STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF MEDICINE

AGENCY FOR HEALTH CARE ADMINISTRATION,

PETITIONER,

vs. CASE NO. 94-01503

ERNEST C. MILLER, M.D.

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Agency for Health Care Administration, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Ernest C. Miller, 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 20.42, 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 0010751. Respondent's last known address is University Hospital, 655 West 8th Street, Jacksonville, Florida 32209.

3. Respondent's area of practice is Psychiatry.

4. On or about February 26, 1983, Patient J.W., a forty-two (42) year old female with a history of alcohol abuse, first

presented to Respondent with complaints of anguish originating from the fact that her fourth marriage of four months was ending.

5. Respondent diagnosed Patient J.W. as suffering from Reactive Depression and episodic drinking. Patient J.W. was to return as needed.

6. From on or about August 1983, to on or about December 1983, Patient J.W. was seen by Respondent approximately sixteen (16) times for the purposes of emotional support regarding her failed marriage and her father's illness.

7. Respondent concluded that Patient J.W. had narcissistic characteristics and features of insecurity.

8. From on or about January, 1984, to on or about April, 1984, and one time in or about October 1984, Patient J.W. was seen by Respondent for the purposes of emotional support regarding her father's illness and death.

9. In or about February, 1987, through in or about April 1987, Patient J.W. presented to Respondent with problems regarding starting to drink again.

10. On or about March 2, 1990, Patient J.W., after having been in an automobile accident in 1989 in which she struck her head, presented to Respondent with complaints of confusion, depression, and weight gain.

11. Respondent diagnosed Patient J.W. as depressed and prescribed Librium 10 mg. three times a day with two refills and she was to return in two weeks.

12. Librium is a Schedule IV drug listed in Chapter 893, Florida Statutes. Librium is defined as a legend drug by Section 465.007(7), Florida Statutes. Librium contains chlordiazepoxide HCL and is indicated for the management of anxiety disorders or for the short-term relief of symptoms of anxiety, withdrawal symptoms of acute alcoholism and preoperative apprehension and anxiety. Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving chlordiazepoxide or other psychotropic agents because to the predisposition of such patients to habituation and dependence.

13. On or about May 18, 1990, Patient J.W. presented to Respondent with problems related to the automobile accident.

14. In Patient J.W's medical records for on or about May 18, 1990, Respondent documented that he prescribed Lomotil for colitis to Patient J.W.

15. Respondent failed to document the amount prescribed, the dosage, and how often Patient J.W. was take the Lomotil.

16. Respondent failed to document a physical examination, taking Patient J.W.'s history and ordering the appropriate tests with their results as to the reason why Patient J.W. needed Lomotil.

17. Lomotil is a Schedule V drug listed in Chapter 893, Florida Statutes. Librium is defined as a legend drug by Section 465.007(7), Florida Statutes. Lomotil contains diphenoxylate hydrochloride and may be habit forming. Lomotil is effective as adjunctive therapy in the management of diarrhea. Diphenoxylate

hydrochloride may potentiate the action of barbiturates, tranquilizers, and alcohol.

18. On or about May 29, 1990, Patient J.W. presented to Respondent with complaints that she was having pain because the automobile accident.

19. Respondent documented in Patient J.W's medical records that she was wondering about the following prescription drugs: Flexeril, Darvocet, Tylenol #3 and Tylox. Respondent did not document the reason Patient J.W. was asking about these medication, whether or not another physician had prescribed these medication to her and/or if she was currently taking these medications or for what reason.

20. Patient J.W. continued to see Respondent once a month until on or about August 1990, when she started seeing Respondent approximately twice a month and then approximately once a week.

21. On or about November 9, 1990, Respondent prescribed Lomotil 2.5 mg one to two tablets every 6 hours and Librium 10 mg 30 tablets to Patient J.W.

22. Respondent did not document in Patient J.W's medical records the reason for prescribing the Lomotil and Librium to Patient J.W.

23. On or about December 5, 1990, Respondent documented in Patient J.W.'s medical records that she was depressed about her job, money and that Librium made her more relaxed.

24. Respondent prescribed Librium 10 mg twice a day and a night, 60 tablets and may be refilled twice. Patient J.W. was to return as needed.

25. On or about December 7, 1990, Respondent documented in Patient J.W.'s medical records:

> that Patient J.W. telephoned Respondent stating that "I want you to see me drinking - at my worst. Patient J.W. presented to Respondent's office and the medical records reveal that Patient J.W. was professing love for Respondent; that she was very seductive; asking if its transference; stating that "I'm very good in bed"; "I bet that your good"; kicks off her shoes and runs her toes up his leg; reminded her no Librium while drinking; stated that her job was in jeopardy but that she feels secure that current boyfriend (John) will take care of her; Respondent called cab, patient somewhat unsteady but made it successfully; was to call on Monday - that she needs to be seen this week; and that her binges historically last only 2 days.

26. On or about December 10, 1990, Respondent documented in Patient J.W.'s medical records that she had stopped drinking, apologized for her conduct stating that she "really blew it" and that she will call for an appointment.

27. On or about December 11, 1990 and December 18, 1990, Respondent called in refills for 30 tablets of Lomotil 2.5 mg one to two tablets every 6 hours as needed for Patient J.W.

28. On or about January 8, 1991, Respondent documented in Patient J.W.'s medical records that transference was heavy; Patient J.W. calls Respondent by his first name and he called her by her "Jo".

29. In the medical records of on or about January 8, 1991, for Patient J.W., Respondent further documented that he assured her that his feelings were very positive and that Patient J.W. was

indeed desirable that ethic prevented any reciprocation on his part.

30. On or about January 11, 1991, Respondent documented in Patient J.W.'s medical records that they agreed mutually to end the therapy sessions with him.

31. However, on or about June 27, 1991, Respondent documented in Patient J.W.'s medical records that he prescribed 20 tablets of Lomotil every 6 hours as needed with 8 refills.

32. On or about November 12, 1991, Respondent documented in Patient J.W's medical records that she was depressed and prescribed Prozac 20 mg once a day.

33. Prozac is defined as a legend drug by Section 465.007(7), Florida Statutes and contains fluoxetine hydrochloride. Prozac is indicated for the treatment of depression. The efficacy of Prozac was established in 5 and 6 week trials with depressed outpatients whose diagnoses corresponded most closely to the DSM-III category of major depressive order.

34. On or about November 14, 1991, Respondent documented in Patient J.W.'s medical records: headache severe and prescribed Fiorinal #30 one tablet every 6 hours as needed with 2 refills.

35. Fiorinal is a Schedule III controlled substance listed in Chapter 893, Florida Statutes. Fiorinal is defined as a legend drug by Section 465.003(7), Florida Statues. Fiorinal contains butalbital, USP, 50 mg and may be habit forming. Fiorinal is indicated for the relief of the symptom complex of tension (or muscle contraction) headache.

36. On or about December 19, 1991, Respondent documented in Patient J.W.'s medical records that he prescribed 12 tablets of Tylox one every 6 hours as needed for severe migraine and Lomotil 1 to 2 tablets very 6 hours as needed for diarrhea and increased the Prozac to 20 mg twice a day.

37. Tylox is a Schedule II controlled substance listed in Chapter 893, Florida Statutes. Tylox is defined as a legend drug by Section 465.003(7), Florida Statues. Tylox contains oxycodone hydrochloride and may be habit forming. Tylox is indicated for the relief of moderate to moderately severe pain.

38. Respondent failed to refer Patient J.W. in an appropriate and timely manner for consultations regarding Patient J.W.'s diarrhea and headaches.

39. On or about December 26, 1991, Respondent documented in Patient J.W.'s medical records that she called complaining of diarrhea and headache. Respondent prescribed Prozac 20 mg twice a day, Tylox one every 6 hours and Lomotil 1-2 tablets every 6 hours as needed.

40. On or about December 26, 1991, Respondent documented in Patient J.W.'s medical records that she discuss with a Dr. Kilgore her headaches; that she never used Tylox like this before and that she was losing it.

41. On or about January 3, 1992, Respondent documented in Patient J.W.'s medical records that Patient J.W. called and was planning on going to the Betty Ford Clinic.

42. On or about February 4, 1992, Respondent documented in Patient J.W's medical records that Patient J.W. had gone to the Betty Ford Clinic and that she was back needing follow-up care.

43. Respondent failed to refer Patient J.W. for follow-up care.

44. On or about March 10, 1992, and on or about March 16, 1992, Respondent documented that he had spoken to Patient J.W. and her lawyer regarding releasing Patient J.W.'s medial records for a civil suit.

45. On or about March 10, 1992, Respondent documented in Patient J.W.'s medical records that Patient J.W. had called from Jacksonville where she had gone for follow-up treatment from her stay at the Betty Ford Clinic; that she needed more time there but no money; and Respondent documented that in regard to Patient J.W's civil suit - his career was over - regarding Patient J.W.'s medical records he needed to use discretion (edition) of portions of the records not relevant to suit.

46. On or about March 16, 1992, Respondent documented in Patient J.W.'s medical records that he had spoken to her regrading her worry over her son; urged her to stay dry; and get on with her life.

47. From on or about February 1991, through on or about September, 1993, Respondent engaged in sexual activity with Patient J.W., including physical touching and sexual intercourse.

48. Section 458.329, Florida Statutes, states: 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 practice or the scope of generally accepted examination or treatment of the patient. Sexual misconduct in the practice of medicine is prohibited.

49. The Respondent violated Section 458.329, Florida Statutes, by engaging Patient J.T. in sexual activity outside the scope of treatment of the patient.

COUNT ONE

50. Petitioner realleges and incorporates paragraphs one (1) through forty-nine (49), as if fully set forth herein this Count One.

51. Respondent is guilty of 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 in that Respondent failed to appropriately diagnose and treat Patient J.W.'s diarrhea and headaches; failed to appropriately and timely refer Patient J.W. for consultations and for continued care; and by violating Section 458.329, Florida Statutes.

52. Based on the proceeding allegations, Respondent has violated Section 458.331(1)(t), Florida Statutes, by 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 circumstance.

COUNT TWO

53. Petitioner realleges and incorporates paragraphs one (1) through forty-nine (49), and fifty (50), as if fully set forth herein this Count Two.

54. Respondent is guilty of 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; reports of consultations and hospitalizations, in that Respondent failed to justify Patient J.W.'s diagnosis and treatment for her headaches and diarrhea and failed to document the reason for the quantities and the need for narcotic medication.

55. Based on the proceeding 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; reports of consultations and hospitalizations.

COUNT THREE

56. Petitioner realleges and incorporates paragraphs one (1) through forty-nine (49), fifty (50), and fifty-three (53), as if fully set forth herein this Count Three.

57. Respondent is guilty of prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the Respondent inappropriately prescribed medications to Patient J.W. during the course of their physician-patient relationship, or, in the alternative, inappropriately prescribed medications to Patient J.W. outside the context of a physician-patient relationship.

58. Based on the proceeding 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 practice.

COUNT FOUR

59. Petitioner realleges and incorporates paragraphs one (1) through forty-nine (49), fifty (50), fifty-three (53), and fifty-six (56), as if fully set forth herein this Count Four.

60. Respondent is guilty of exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity in that Respondent had a sexual relationship with Patient J.W. while he was Patient J.W's treating physician.

61. Based on the proceeding allegations, Respondent has violated Section 458.331(1)(j), Florida Statutes, in that Respondent is guilty of exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity.

COUNT FIVE

62. Petitioner realleges and incorporates paragraphs one (1) through forty-nine (49), fifty (50), fifty-three (53), fifty-six (56), and fifty-nine (59), as if fully set forth herein this Count Five.

63. Respondent is guilty of violating any provision of this chapter, a rule of the board or department, or a lawful order of the board or department previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the department when he violated Section 458.329, Florida Statutes.

64. Based on the proceeding allegations, Respondent has violated Section 458.331(1)(x), Florida Statutes, by violating any provision of this chapter, a rule of the board or department, or a lawful order of the board or department previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the department.

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, the assessment of costs related to the investigation and prosecution of this case, other than costs associated with an attorney's time, as provided for in Section 455.227(3), Florida Statutes, and/or any other relief that the Board deems appropriate.

SIGNED this 1 day of March, 1996.

Douglas M. Cook, Director

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR THE AGENCY:

Larry G. McPherson, Jr.
Chief Medical Attorney
Agency for Health Care Administration
1940 North Monroe Street
Tallahassee, Florida 32399-0750
Florida Bar #788643
HRB/mlm
PCP: February 26, 1996
Katims, Dauer and Cherney

FILED
AGENCY FOR
HEALTH CARE ADMINISTRATION
DEPUTY CLERK
CLERK
DATE 3-5-96

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPTARTMENT OF HEALTH,
AGENCY FOR HEALTH CARE
ADMINISTRATION,
Petitioner,

v.

AHCA Case No. 94-01503

ERNEST C. MILLER, M.D.,
Respondent.
_____/

CONSENT AGREEMENT

THE PARTIES, Ernest C. Miller, M.D. ("Respondent") and the Department of Health ("Department"), by and through the Agency for Health Care Administration ("Agency") stipulate and agree to the following Agreement and to the entry of a Final Order of the Board of Medicine ("Board") incorporating the terms of this Agreement.

In imposing the penalties set forth herein, the Department and the Agency recognize that (1) considerable mitigating circumstances exist in this case, (2) the Petitioner's expert has opined that the Respondent's behavior was not exploitative or predatory in nature, (2) Respondent's behavior in this case represents an isolated incident in a career spanning decades, and (3) Respondent's professional activity is limited to forensic work and volunteer charitable work.

STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed physician in the State of Florida having been issued license number ME 0010751.

2. Respondent was charged by an Administrative Complaint filed by the Department and properly served upon Respondent with violations of Chapter 458, Florida Statutes, and the rules enacted pursuant thereto. A true and correct copy of the Administrative Complaint is attached hereto as Exhibit A.

3. Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaint.

STIPULATED CONCLUSIONS OF LAW

1. Respondent admits that, in his capacity as a licensed physician, he is subject to the provisions of Chapters 455 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the facts set forth in the Administrative Complaint, if proven, would constitute violations of Chapter 458, Florida Statutes, as alleged in the Administrative Complaint.

3. Respondent admits that the Stipulated Disposition in this case is fair, appropriate and acceptable to Respondent.

4. Respondent freely and voluntarily executed this Stipulation after having reviewed same and after having the benefit of advice of counsel.

STIPULATED DISPOSITION

1. FUTURE CONDUCT. Respondent shall not in the future violate Chapters 455, 458, and 893, Florida Statutes, or the rules promulgated pursuant thereto. Prior to signing this agreement, Respondent read Chapters 455, 458, and 893 and the Rules of the Board of Medicine, at Section 59R, Florida Administration Code.

2. FINE AND COSTS. The Respondent shall pay to the Board of Medicine the sum of $10,000 (ten thousand dollars) as a fine and to cover the costs incurred by the Agency. Respondent shall pay this amount within two (2) years after the entry of the final order adopting this stipulation. **RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE FINE/COSTS IS HIS/HER LEGAL OBLIGATION AND RESPONSIBILITY, AND RESPONDENT AGREES TO CEASE PRACTICING IF THE FINE/COSTS ARE NOT PAID AS AGREED TO IN THIS CONSENT AGREEMENT, SPECIFICALLY: IF RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT HAS BEEN RECEIVED BY THE BOARD OFFICE WITHIN TWO (2) YEARS OF THE FILING OF THIS FINAL ORDER, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD. (SEE EXHIBIT B OF THIS CONSENT AGREEMENT FOR BOARD ADDRESS AND STANDARD TERMS.)**

3. The license of Respondent shall be reprimanded.

4. Respondent's license and practice shall be restricted as follows:

A. Respondent shall continue to volunteer at a homeless shelter.

B. Respondent shall practice forensic medicine. The parties agree Respondent's patient contact shall be limited to that necessary to evaluate the patient, and any related testimony.

C. Except as provided in (A) and (B) above, the Respondent shall refrain from practicing medicine in any other setting.

5. STANDARD PROVISIONS. Respondent agrees that this Consent Agreement shall be governed by the "Standard Terms Applicable to Consent Agreements," Exhibit B, which is incorporated as if fully set forth herein.

6. It is expressly understood that this Agreement is subject to the approval of the Agency, Board, and Department. In this regard, the foregoing paragraphs (and only the foregoing paragraphs) shall have no force and effect unless a Final Order incorporating the terms of this Agreement is entered by the Board.

7. Respondent shall appear before the Board at the meeting of the Board where this Agreement is considered. Respondent, in conjunction with the consideration of this Agreement by the Board, shall respond to questions under oath from the Board and/or staff or the Board, Agency, and/or or Department. Respondent shall be prepared to explain the circumstances involved in this matter and what measures he/she has undertaken to prevent a recurrence. Respondent agrees that he shall offer no evidence, testimony, or argument that disputes or contravenes any stipulated fact or conclusion of law.

8. Should this Agreement be rejected, no statement made in furtherance of this Agreement by the Respondent may be used as direct evidence against Respondent in any proceeding; however, such statements may be used by Petitioner for impeachment purposes.

9. Respondent and the Department fully understand that this joint Agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings by the Board, Agency, and/or Department against Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached as Exhibit A herein.

10. Upon the Board's adoption of this Agreement, Respondent expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to

otherwise challenge or contest the validity of the Agreement and the Final Order of the Board incorporating said Agreement.

11. Upon the Board's adoption of this Agreement, the parties hereby agree that each party will bear his own attorney's fees and costs resulting from prosecution or defense of this matter. Respondent waives the right to seek any attorney's fees or costs from the Board, Agency, or Department in connection with this matter.

12. This Agreement is executed by Respondent for the purpose of avoiding further administrative action with respect to this cause. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to or in conjunction with consideration of the Agreement. Furthermore, should this joint Agreement not be accepted by the Board, it is agreed that presentation to and consideration of this Agreement and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration, or resolution of these proceedings.

SIGNED this 2nd day of August, 2000.

ERNEST C. MILLER, M.D.

Before me, personally appeared ERNEST C. MILLER, whose identity is known to me by FLORIDA DRIVER'S LICENSE (type of identification), and who, under oath, acknowledges that his/her signature appears above.

Sworn to and subscribed before me this 2nd day of August, 2000.

My commission expires:

NOTARY PUBLIC, STATE OF FLORIDA
GEM A DAVIS
COMMISSION # CC732072
EXPIRES 4/6/2002
BONDED THRU ASA 1-888-NOTARY1

APPROVED this 5th day of September 2000.

ROBERT G. BROOKS, M.D., SECRETARY
DEPARTMENT OF HEALTH

BY: Kathryn A. Kasprzak
Chief Attorney
Medical Section

Final Order No. DOH-00-2003-S-MQA
FILED DATE - 11/1/2000
Department of Health
By: Vicki R. Kenon
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

CASE NO.: 1994-01503
LICENSE NO.: ME0010751

ERNEST C. MILLER, M.D.,

Respondent.

_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on October 7, 2000, in Orlando, Florida, for consideration of a Consent Agreement (attached hereto as Exhibit A) entered into between the parties in the above-styled cause. Upon consideration of the Consent Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise advised in the premises, the Board rejected the Consent Agreement and offered a Counter Consent Agreement, which was accepted on the record by the parties. The Counter Consent Agreement incorporates the original Consent Agreement with the following amendments:

The fine and costs set forth in Paragraph 2 of the Stipulated Disposition are changed to require an administrative fine in the amount of $5,000 and costs in the amount of $9,674.18, for a total of

$14,674.18. The time frame for payment of the fine and costs remain as set forth in the Consent Agreement.

IT IS HEREBY ORDERED AND ADJUDGED that the Consent Agreement as submitted be and is hereby approved and adopted in toto and incorporated by reference herein with the amendments set forth above. Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Consent Agreement as amended.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 17th day of October, 2000.

BOARD OF MEDICINE

for Larry A. Williams
GEORGES A. EL-BAHRI, M.D.
CHAIRMAN

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to Ernest C. Miller, M.D., 1636 River Road, Jacksonville, Florida 32207; to Samuel S. Jacobson, Esquire, Datz, Jacobson, Lembcke & Wright, One Independent Drive, Suite

2902, Jacksonville, Florida 32202-5036; and by interoffice delivery to Kathryn L. Kasprzak, Chief Medical Attorney, and Simone Marstiller, Senior Attorney - Appeals, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308-5403, on or before 5:00 p.m., this _____ day of _____, 2000.

_____

Jeb Bush
Governor

FLORIDA DEPARTMENT OF HEALTH

John O. Agwunobi, M.D., M.B.A.
Secretary

August 19, 2004

Office of the State Attorney
Fourth Judicial Circuit
Mr. Harry Shorstein
330 East Bay Street
County Courthouse, 5th Floor
Jacksonville, Florida 32202

Complaint #199401503

Subject: Ernest C. Miller

Dear Mr. Shorstein:

Enclosed is a copy of a complaint and/or document that may indicate a criminal violation by a licensee regulated by the Department of Health. Pursuant to 456.066, Florida Statues this information is being forwarded to your office for your review and disposition. This complaint is currently under investigation by the Department of Health for a possible violation of 458.329 and 458.331 (1)(J)(X), Florida Statutes. At such time that probable cause is found and an administrative complaint is issued or the case is closed, the Department will notify you and provide any supplemental information you may request.

Please be advised that pursuant to section 456.073(10), Florida Statutes this complaint and all information obtained during the Department's investigation are confidential and exempt from section 119.07(1), Florida Statutes, until ten (10) days after probable cause has been found to exist or the subject of the investigation waives his/her right of confidentiality, whichever occurs first. We are required, pursuant to section 456.057 (8), Florida Statutes to maintain confidentiality, at all times, of patient names, patient records and any documents that may identify the patient by name.

Please do not hesitate to contact me if I can be of further assistance to you.

Sincerely,

Sondra N. Allen

Sondra N. Allen
Regulation Specialist III
Consumer Services Unit
Division of Medical Quality Assurance

/sna

Enclosure