Statutes.

2. The findings of fact set forth above do not establish that Respondent has violated Section 458.331(1)(q), Florida Statutes as charged in the Administrative Complaint.

3. The findings of fact set forth above do establish that Respondent has violated Sections 458.331(1)(m), (q) and (t), Florida Statutes as charged in the Administrative Complaint.

4. The Conclusions of Law of the Recommended Order are approved and adopted and incorporated herein.

DISPOSITION

Based upon the Recommended Findings of Fact and Conclusions of Law, the Hearing Officer recommended the following penalty:

1. That the Respondent is guilty of violating Sections 458.331(1)(m), (q) and (t), Florida Statutes.

In light of the foregoing Findings of Fact and Conclusions of Law the Board hereby determines that pursuant to Rule 59R-8, Florida Administrative Code, the penalty recommended by the Hearing Officer is appropriate as set forth in the Recommended Order.

WHEREFORE, it is found, ordered and adjudged that the Respondent is guilty of violating Sections 458.331(1)(m), (q) and (t) of the Administrative Complaint and pursuant to Rule 59R-8, F.A.C., the Board of Medicine imposes the following penalty:

1. The Respondent shall receive a Reprimand.

2. Within ninety (90) days filing of the Final Order in this cause, Respondent shall pay an administrative fine in the amount of three thousand five hundred dollars ($3,500.00) to the Board of Medicine.

3. Within one (1) year of the filing of the final order in this cause, Respondent shall complete the course "Quality Medical Record Keeping for the Health Care Professional" sponsored by the Florida Medical Association Committee on Clinical Excellence, or a Board-approved equivalent. In addition, Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical education course within one (1) year of the entry of the Final Order in this matter. All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such documentation was previously provided during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education courses shall consist of a formal, live lecture format.

4. Within one (1) year of the filing of the final order in this cause, Respondent shall complete the course, Protecting Your Medical Practice, Clinical, Legal and Ethical Issues in Prescribing Abusable Drugs," sponsored by the Florida Medical Association and the University of South Florida, or a Board-approved equivalent.

This Final Order becomes effective upon its filing with the Clerk of the Agency for Health Care Administration.

NOTICE

The parties are hereby notified pursuant to Section 120.59(4), Florida Statutes, that an appeal of this Final Order may be taken pursuant to Section 120.68, Florida Statutes, by filing one copy of a Notice of Appeal with the Clerk of the Agency for Health Care Administration and one copy of a Notice of Appeal with the required filing fee with the District Court of Appeal within thirty (30) days of the date this Final Order is filed.

DONE and ORDERED this 30 DAY OF August, 1995.

BOARD OF MEDICINE

Gary E Winchester MD

GARY E. WINCHESTER, M.D.
CHAIRMAN

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order and its attachments have been forwarded by U.S. Mail to Grover C. Freeman, Esquire, 201 E. Kennedy Blvd., Suite 1950, Tampa, Florida 33602, Arnold H. Pollock, Hearing Officer, Division of Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-1550 and by hand delivery to Larry G. McPherson, Jr., Chief Medical Attorney, Agency for Health Care Administration, 1940 North Monroe Street, Tallahassee, Florida 32399-0792 on this _____ day of _____, 1995.

_____
Marm Harris, Ed.D.
Executive Director