Final Order No. DOH-06-1036-FOF-MQA
FILED DATE - 6-20-06
Department of Health
By: Theresa McKown
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH Case No.: 2002-15730
DOAH Case No.: 05-3646PL
License No.: ME0045950

ABBEY STRAUSS, M.D.,

Respondent.
_______________________________/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(1), Florida Statutes, on June 3, 2006, in Orlando, Florida, for the purpose of considering the Administrative Law Judge's Recommended Order and Exceptions to the Recommended Order, (copies of which are attached hereto as Exhibits A and B) in the above-styled cause. Petitioner was represented by Diane K. Kiesling, Assistant General Counsel. Respondent was present and was represented by Lawrence Brownstein, Esquire, at the hearing.

Upon review of the Recommended Order, the argument of the parties, and after a review of the complete record in this case, the Board makes the following findings and conclusions.

RULING ON EXCEPTIONS

The Board reviewed and considered the Exceptions filed by the Respondent and denied the Exceptions.

FINDINGS OF FACT

1. The findings of fact set forth in the Recommended Order are approved and adopted and incorporated herein by reference.

2. There is competent substantial evidence to support the findings of fact.

CONCLUSIONS OF LAW

1. The Board has jurisdiction of this matter pursuant to Section 120.57(1), Florida Statutes, and Chapter 458, Florida Statutes.

2. The conclusions of law set forth in the Recommended Order are approved and adopted and incorporated herein by reference.

3. There is competent substantial evidence to support the conclusions of law.

PENALTY

Upon a complete review of the record in this case, the Board determines that the penalty recommended by the Administrative Law Judge be ACCEPTED.

WHEREFORE, IT IS HEREBY ORDERED AND ADJUDGED that

1. Respondent shall pay an administrative fine in the amount of $15,000 to the Board within 30 days from the date this Final Order is filed.

2. Respondent shall document completion of the medical records course sponsored by the Florida Medical Association (FMA) within one (1) year from the date this Final Order is filed.

3. Respondent shall document completion of the drug course sponsored by the University of South Florida (USF) within one (1) year from the date this Final Order is filed.

4. Respondent shall be and is hereby issued a letter of concern by the Board.

RULING ON MOTION TO ASSESS COSTS

The Board reviewed the Petitioner's Motion to Assess Costs and imposes the costs associated with this case in the amount of $6,774.10. Said costs are to be paid within 30 days from the date this Final Order is filed.

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

DONE AND ORDERED this 19 day of JUNE, 2006.

BOARD OF MEDICINE

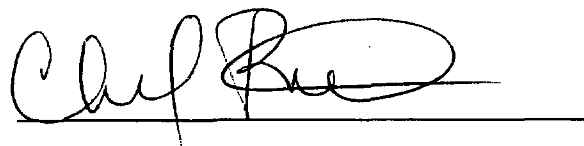
Larry McPherson, Jr., Executive Director
for Mammen P. Zachariah, M.D., Chair

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES. REVIEW PROCEEDINGS ARE GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. SUCH PROCEEDINGS ARE COMMENCED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF THE DEPARTMENT OF HEALTH AND A SECOND COPY, ACCOMPANIED BY FILING FEES PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL, FIRST DISTRICT, OR WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES. THE NOTICE OF APPEAL MUST BE FILED WITHIN THIRTY (30) DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

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 ABBEY STRAUSS, M.D., 1050 NW 15th Street, #207-A, Boca Raton, Florida 33486; to Lawrence Brownstein, Esquire, Northbridge Center, 515 N. Flagler Drive, Suite 300-Pavilion, West Palm Beach, Florida 33401; to Larry J. Sartin, Administrative Law Judge, Division of Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-3060; and by interoffice delivery to Denise O'Brien and Dana Baird, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3265 this 20th day of June, 2006.



Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2002-15730**

ABBEY STRAUSS, M.D.,

RESPONDENT.

______________________________/

FIRST AMENDED ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against the Respondent, Abbey Strauss, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 45950.

3. Respondent's last known address is 1050 NW 15th Street, # 207-A, Boca Raton, Florida 33486.

4. Respondent is board certified in Psychiatry by the American Board of Psychiatry and Neurology.

5. On or about November 11, 1997, Patient S.R., a fifty-one (51) year-old male, presented to Respondent's office with complaints of chronic back pain and pain of the lower extremities due to arthritis and injuries from an automobile accident.

6. During Patient S.R.'s first visit, Respondent documented that Patient S.R. was taking OxyContin 80 mg twice a day and Valium. Patient S.R. admitted to Respondent that because of the chronic pain, he had become addicted to his pain medication and was worried about being able to get his prescription.

7. Respondent failed to document that she performed a physical examination of Patient S.R., failed to document that she made a diagnosis, failed to refer Patient S.R. for any consultations or additional diagnostic testing, failed to obtain any confirmatory medical records and failed to document that she and Patient S.R. developed a written treatment plan. Following Respondent's conversation with Patient S.R., Respondent

prescribed Patient S.R. OxyContin 40 mg three times a day and OxyContin 20 mg as needed or required (prn).

8. OxyContin is a semi-synthetic opiate that contains oxycodone hydrochloride, a schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for the relief of moderate to severe pain. OxyContin has a high potential for abuse and has a currently accepted but limited medical use in treatment in the United States. Abuse of this substance may lead to severe physical and psychological dependence.

9. Valium contains diazepam, a schedule IV controlled substance listed in Chapter 893, Florida Statutes, which is used for management of anxiety disorders and short term relief of anxiety. Diazepam has a potential for abuse and has a currently accepted medical use in treatment in the United States. Abuse of this substance may lead to physical and psychological dependence.

10. On or about November 17, 1997, Patient S.R. presented to Respondent with complaints of pain. Respondent increased Patient S.R.'s dosage of OxyContin to 40 mg four times per day and 20 mg as needed. Respondent failed to perform or document an examination of Patient S.R.

to justify increasing the medication outside of inquiring of Patient S.R. about his pain.

11. On or about December 4, 1997, Patient S.R. presented to Respondent's office. Respondent prescribed Valium 2.5 mg three times a day (TID) in addition to the OxyContin. Respondent failed to perform or document a physical examination of Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation, additional diagnostic testing or without consideration of Patient S.R.'s self-reported drug addiction.

12. On or about January 2, 1998, Respondent presented to Respondent's office. Respondent increased Patient S.R.'s dosage of OxyContin to 80 mg, three tablets twice a day or 240 mg twice a day. Respondent failed to perform or document a physical examination or treatment plan for Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation, additional diagnostic testing or without consideration for Patient S.R.'s self-reported drug addiction.

13. On or about January 22, 1998, Patient S.R. presented to Respondent's office. Respondent increased Patient S.R.'s dosage of OxyContin to 320 mg, twice a day. Respondent failed to perform or document a physical examination of Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation, additional diagnostic testing or without consideration for Patient S.R.'s self-reported drug addiction.

14. On or about March 17, 1998, Patient S.R. presented to Respondent's office. Respondent changed Patient S.R.'s dosage from OxyContin 80 mg, seven tablets twice a day to five tablets, three times a day. Respondent failed to perform or document a physical examination of Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation, additional diagnostic testing or without consideration for Patient S.R.'s self-reported drug addiction.

15. On or about April 9, 1998, Respondent noted that Patient S.R. was averaging 960 mg of OxyContin twice a day.

16. On or about April 27, 1998, Respondent noted that Patient S.R. was taking OxyContin 80 mg, 12 tablets in the morning, six tablets at mid-day and 12 tablets at bedtime or 1,440 mg per day.

17. On or about July 30, 1998, Patient S.R. was taking OxyContin 2400 mg per day and requested Respondent to prescribe Morphine. Respondent prescribed and instructed Patient S.R. to take MS Contin 200 mg, 12 tablets a day. Respondent failed to perform or document a physical examination or treatment plan for Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation.

18. MS Contin contains morphine, a schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for relief of moderate to severe pain. Morphine has a high potential for abuse and has a currently accepted but limited medical use in treatment in the United States. Abuse of this substance may lead to severe physical and psychological dependence.

19. From July 30, 1998, through August 9, 2002, Respondent examined Patient S.R. approximately once a month. When Patient S.R. complained of increased pain, Respondent increased Patient S.R.'s

medication without referral for consultation, additional diagnostic testing or without consideration for Patient S.R.'s self-reported drug addiction.

20. Between July 1999, and August 2002, Respondent prescribed controlled substances to Patient S.R., including MS Contin, Valium and Ativan. These prescriptions were about the same each month: (1) MS Contin 200 mg, dispense 500 tablets with instructions to take 10 to 12 tablets two or three times per day; (2) Valium 10 mg dispense 100 tablets and take one tablet three times per day; and (3) Ativan one mg 30 tablets, one tablet prn.

21. Ativan contains lorazepam, a schedule IV controlled substance listed in Chapter 893, Florida Statutes, which is used for management of anxiety disorders and short term relief of anxiety. Lorazepam has a low potential for abuse and has a currently accepted medical use in treatment in the United States. Abuse of this substance may lead to limited physical and psychological dependence.

22. Respondent failed to do one or more of the following for Patient S.R., a patient with a history of narcotic abuse or addiction and chronic pain:

a) make detailed notes of Patient's S.R.'s physical condition and pain;

b) make frequent reviews of Patient S.R.'s needs;

c) make a treatment plan with objectives;

d) justify changes in Patient S.R.'s medications, dosages or frequency; or

e) communicate with Patient S.R.'s other health care providers in order to furnish adequate pain medication but without enabling drug seeking behavior.

COUNT ONE

23. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

24. Section 458.331(1)(t), Florida Statutes (1997 through 2002), provides that 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 is grounds for discipline by the Board of Medicine.

25. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician, in one or more of the following ways:

a) by failing to perform an adequate physical examination of Patient S.R. during his first visit;

b) by failing to make a treatment plan with objectives;

c) by failing to justify changes in medications, dosages or frequency; or

d) by failing to use specialized consultations for diagnosis and/or treatment.

26. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (1997 through 2002), by failing 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.

COUNT TWO

27. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

28. Section 458.331(1)(m), Florida Statutes (1997 through 2002), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations are grounds for disciplinary action by the Board of Medicine.

29. Respondent failed to keep legible medical records that justify the course of treatment of Patient S.R. in one or more of the following ways:

a) by failing to record or inadequately recording a physical examination during Patient S.R.'s first visit;

b) by failing to make detailed notes and perform regular reviews of patient needs; or

c) by failing to document a complete and proper history of Patient S.R.

30. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (1997 through 2002), by failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test

results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

COUNT THREE

31. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

32. Section 458.331(1)(q), Florida Statutes (1997 through 2002), provides that 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, is grounds for disciplinary action by the Board of Medicine. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and not in the course of the physician's professional practice, without regard to his or her intent.

33. Respondent prescribed OxyContin, MS Contin, Valium and Ativan, all controlled substances, to Patient S.R. inappropriately or in excessive or inappropriate quantities, in that Respondent prescribed controlled substances without medical justification, in quantities which

endangered the patient's health, and were not in the best interest of the patient and in a manner not in the course of the physician's professional practice.

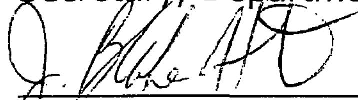
34. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (1997 through 2002), by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and not in the course of the physician's professional practice, without regard to his or her intent.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of

fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 5th day of October, 2005.

M. Rony François, M.D., M.S.P.H., Ph.D
Secretary, Department of Health



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Abbey Strauss, M.D., DOH Case: 2002-15730

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2002-15730**

ABBEY STRAUSS, M.D.,

RESPONDENT.

______________________________/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against the Respondent, Abbey Strauss, M.D., and in support thereof alleges:

1. Petitioner is the state department charged with regulating the practice of medicine pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 458, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 45950.

3. Respondent's last known address is 1050 NW 15th Street, # 207-A, Boca Raton, Florida 33486.

4. Respondent is board certified in Psychiatry by the American Board of Psychiatry and Neurology.

5. On or about November 11, 1997, Patient S.R., a fifty-one (51) year-old male, presented to Respondent's office with complaints of chronic back pain and pain of the lower extremities due to arthritis and injuries from an automobile accident.

6. During Patient S.R.'s first visit, Respondent documented that Patient S.R. was taking OxyContin 80 mg twice a day and Valium. Patient S.R. admitted to Respondent that because of the chronic pain, he had become addicted to his pain medication and was worried about being able to get his prescription.

7. Respondent failed to document that she performed a physical examination of Patient S.R., failed to document that she made a diagnosis, failed to refer Patient S.R. for any consultations or additional diagnostic testing, failed to obtain any confirmatory medical records and failed to document that she and Patient S.R. developed a written treatment plan. Following Respondent's conversation with Patient S.R., Respondent

prescribed Patient S.R. OxyContin 40 mg three times a day and OxyContin 20 mg as needed or required (prn).

8. OxyContin is a semi-synthetic opiate that contains oxycodone hydrochloride, a schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for the relief of moderate to severe pain. OxyContin has a high potential for abuse and has a currently accepted but limited medical use in treatment in the United States. Abuse of this substance may lead to severe physical and psychological dependence.

9. Valium contains diazepam, a schedule IV controlled substance listed in Chapter 893, Florida Statutes, which is used for management of anxiety disorders and short term relief of anxiety. Diazepam has a potential for abuse and has a currently accepted medical use in treatment in the United States. Abuse of this substance may lead to physical and psychological dependence.

10. On or about November 17, 1997, Patient S.R. presented to Respondent with complaints of pain. Respondent increased Patient S.R.'s dosage of OxyContin to 40 mg four times per day and 20 mg as needed. Respondent failed to perform or document an examination of Patient S.R.

to justify increasing the medication outside of inquiring of Patient S.R. about his pain.

11. On or about December 4, 1997, Patient S.R. presented to Respondent's office. Respondent prescribed Valium 2.5 mg three times a day (TID) in addition to the OxyContin. Respondent failed to perform or document a physical examination of Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation, additional diagnostic testing or without consideration of Patient S.R.'s self-reported drug addiction.

12. On or about January 2, 1998, Respondent presented to Respondent's office. Respondent increased Patient S.R.'s dosage of OxyContin to 80 mg, three tablets twice a day or 240 mg twice a day. Respondent failed to perform or document a physical examination or treatment plan for Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation, additional diagnostic testing or without consideration for Patient S.R.'s self-reported drug addiction.

13. On or about January 22, 1998, Patient S.R. presented to Respondent's office. Respondent increased Patient S.R.'s dosage of OxyContin to 320 mg, twice a day. Respondent failed to perform or document a physical examination of Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation, additional diagnostic testing or without consideration for Patient S.R.'s self-reported drug addiction.

14. On or about March 17, 1998, Patient S.R. presented to Respondent's office. Respondent changed Patient S.R.'s dosage from OxyContin 80 mg, seven tablets twice a day to five tablets, three times a day. Respondent failed to perform or document a physical examination of Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation, additional diagnostic testing or without consideration for Patient S.R.'s self-reported drug addiction.

15. On or about April 9, 1998, Respondent noted that Patient S.R. was averaging 960 mg of OxyContin twice a day.

16. On or about April 27, 1998, Respondent noted that Patient S.R. was taking OxyContin 80 mg, 12 tablets in the morning, six tablets at mid-day and 12 tablets at bedtime or 1,440 mg per day.

17. On or about July 30, 1998, Patient S.R. was taking OxyContin 2400 mg per day and requested Respondent to prescribe Morphine. Respondent prescribed and instructed Patient S.R. to take MS Contin 200 mg, 12 tablets a day. Respondent failed to perform or document a physical examination or treatment plan for Patient S.R. to justify increasing the medication outside of inquiring of Patient S.R. about his pain. Respondent increased Patient S.R.'s medication without referral for consultation.

18. MS Contin contains morphine, a schedule II controlled substance listed in Chapter 893, Florida Statutes, which is indicated for relief of moderate to severe pain. Morphine has a high potential for abuse and has a currently accepted but limited medical use in treatment in the United States. Abuse of this substance may lead to severe physical and psychological dependence.

19. From July 30, 1998, through August 9, 2002, Respondent examined Patient S.R. approximately once a month. When Patient S.R. complained of increased pain, Respondent increased Patient S.R.'s

medication without referral for consultation, additional diagnostic testing or without consideration for Patient S.R.'s self-reported drug addiction.

20. Between July 1999, and August 2002, Respondent prescribed controlled substances to Patient S.R., including MS Contin, Valium and Ativan. These prescriptions were about the same each month: (1) MS Contin 200 mg, dispense 500 tablets with instructions to take 10 to 12 tablets two or three times per day; (2) Valium 10 mg dispense 100 tablets and take one tablet three times per day; and (3) Ativan one mg 30 tablets, one tablet prn.

21. Ativan contains lorazepam, a schedule IV controlled substance listed in Chapter 893, Florida Statutes, which is used for management of anxiety disorders and short term relief of anxiety. Lorazepam has a low potential for abuse and has a currently accepted medical use in treatment in the United States. Abuse of this substance may lead to limited physical and psychological dependence.

22. Respondent failed to do one or more of the following for Patient S.R., a patient with a history of narcotic abuse or addiction and chronic pain:

a) make detailed notes of Patient's S.R.'s physical condition and pain;

b) make frequent reviews of Patient S.R.'s needs;

c) make a treatment plan with objectives;

d) justify changes in Patient S.R.'s medications, dosages or frequency; or

e) communicate with Patient S.R.'s other health care providers in order to furnish adequate pain medication but without enabling drug seeking behavior.

COUNT ONE

23. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

24. Section 458.331(1)(t), Florida Statutes (1997 through 2002), provides that 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 is grounds for discipline by the Board of Medicine.

25. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician, in one or more of the following ways:

a) by failing to perform an adequate physical examination of Patient S.R. during his first visit;

b) by inadequately recording a physical examination of Patient S.R. during his first visit and all subsequent visits;

c) by failing to make and adequately document a specific diagnosis of Patient S.R. during his first visit;

d) by failing to make detailed notes and perform regular reviews of patient needs;

e) by failing to make a treatment plan with objectives;

f) by failing to justify changes in medications, dosages or frequency;

g) by failing to use specialized consultations for diagnosis and/or treatment; or

h) by failing to document a complete and proper history of Patient S.R.

26. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (1997 through 2002), by failing 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.

COUNT TWO

27. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

28. Section 458.331(1)(m), Florida Statutes (1997 through 2002), provides that failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations are grounds for disciplinary action by the Board of Medicine.

29. Respondent failed to keep legible medical records that justify the course of treatment of Patient S.R. in one or more of the following ways:

a) by failing to record or inadequately recording a physical examination during Patient S.R.'s first visit;

b) by failing to make detailed notes and perform regular reviews of patient needs;

c) by failing to make a treatment plan with objectives;

d) by failing to justify changes in medications, dosages or frequency; or

e) by failing to document a complete and proper history of Patient S.R.

30. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (1997 through 2002), by failing to keep legible medical records that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

COUNT THREE

31. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22) as if fully set forth herein.

32. Section 458.331(1)(q), Florida Statutes (1997 through 2002), provides that 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, is grounds for disciplinary action by the Board of Medicine. For the purposes of this

paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and not in the course of the physician's professional practice, without regard to his or her intent.

33. Respondent prescribed OxyContin, MS Contin, Valium and Ativan, all controlled substances, to Patient S.R. inappropriately or in excessive or inappropriate quantities, in that Respondent prescribed controlled substances without medical justification, in quantities which endangered the patient's health, and were not in the best interest of the patient and in a manner not in the course of the physician's professional practice.

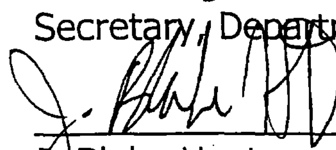
34. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (1997 through 2002), by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including all controlled

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

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

SIGNED this 27th day of June, 2005.

John O. Agwunobi, M.D., M.B.A., M.P.H.
Secretary, Department of Health



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FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Heather Coleman
DATE 6-28-05

Reviewed and approved by: CS (initials) 5/3/05 (date)

J:\PSU\Medical\blake\Regular ACs\Strauss.A.2002-15730.458.331(m)(q)(t).doc

PCP: June 24, 2005
PCP Members: El-Bahri, Ondra, Dyches

Abbey Strauss, M.D., DOH Case: 2002-15730

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 05-3646PL

ABBEY STRAUSS, M.D.,

Respondent.

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case before Larry J. Sartin, an Administrative Law Judge of the Division of Administrative Hearings, On December 16, 2005, by video teleconference between West Palm Beach and Tallahassee, Florida, and on January 31, 2006, by video teleconference between Jacksonville and Tallahassee, Florida.

APPEARANCES

For Petitioner: J. Blake Hunter
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For Respondent: Lawrence E. Brownstein, Esquire
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STATEMENT OF THE ISSUE

The issue in this case is whether Respondent, Abbey Strauss, M.D., committed violations of Chapter 458, Florida Statutes, as alleged in a First Amended Administrative Complaint issued by Petitioner, the Department of Health, on October 5, 2005, in DOH Case Number 2002-15730; and, if so, what disciplinary action should be taken against his license to practice medicine in Florida.

PRELIMINARY STATEMENT

On or about June 28, 2005, the Department of Health filed a three-count Administrative Complaint against Respondent Abbey Strauss, M.D., an individual licensed to practice medicine in Florida, before the Board of Medicine, in which it alleged that Dr. Strauss had committed violations of Section 458.331(1)(m), (q), and (t), Florida Statutes (1997 through 2002).[1] Respondent disputed the allegations of fact contained in the Administrative Complaint and, on or about July 19, 2005, executed an Election of Rights form requesting a formal administrative hearing pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes (2005).

On October 4, 2005, the matter was filed with the Division of Administrative Hearings with a request that an administrative law judge be assigned to conduct proceedings pursuant to Section

120.57(1), Florida Statutes (2005). The matter was designated DOAH Case Number 05-3646PL and was assigned to the undersigned.

On October 6, 2005, a Motion to Amend Administrative Complaint was filed by Petitioner. A First Amended Administrative Complaint, issued October 5, 2005, was filed with the Motion. That Motion was granted by an Order Granting Motion to Amend Administrative Complaint entered October 11, 2005.

The final hearing was scheduled to be held on December 16, 2005, by Notice of Hearing by Video Teleconference entered October 12, 2005. The hearing was scheduled to be conducted between West Palm Beach, Florida, and the offices of the Division of Administrative Hearings in Tallahassee, Florida.

On November 16, 2005, Petitioner's Motion for Official Recognition was granted. Official recognition was taken of Subsections 458.331(1)(m), (q), and (t), Florida Statutes (1997 through 2002).

On November 29, 2005, a Joint Prehearing Stipulation was filed by the parties. The Joint Prehearing Stipulation provides that "those facts that are admitted" are "[t]hose admissions of Respondent to his Responses to Petitioner's Request for Admissions." Those admissions have been incorporated into the Findings of Fact of this Recommended Order.

Prior to the commencement of the final hearing, the following motions were filed for which there was inadequate time

for response and ruling prior to the commencement of the hearing:

1. Respondent's Motion for Partial Summary Judgment/Motion in Limine with Respect to Ativan;

2. Respondent's Motion to Add Billing Ledger to Exhibit List;

3. Respondent's Motion for Official Recognition;

4. Petitioner's Second Motion for Official Recognition; and

5. Respondent's Motion in Limine to Exclude Testimony of Petitioner's Experts.

Argument on most of the Motions was heard at the commencement of the final hearing but before the court reporter arrived. The following rulings were entered on the first four Motions: Respondent's Motion for Partial Summary Judgment/Motion in Limine with Respect to Ativan was denied; Respondent's Motion to Add Billing Ledger to Exhibit List was granted without objection; Respondent's Motion for Official Recognition was granted without objection; and Petitioner's Second Motion for Official Recognition was granted to the extent ultimately determined relevant.

Argument was heard after the court reporter arrived on Respondent's Motion in Limine to Exclude Testimony of Petitioner's Experts. A ruling on that Motion was reserved to

give the parties an opportunity to make additional argument in their proposed recommended orders. Petitioner addressed the issues raised in Respondent's Motion in Limine to Exclude Testimony of Petitioner's Experts in its Proposed Recommended Order. Respondent did not. After consideration of the Motion, the argument presented at hearing, and the Petitioner's written argument, the Motion is hereby denied.

On December 16, 2005, Petitioner presented the testimony of Joseph T. Worden, M.D., an expert in pain management, and, by deposition, the testimony of James Edgar, M.D., who is hereby accepted as an expert in pain medicine and pain management. Petitioner offered and had admitted Petitioner's Exhibits 1 through 4 and 6 through 7. Petitioner's Exhibit 8 is the Transcript of the deposition testimony of Dr. Edgar. Petitioner's Exhibit 8 is admitted.

Respondent testified on his own behalf. Respondent offered and had admitted Respondent's Exhibits 5 through 6,[2] 8, and 10. A ruling on the admissibility of Respondent's Exhibit 9 was reserved. That exhibit is hereby rejected. Had it been admitted, it would not have supported any relevant finding of fact.

Having been unable to complete the final hearing on December 16, 2005, the hearing was continued until January 31, 2006. On that date the hearing was reconvened by video

teleconferencing between Jacksonville and Tallahassee, Florida. During this portion of the hearing, Respondent presented the testimony of William Jacobs, M.D.

The Transcript of the portion of the final hearing conducted on December 16, 2005, was filed on February 1, 2006. On February 17, 2006, the Transcript of the portion of the hearing conducted on January 31, 2006, was filed. By Notice of *Filing Transcript*, entered February 22, 2006, the parties were informed that the Transcripts had been filed and that their proposed recommended orders were to be filed on or by March 20, 2006.

Petitioner filed Petitioner's Proposed Recommended Order on March 20, 2006. Respondent filed Respondent's Proposed Recommended Order on March 21, 2006, along with Respondent's *Unopposed* Motion for One Day Extension of Time to File Proposed Recommended Order. It appearing that Petitioner has not been prejudiced by Respondent having filed his proposed order one day late, the Motion is hereby granted. The proposed orders of both parties have been fully considered in rendering this Recommended Order.

FINDINGS OF FACT

A. The Parties.

1. Petitioner, the Department of Health (hereinafter referred to as the "Department"), is the agency of the State of

Florida charged with the responsibility for the investigation and prosecution of complaints involving physicians licensed to practice medicine in Florida. § 20.43 and Chs. 456 and 458, Fla. Stat. (2005).

2. Respondent, Abbey Strauss , M.D., is, and was at the times material to this matter, a physician licensed to practice medicine in Florida, having been issued license number ME 45950. Dr. Strauss has been licensed in Florida since 1985.

3. Dr. Strauss is board-certified in psychiatry by the American Board of Psychiatry and Neurology.

4. Dr. Strauss has not previously been the subject of a license disciplinary proceeding in Florida.

5. The following description of Dr. Strauss' education and experience, contained in Respondent's Proposed Recommended Order, was uncontroverted by the evidence in this case, and is accepted as accurate:

> Respondent has significant background and experience in diagnosing and treating addiction and substance abuse issues. For instance, before becoming a physician, Respondent achieved a Master's Degree in Psychiatric Social Work from New York University in 1972. . . . As a social worker, Respondent gained significant experience in the areas of drug abuse and addiction while working for the South Carolina Department of Mental Health. Part of his duties was to set up a crisis intervention center relating to drug abuse problems. . . . He also took part in the establishment of the County Drug Abuse

> Society as a member of a committee, established by the governor of South Carolina, concerning substance abuse issues in that state. . . .
>
> Respondent graduated from the Medical University of South Carolina in 1981 and was Chief Resident at Beth Israel Medical Center in New York City. . . . His academic and clinical experience in addiction and substance abuse related issues continued. Upon completion of medical school, Respondent also taught at New York University in the areas of psychopharmacology which included issues relating to substance abuse. . . . While a psychiatric resident at Beth Israel Medical Center in New York City, Respondent gained more clinical experience in the area of addiction at Beth Israel Medical Center . . . which at that time had one of the largest addiction units in New York City. . . . Respondent treated patients at the Methadone Maintenance Clinic in New York City for dual diagnosis, i.e., people having both psychiatric and substance abuse problems. . . . Respondent has also been retained in the past to study the effects of medications, including cocaine, on behaviors.

6. Dr. Strauss is not certified in pain management or addiction medicine.

B. Patient S.R.

7. At issue in this case is Dr. Strauss' treatment of S.R., a 51-year-old male, from November 1997 through August 2002.

8. S.R. has a history of having sustained severe injuries and having received treatment for those injuries. S.R. was

injured in vehicle accidents in 1987 and 1996. He suffered a fractured pelvis, a closed-head injury, and a left-leg fracture, which required open reduction internal fixation, including the insertion of three steel screws. As a result of the leg fracture and resulting surgery, S.R.'s left leg is shorter than his right leg, causing him to walk with an antalgic gait, which, in turn puts stress on his spine. Additionally, S.R. is becoming arthritic and suffers from herniations in the lumbar and cervical spine.

9. S.R. suffers from chronic pain associated with his injuries and condition.

10. S.R. has a history of abuse and addiction to heroin and alcohol. Prior to coming under Dr. Strauss' care, S.R. had been discharged from a drug rehabilitation facility due to a relapse and had, just eight months prior to his first visit to Dr. Strauss, relapsed for alcohol abuse.

11. At the time that S.R. first saw Dr. Strauss, he was under the care of a Dr. Porter.

12. More than a year before S.R. first saw Dr. Strauss, S.R. had been treated by Joseph Alshon, D.O., who practices physical medicine and rehabilitation, for chronic pain. Among the treatments prescribed by Dr. Alshon were epidural steroid injections, trigger point injections, an exercise program, hydroculator therapy, spinal manipulations and small doses of

pain medications. According to Dr. Alshon's medical records, these treatments helped to control and alleviate S.R.'s pain.

13. S.R. had also previously been under the care of others, including a number of surgeons, who were not identified at hearing. These physicians were responsible for care given to S.R. as a result of the injuries he sustained in 1987 and 1996.

C. <u>S.R.'s First Visit to Dr. Strauss</u>.

14. On November 11, 1997, S.R. presented to Dr. Strauss' office with complaints of chronic back pain and pain of the lower extremities due to arthritis and the fracture of his left leg.

15. S.R. indicated that, but for his pain, his life was adequate and that he understood that he could not function without medications to control his pain.

16. Based upon the then used Visual Analog Scale, which involves a patient giving a subjective measure of his or her pain, with ten being the worst and zero being "without pain," S.R. told Dr. Strauss that he was a "nine" without medication and a "three or four" with medication.

17. S.R. was somewhat candid to Dr. Strauss about his prior addiction history. S.R. also expressed concern about obtaining future treatment for his chronic pain because of his past history. Dr. Strauss' notes, however, to the extent legible, only report that S.R. had been involved in Alcoholics

Anonymous for eight years, but had relapsed "8 months ago"; that he was afraid "that his addiction" history would prevent him from getting necessary medications; and that "methadone" had "worked well for pain." There is no indication in Dr. Strauss' notes what "his addiction history" was or why he was taking methadone.

18. S.R. also reported to Dr. Strauss that he was currently taking OxyContin.

19. OxyContin is a semi-synthetic opiate containing oxycodone hydrochloride, a schedule II controlled substance listed in Chapter 893, Florida Statutes. OxyContin is used to give relief from moderate to severe pain. It has a high potential for abuse, which may lead to severe physical and psychological dependence.[3]

20. Physical dependence is an expected and natural result of the use of OxyContin. See Fla. Admin. Code R. 64B8-9.013(2)(b) and (f). Physical dependence is defined in Florida Administrative Code Rule 64B8-9.013(2)(f), as follows:

> For the purpose of this rule, "physical dependence" on a controlled substance is defined as a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

21. During S.R.'s first visit Dr. Strauss diagnosed him as having "degenerative disc disease." Due to the possible adverse impact on S.R. if he did not continue to take OxyContin, Dr. Strauss prescribed two 40 mg tablets of OxyContin, to be taken twice a day. Dr. Strauss also prescribed Valium and Flexeril.

22. Valium contains diazepam, a schedule IV controlled substance listed in Chapter 893, Florida Statutes. It is used for the management of anxiety disorders and short-term relief of anxiety. Diazepam has a potential for abuse, which may lead to physical and psychological dependence.

23. Dr. Strauss did not perform a physical examination of S.R. during his first visit. Consequently, no medical record of a physical examination was made on November 11, 1997. Not having the medical records, including records of any physical examination, on November 11, 1997, of any other physician from whom S.R. was currently receiving treatment or had in the past received treatment, Dr. Strauss relied solely on S.R.'s representations as to his prior history and condition to diagnose and treat S.R. on November 11, 1997.

D. S.R.'s Continued Treatment Through August 2002.

24. After S.R.'s initial visit, Dr. Strauss saw S.R. on the following dates and prescribed the following medications:

a. December 4, 1997: four 40 mg tablets of OxyContin, to be taken twice a day, and 20 mg to be taken as needed (a total of 160 mg twice a day, plus 20 mg "as needed"), and; 2.5 mg of Valium to be taken three times a day;

b. January 2, 1998: three 80 mg tablets of OxyContin, to be taken twice a day (a total of 240 mg twice a day); and the same amount of Valium previously prescribed;

c. January 22, 1998: five 80 mg tablets of OxyContin, to be taken twice a day (a total of 400 mg twice a day);

d. Between January 22 and March 17, 1998: seven 80 mg tablets of OxyContin, to be taken twice a day (a total of 560 mg twice a day);

e. March 17, 1998: five 80 mg tablets of OxyContin, to be taken three times a day (a total of 400 mg three times a day);

f. April 9, 1998: 960 mg of OxyContin, to be taken twice a day;

g. April 27, 1998: 80 mg tablets of OxyContin, 12 tablets to be taken in the morning, six tablets at mid-day, and 12 tablets at bedtime (a total of 30 tablets or 2,400 mg a day);

h. July 30, 1998: 200 mg tablets MS Contin, 12 tablets to be taken per day. MS Contin contains morphine, a schedule II controlled substance listed in Chapter 893, Florida Statutes. It is indicated for the relief of moderate to severe pain. Morphine has a high potential for abuse, which may lead to

severe physical and psychological dependence. Dr. Strauss failed to discuss with S.R. and, as a consequence, to document any such discussion, the risks and benefits of taking MS Contin instead of OxyContin.

i. July 1998 to August 2002: 200 mg tablets MS Contin, ten to 12 tablets, to be taken two or three times a day (a total of 2,000 to 2,200 mg two or three times a day); 10 mg tablets Valium, one tablet, to be taken three times a day; and one mg tablet of Ativan, one tablet to be taken as needed. Ativan contains lorazepam, a schedule IV controlled substance listed in Chapter 893, Florida Statutes. It is indicated for management of anxiety disorders and short-term relief of anxiety. Lorazepam has a low potential for abuse. Where abuse occurs, it can lead to limited physical and psychological dependence.

E. S.R.'s Medical History.

25. Subsequent to seeing S.R. on November 11, 1997, Dr. Strauss obtained some, but not all, of S.R.'s medical records which had been created by Dr. Alshon. Apparently, Dr. Alshon was giving S.R. trigger-point injections while under Dr. Strauss' care, but Dr. Strauss did not have any medical records concerning those injections.

26. Dr. Strauss did not obtain S.R.'s medical records from Dr. Porter. Although there was argument presented at hearing to suggest that an effort was made to obtain S.R.'s medical records

from Dr. Porter, but that the effort failed because Dr. Porter was no longer in practice, the evidence failed to prove this assertion. Dr. Strauss' testimony in this regard was not convincing, especially in light of the fact that his records fail to reflect that he obtained a signed consent form from S.R. allowing him to obtain his records from Dr. Porter. More importantly, Dr. Strauss was not able to state with certainty whether any effort had been made to obtain Dr. Porter's records:

> Q. Why didn't you get Dr. Porter's records?
>
> A. As we sit here, I don't know why we didn't get them. I know that we certainly would have tried to, because it would have been illogical to get records from one doctor and not the next. I don't know when Dr. Porter went out of practice, it was a long time ago, and we were just unable to get them.

Transcript of December 16, 2005, page 197, lines 20 to 25, and page 198, line 1. In essence, Dr. Strauss merely testified about what he believed should have happened. Given the lack of signed consent from S.R. to obtain Dr. Porter's records, Dr. Strauss' testimony that it would have "illogical" to get records from one doctor and not Dr. Porter is rejected.

27. Other than Dr. Alshon's records, Dr. Strauss did not obtain any other relevant medical records, including those related to S.R.'s treatment for heroin addiction or his treatment for injuries and the surgery he had undergone prior to

his treatment by Dr. Alshon. Rather, he relied largely on Dr. Alshon's diagnosis for the cause of S.R.'s chronic pain.

F. Treatment Plan for S.R.

28. Dr. Strauss' testified at hearing that he indeed had a treatment plan, including objectives, for S.R. According to Dr. Strauss his treatment plan included, most significantly, managing S.R.'s chronic pain. He indicated that he intended to achieve this goal through increased exercise, weight control, working on improved personal relationships with, among others, his daughter, mother, father, and girl friend (whom he ultimately married), and his ability to remain employed.

29. While there are indeed references to the objectives outlined by Dr. Strauss during his testimony in his medical notes for S.R., his medical notes do not indicate the type of treatment plan, including objectives, described by Dr. Strauss at hearing. Indeed, his medical records do not include anything which could be considered a well-devised treatment plan.

30. Dr. Strauss failed to prepare a plan which included the source of S.R.'s pain, a copy of the medical records that describe and validate previous treatments of S.R., consultations with specialists which were, at a minimum, at least considered and discussed, or any consideration of how S.R.'s pain could be further controlled and alleviated. Dr. Strauss, whose primary treatment was to continue increasing the amount of pain

medication prescribed to S.R. until S.R. indicated that he was doing okay was not even reflected in Dr. Strauss's notes.

31. Dr. Strauss also failed to document the extent to which psychiatric issues were contributing to S.R.'s chronic pain, if at all. Dr. Strauss also failed to document his conclusions concerning S.R.'s character as it related to his treatment, something which Dr. Strauss did do during his testimony as to why he concluded that S.R. was not abusing his medications.

G. Special Consultations.

32. Throughout the period of S.R.'s treatment by Dr. Strauss from November 1997 to August 2002, and, most importantly, during the first few months of his treatment of S.R., Dr. Strauss did not refer S.R. to any other physician for consultation or additional diagnostic testing. The first few months of his treatment are significant because it was during this period of time that he significantly increased the dosage and frequency that S.R. was to take OxyContin.

H. Justification for S.R.'s Treatment.

33. Based upon that the fact that Dr. Strauss failed to prepare a treatment plan for S.R., to obtain all of the available medical records concerning S.R., and to refer S.R. for special consultations, Dr. Strauss did not have justification

for the rapid increase in the dose of OxyContin and MS Contin Dr. Strauss prescribed for S.R.

34. The foregoing finding is somewhat mitigated, but no less accurate, by the fact that it appears that Dr. Strauss' treatment of S.R. has been effective, with S.R. continuing in Dr. Strauss' care up to the final hearing of this matter. S.R. has been able to improve his personal relationship with his daughter and his mother and father. S.R. also married while under Dr. Strauss' care and was able to study to take a real estate broker's license test. Most significantly, after August 2002, S.R. remained on the same dosage of MS Contin for 35 months and, since then, the dosage has been reduced from 4,800 mg a day to, as of September 2005, 1,400 mg a day. These facts, however, are based upon hindsight, while the finding in paragraph 33 is based upon what Dr. Strauss knew during the time period in question when he was increasing S.R.'s medications.

I. The Standard of Care.

35. Dr. Strauss was required to practice medicine in his care of S.R. with "that level of care, skill, and treatment which is recognized by a reasonable prudent similar physician as being acceptable under similar conditions and circumstances. . . ." (hereinafter referred to as the "Standard of Care").

36. Dr. Strauss's treatment and care of S.R. as described in this Recommended Order and based upon the credited opinions

of Drs. Worden and Edgar, violated the Standard of Care as hereafter further found.

37. First, Dr. Strauss' failure to perform an adequate physical examination of S.R. during his first visit on November 11, 1997, violated the Standard of Care.

38. An adequate physical examination of S.R. during his first visit to Dr. Strauss on November 11, 1997, should have included observing S.R.'s general demeanor, his speech pattern, including whether or not he was slurring his words, whether he looked overdosed, and the manner in which he walked, including noting whether he evidenced any limp or whether he favored any part of his body. An adequate physical examination should also have included the performance of neurological tests, such as reflex testing and/or straight-leg testing.

39. The purpose for performing and recording a physical examination on the first visit of a patient is to make sure that the patient's description of his or her complaints are corroborated to the greatest extent possible. Additionally, a physical examination may even help the treating physician to discover problems which the patient may not be aware of and other physicians overlooked.

40. Performing a physical examination was crucial on S.R.'s first visit.[4] S.R. was complaining of chronic pain, admitted having a previous history of drug abuse, and expressed

a concern about obtaining continuing medical care for his pain. As noted in Respondent's Proposed Recommended Order "[t]here is no way to objectively measure pain. . . ." Therefore the physician must "rely on the subjective complaints of pain by the patient." While this is true, given the circumstances of this case, Dr. Strauss was obligated to perform a physical examination of S.R. rather than relying solely on S.R.'s subjective complaints to prescribe OxyContin and Valium, both controlled substances.

41. At hearing, Dr. Strauss and Dr. Jacobs both suggested that "psychiatrist" by and large do not perform physical examinations. Both suggested that this practice is common and that it is within the Standard of Care for psychiatrist to rely upon the physical examination findings of other physicians. This testimony is rejected. First, Dr. Strauss was not simply providing psychiatric care to S.R; he was also treating him for chronic pain. Secondly, and more importantly, Dr. Strauss did not have any medical records reflecting any physical examination for S.R. during his first visit on November 11, 1997, a visit for which he prescribed OxyContin.

42. Secondly, Dr. Strauss violated the Standard of Care by failing to make a treatment plan with objectives for S.R. While Dr. Strauss testified at hearing as to what he believed his plan was, he should have created a written treatment plan, setting

out objectives, and identifying the sources of S.R.'s pain, the medical records that documented and validated treatment by previous physicians, consultations to evaluate how S.R. was feeling, and specifically how S.R.'s pain could be further controlled and alleviated. An adequate plan should have also included the discussion of whether any psychiatric issues were contributing to S.R.'s condition; a description of S.R.'s character as it related to any attempt on S.R.'s part to obtain medications, which were more than he needed to control his pain, his social situation, and any stresses S.R. was experiencing.

43. Thirdly, Dr. Strauss violated the Standard of Care by failing to adequately justify the changes in the medications and dosages/frequency of those medications. This finding is based upon Dr. Strauss' failure to prepare a treatment plan for S.R., to obtain all of the available medical records concerning S.R., and to refer S.R. for special consultations.

44. Finally, Dr. Strauss violated the Standard of Care by failing to use specialized consultations for diagnosis and/or treatment of S.R.

45. Given S.R.'s prior addiction history, the lack of a physical examination, and the lack of S.R.'s medical records other than those of Dr. Alshon, Dr. Strauss should have referred S.R. to a physician specializing in addiction medicine.

Dr. Strauss's treatment of S.R. without referral, although with

perfect 20-20 hindsight treatment that turned out to be beneficial to S.R., relied too heavily on what S.R. told him and the assumption, uncorroborated at the time by Dr. Strauss, that there was nothing except Dr. Strauss' course of treatment that would work. Without a physical examination and thorough medical records, Dr. Strauss lacked adequate reliable information to conclude that a referral to a pain management specialist or an expert in addictive medicine would not benefit S.R.

J. Medical Records.

46. Dr. Strauss' notes, especially in light of the more detailed explanation of his treatment of S.R. provided at hearing, lack the kind of specificity necessary to justify his treatment of S.R.

47. Dr. Strauss' notes also do not memorialize any regular review of S.R.'s medical needs that Dr. Strauss performed. Such a review should have included documentation of how S.R. was being monitored to determine whether he was actually taking the medications prescribed for him, including the results of drug urinalysis testing.

48. Regular reviews should have also noted whether S.R. was suffering any specific side effects to the medications he was taking. Simply stating that S.R. reported "no side effects" was inadequate. Dr. Strauss should have noted, especially when increasing the dosage of OxyContin and MS Contin, and when

changing his medication to MS Contin, that he had thoroughly discussed the side effects of the drugs and that S.R. was not experiencing those side effects.

49. Dr. Strauss' notes also failed to reflect that he had discussed with S.R. the dangers of taking OxyContin or MS Contin other than as prescribed. Although the number of occasions when S.R. took more medication than prescribed were few and S.R. apparently candidly reported these incidents to Dr. Strauss, Dr. Strauss still should made sure S.R. understood the hazards associated with increasing the dosage on his own. This is especially true given S.R.'s past abuse history and the other shortcomings between November 1997 and August 2002 of Dr. Strauss' treatment of S.R. noted in this Recommended Order.

50. Without the detailed medical notes and recorded periodic reviews Dr. Strauss should have made, it appears from the medical records that it was S.R.'s subjective complaints that controlled and formed the basis for the decisions made concerning his treatment with OxyContin and MS Contin.

CONCLUSIONS OF LAW

A. Jurisdiction.

51. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569, 120.57(1), and 456.073(5), Florida Statutes (2005).

B. The Charges of the Administrative Complaint.

52. Section 458.331(1), Florida Statutes, authorizes the Board of Medicine (hereinafter referred to as the "Board"), to impose penalties ranging from the issuance of a letter of concern to revocation of a physician's license to practice medicine in Florida if a physician commits one or more acts specified therein.

53. In its First Amended Administrative Complaint in this case, the Department has alleged that Dr. Strauss has violated Section 458.331(1)(m), (q), and (t), Florida Statutes.

C. The Burden and Standard of Proof.

54. The Department seeks to impose penalties against Dr. Strauss through the First Amended Administrative Complaint that include suspension or revocation of his license and/or the imposition of an administrative fine. Therefore, the Department has the burden of proving the specific allegations of fact that support its charge that Dr. Strauss violated Section 458.331(1)(m), (q), and (t), Florida Statutes, by clear and convincing evidence. Department of Banking and Finance, Division of Securities and Investor Protection v. Osborne Stern and Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Pou v. Department of Insurance and Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998); and Section 120.57(1)(j), Florida Statutes (2005)("Findings of fact shall be

based on a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute.").

55. What constitutes "clear and convincing" evidence was described by the court in Evans Packing Co. v. Department of Agriculture and Consumer Services, 550 So. 2d 112, 116, n. 5 (Fla. 1st DCA 1989), as follows:

> . . . [C]lear 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 evidence must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact the firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

See also In re Graziano, 696 So. 2d 744 (Fla. 1997); In re Davey, 645 So. 2d 398 (Fla. 1994); and Walker v. Florida Department of Business and Professional Regulation, 705 So. 2d 652 (Fla. 5th DCA 1998)(Sharp, J., dissenting).

D. Count One: Section 458.331(1)(t), Florida Statutes; The Standard of Care.

56. In Count One of the First Amended Administrative Complaint it is alleged that Dr. Strauss violated Section

458.331(1)(t), Florida Statutes (2001), which defines the following disciplinable offense:

> (t) . . . [T]he 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. . . .

57. The Department has alleged that Dr. Strauss violated the Standard of Care in "one or more of the following ways":

> a) by failing to perform an adequate physical examination for Patient S.R. during his first visit;
>
> b) By failing to make a treatment plan with objectives;
>
> c) by failing to justify changes in medications, dosages or frequency; or
>
> d) by failing to use specialized consultations for diagnosis and/or treatment.

58. The evidence has clearly and convincingly proved that Dr. Strauss has violated the Standard of Care as alleged in the First Amended Administrative Complaint.

E. Count Two: Section 458.331(1)(m), Florida Statutes; Medical Records.

59. In Count two of the First Amended Administrative Complaint it is alleged that Dr. Strauss violated Section 458.331(1)(m), Florida Statutes, which defines the following disciplinable offense:

(m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

60. The First Amended Administrative Complaint alleges that Dr. Strauss' medical records were inadequate because he failed to keep legible medical records that justify the course of treatment of Patient S.R. in one or more of the following ways:

a) by failing to record or inadequately recording a physical examination during Patient S.R.'s first visit;

b) by failing to make detailed notes and perform regular reviews of patient needs; or

c) by failing to document a complete and proper history of Patient S.R.

61. Obviously, having failed to perform a physical examination during S.R.'s first visit, Dr. Strauss failed to record one. He also failed to make the kind of detailed notes, including memoralizing regular reviews, necessary to justify the course of medication treatment prescribed for S.R. Finally,

Dr. Strauss' medical history of S.R. was inadequate. It is, therefore, concluded that Dr. Strauss failed to keep adequate medical records in violation of Section 458.331(1)(m), Florida Statutes.

F. Count Three: Section 458.331(1)(q), Florida Statutes; Legend Drugs.

62. In Count Three of the First Amended Administrative Complaint it is alleged that Dr. Strauss violated Section 458.331(1)(q), Florida Statutes, which defines the following disciplinable offense:

> (q) 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 or her intent.

63. The Administrative Complaint alleges that Dr. Strauss violated Section 458.331(1)(q), Florida Statutes, with regard to Patient S.R. in that he

> prescribed OxyContin, MS Contin, Valium and Ativan, all controlled substances, to S.R. inappropriately or in excessive or inappropriate quantities, in that Respondent

> prescribed controlled substances without medical justification, in quantities which endangered the patient's health, and were not in the best interest of the patient and in a manner not in the course of the physician's professional practice.

64. Although the evidence proved that Dr. Strauss used controlled substances to treat S.R. "in the course of the physician's professional practice," given the definition of Section 458.331(1)(q), Florida Statutes, and the findings of this Recommended Order, the Department proved that Dr. Strauss violated Section 458.331(1)(q), Florida Statutes.

G. The Appropriate Penalty.

65. In determining the appropriate punitive action to recommend to the Board in this case, it is necessary to consult the Board's "disciplinary guidelines," which impose restrictions and limitations on the exercise of the Board's disciplinary authority under Section 458.331, Florida Statutes. See Parrot Heads, Inc. v. Department of Business and Professional Regulation, 741 So. 2d 1231 (Fla. 5th DCA 1999).

66. The Board's guidelines are set out in Florida Administrative Code Rule 64B8-8.001, which provides the following "purpose" and instruction on the application of the penalty ranges provided in the Rule:

> (1) Purpose. Pursuant to Section 456.079, F.S., the Board provides within this rule disciplinary guidelines which shall be imposed upon applicants or

licensees whom it regulates under Chapter 458, F.S. The purpose of this rule is to notify applicants and licensees of the ranges of penalties which will routinely be imposed unless the Board finds it necessary to deviate from the guidelines for the stated reasons given within this rule. The ranges of penalties provided below are based upon a single count violation of each provision listed; multiple counts of the violated provisions or a combination of the violations may result in a higher penalty than that for a single, isolated violation. Each range includes the lowest and highest penalty and all penalties falling between. The purposes of the imposition of discipline are to punish the applicants or licensees for violations and to deter them from future violations; to offer opportunities for rehabilitation, when appropriate; and to deter other applicants or licensees from violations.

(2) Violations and Range of Penalties. In imposing discipline upon applicants and licensees, in proceedings pursuant to Section 120.57(1) and 120.57(2), F.S., the Board shall act in accordance with the following disciplinary guidelines and shall impose a penalty within the range corresponding to the violations set forth below. The verbal identification of offenses are descriptive only; the full language of each statutory provision cited must be consulted in order to determine the conduct included.

67. Florida Administrative Code Rule 64B8-8.001(2), goes on to provide, in pertinent part, the following penalty guidelines for the violations proved in this case:

a. For a violation of Section 458.331(1)(m), Florida Statutes, a range of relevant penalties from a reprimand to two

years' suspension followed by probation, and an administrative fine from $1,000.00 to $10,000.00;

b. For a violation of Section 458.331(1)(q), Florida Statutes, a range of relevant penalties from a one-year probation to revocation, and an administrative fine from $1,000.00 to $10,000.00; and

c. For a violation of Section 458.331(1)(t), Florida Statutes, a range of relevant penalties from two years' probation to revocation, and an administrative fine from $1,000.00 to $10,000.00.

68. Florida Administrative Code Rule 64B8-8.001(3) provides that, in applying the penalty guidelines, the following aggravating and mitigating circumstances are to be taken into account:

> (3) Aggravating and Mitigating Circumstances. Based upon consideration of aggravating and mitigating factors present in an individual case, the Board may deviate from the penalties recommended above. The Board shall consider as aggravating or mitigating factors the following:
>
> (a) Exposure of patient or public to injury or potential injury, physical or otherwise: none, slight, severe, or death;
>
> (b) Legal status at the time of the offense: no restraints, or legal constraints;
>
> (c) The number of counts or separate offenses established;
>
> (d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;

(e) The disciplinary history of the applicant or licensee in any jurisdiction and the length of practice;
(f) Pecuniary benefit or self-gain inuring to the applicant or licensee;
(g) The involvement in any violation of Section 458.331, Florida Statutes, of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure;
(h) Any other relevant mitigating factors.

69. In its Proposed Recommended Order, the Department has requested that it be recommended that the following discipline be imposed upon Dr. Strauss' license:

a. A letter of concern;
b. An administrative fine of $15,000.00;
c. Continuing education classes in the amount and nature to be specified by the Board;
d. Fifty (50) hours of community service

70. Having carefully considered the facts of this matter in light of the provisions of Florida Administrative Code Rule 64B8-8.001, it is concluded that the Department's suggested penalty, without the fifty hours of community service, is reasonable. No explanation of why Dr. Strauss should be required to provide community service has been given by the Department, and the facts do not support such discipline.

RECOMMENDATION

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

RECOMMENDED that the a final order be entered by the Board of Medicine finding that Abbey Strauss, M.D., has violated Section 458.331(1)(m), (q), and (t), Florida Statutes, as described in this Recommended Order; issuing him a letter of concern; requiring that he pay an administrative fine of $15,000.00; and requiring that he attend continuing education classes in an amount and of a nature to be determined by the Board.

DONE AND ENTERED this 26th day of April, 2006, in Tallahassee, Leon County, Florida.

LARRY J. SARTIN
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 26th day of April, 2006.

ENDNOTES

1/ The substantive definitions of wrong-doing contained in Section 458.331(1)(m), (q), and (t), Florida Statutes (1997 through 2002), did not change appreciably. Therefore, references to the year of the statute will be excluded from further citations of those provisions.

[2]/ The Transcript of the December 16, 2005, hearing, at line 22, page 3, incorrectly identifies "Petitioner's" Exhibit 6 being addressed at page 28 of the Transcript. At line 17, page 28, it is Respondent's Exhibit 6 that is admitted.

[3]/ The evidence in this case failed to prove that S.R., at any time during Dr. Strauss' treatment, was addicted to, or abusing OxyContin or any other drug. Petitioner's suggested Finding of Fact number 10, that "[a]t the time Respondent was treating Patient S.R., Patient S.R. may have been addicted and abusing the pain medication that was being prescribed to him by the Respondent" is rejected as too speculative and not supported by the weight of the evidence.

[4]/ There was also evidence presented at hearing as to the need to continue to conduct physical examinations of S.R. on subsequent visits. The First Amended Administrative Complaint does not allege, however, that the failure to conduct subsequent physical examinations constituted a violation of Section 458.331(1)(t), Florida Statutes.

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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 these cases.

Fax Message From:

May 16 2006 10:22

Name:
Fax Number:

Jeb Bush
Governor

M. Rony François, M.D., M.S.P.H., Ph.D.
Secretary

FAX COVERSHEET

TO: Crystal List, Board of Medicine

FROM: Kathryn Therrien, Prosecution Services Unit

RE: Rosenthal – Supplemental Correspondence from Respondent

DATE: May 16, 2006

NUMBER OF PAGES: 11
INCLUDING COVER SHEET

CONTACT PERSON: Kathryn S. Therrien

COMMENTS: Let me know if all the pages don't come through. (850) 245-4444 (ext. 8115). Thanks. ☺

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Kathryn S. Therrien – (850) 245-4444 (ext. 8115)

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DEPUTY CLERK
CLERK [signature]
DATE 5-9-06

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE

Petitioner,

v.

ABBEY STRAUSS, M.D.,

Respondent.

CASE NO: 05-3646PL

Dept. Of Health Case No: 2002-15730

RESPONDENT'S EXCEPTIONS TO RECOMMENDED ORDER

Respondent, ABBEY STRAUSS, M.D, hereby files his Exceptions to Recommended Order entered April 26, 2006 in the above-referenced cause and states as follows:

I. Background information and statement of the case.

This matter concerns the treatment of a patient for chronic pain. Although the filing of the Administrative Complaint did not take place until October, 2005, the treatment under review took place between November, 1997 and the summer of 2002. Despite the fact that the patient has continued under Respondent's care through the hearing date, Petitioner never addressed the treatment rendered after the summer of 2002.

As shown by paragraphs 7, 8 of the Recommended Order, the patient came to Respondent in November, 1997 for treatment of chronic pain due to two severe motor vehicle accidents that took place in 1987 and 1996. As a result, as indicated in paragraph 8 of the Recommended Order and the record, the 1987 accident resulted in the patient suffering a fractured pelvis , closed head injury, left leg fracture which required open reduction and internal fixation with hardware. As a result of that surgery the left leg was shorter than the right which caused the patient to walk with an antalgic gait which in turn put significant stress on the spine. The patient was arthritic due to the injuries and surgery and further suffered from herniated discs at the lumbar and cervical level. As shown by the Recommended Order, Respondent treated the patient by avoiding invasive procedures such as trigger point and epidural steroid injections and by prescribing opioid medication, Oxycontin, then changing to MS Contin, for effective chronic pain control. He also prescribed Valium and Ativan for the

effective control of the chronic pain..

The patient's prior treating physician, Dr. Alshon, began treating the patient for chronic pain from 1995 into 1997. See Respondent's medical records attached to the record as Petitioners Ex. 7. As shown by Exhibit 7, Respondent obtained 1 ½ years of Dr Alshon's records, which equated to 19 visits. Those records showed that Dr. Alshon had administered to the patient approximately 19 trigger point and epidural steroid injections, 8 different medications for pain, giving a total of approximately 13 prescriptions, again, all in the space of 19 visits. As shown by the records, these invasive procedures had only minimal, short term relief. Those records also show that other treatment modalities were attempted by Dr. Alshon or others to no effective avail. (See paragraph 12 of the Recommended Order). In addition to these records, Petitioner's Exhibit 7 shows that Respondent obtained various physical rehabilitation records from 1987 from Pinecrest Hospital. In addition, Respondent's chart also contains radiology records from Pinecrest Hospital from 1987, Boca Raton Community Hospital from 1995, Concept Medical Diagnostic Center from 1997. (See Respondent's Exhibit 10 attached to the record and admitted into evidence.) The medical records in Dr. Strauss' possession when treating the patient irrefutably establish, by objective evidence, permanent and debilitating injuries, multiple pain generators and chronic pain suffered by the patient for years.

Respondent submits that the Recommended Order that Respondent violated of §§ 458.331(1)(m), (q), and (t) must be rejected by the Department for the following reasons: (1) The Recommended Order ignores the policies and principles expressed in Fla. Admin. Code § 64B8-9.013, Standards for the Use of Controlled Substances for the Treatment of Pain; (2) the Petitioner, as shown by the record, failed to prove the allegations in the First Administrative Complaint by clear and convincing evidence that Respondent violated of §§ 458.331(1)(m), (q), and (t) , *Heburn v. Dept. of Children & Families*, 772 So.2d 561 (Fla. 1st DCA 2000, or the findings of fact and conclusions of law are not supported by competent substantial evidence; and, (3) the ALJ's rulings depart from the essential requirements of the law.

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I. The Recommended Order ignores and fails to apply the policies and principles expressed in Fla. Admin. Code § 64B8-9.013, Standards for the Use of Controlled Substances for the Treatment of Pain.

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Paragraph 34 of the Recommended Order expressly states that Dr. Strauss' treatment of the patient "has been effective...". According to the order at paragraph 34, while under Dr. Strauss' care, the patient was able to improve his personal relationship with his daughter, mother and father, was able to marry, and was able to study for his real estate broker's license. Further, according to the order at paragraph 34, an effective balance of pain control was established as the patient remained on the same dosage of MS Contin for 35 months and following that, Dr. Strauss based on the effectiveness of the treatment was able to reduce the dose of MS Contin from 4800 mg per day to 1400 mg per day and maintain effective control of the chronic pain.

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Fla. Admin. Code 64B8-9.013(1)(f) expressly states that "***The physician's conduct will be evaluated to a great extent** by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized as appropriate for the diagnosis, the patient's individual needs including any improvement in functioning, and recognizing that some types of pain cannot be completely relieved.*" Subsection (1)(g) of that code further states: "*The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social, and work- related factors.*" Subsection (1)(c) provides that: "*Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain.*" That subsection further provides that "*Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.*"

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Although paragraph 34 of the Recommended Order establishes that these principles were achieved, the subject Recommended Order fails to even mention the policies and principles of the Fla. Admin. Code referenced above. There is no indication in the Order that the ALJ even considered them notwithstanding that they are the principles upon which the "physician's conduct will be evaluated." The Respondent met the above-referenced primary policies and principles of Fla. Admin. Code 64B-9.013 by clear and convincing evidence but the ALJ failed to apply those policies and

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principles properly. As a result, the Recommended Order should properly be rejected. This matter now involves a situation where a chronic pain patient was treated successfully, his pain controlled, his function and every day capabilities optimized, his inter-personal relationships stabilized, yet the physician who accomplished this where others failed is being punished. Respondent's chart on this patient clearly establishes, and as the ALJ's finding in paragraph 12 of the Recommended reveals, this patient presented as one who suffered with chronic pain for years due to multiple pain generators as a result of a severe motor vehicle accident in 1987 which caused permanent injury; who walked with a limp due to a prior failed surgery; who in the past had attempted various treatment modalities and invasive injections to no avail; who had difficulty functioning in a work related environment and had unstable inter-personal relationships. According to the record and the findings of the ALJ, Dr. Strauss was the only physician to successfully treat this patient in the areas of pain control, function and relationships.

II. The ALJ departed from the essential requirements of the law and the Recommended Order is not supported by clear and convincing evidence or competent substantial evidence.

At page 4 of the Recommended Order, the ALJ accepts Dr. James Edgar as an expert in pain medicine and pain management. Dr. Edgar's testimony was by deposition and admitted into evidence over objection as Petitioner's Exhibit 8 to the record. The ALJ expressly relies on the opinions of Dr. Edgar in finding against the Respondent. (See paragraph 33 of the Recommended Order). Accepting Dr. Edgar as an "expert in pain medicine and pain management" departs from the essential requirements of the law.

It is well settled Florida law that an expert witness may only testify in his or her area of expertise. *Gilliam v. State*, 514 So.2d 1098, 1100 (Fla. 1987)(medical examiner admitted that she did not hold herself out as an expert on shoe pattern evidence and her testimony on shoe pattern evidence should not have been allowed). In the subject case, Dr. Edgar admitted at deposition that he does not hold himself out as an expert in the treatment of pain or addiction. (Exhibit 8 at pg. 22, lines 17-22). Although Dr. Edgar states that he is "as qualified as anyone to evaluate a case being

treated for pain", that is a self serving, huge exaggeration and inconsistent with the clear facts. Dr. Edgar holds no board certification or added qualifications in pain management. (Exhibit 8 at pg. 19). He has never taken any examination for board certification in pain management. (Exhibit 8 at pg. 20). He does not know if there is an added qualification for pain management through the American Board of Psychiatry and Neurology. (Exhibit 8 at pg. 20). He is does not know what other organizations give certifications in pain management. (*Id.*). He is not a member of any pain management organization. (*Id.*). He does not know what organizations or societies are in existence relating to pain management. (*Id.* at pgs. 20-21). Dr. Edgar does not know how one would go about obtaining board certification or added qualifications in pain management. (Exhibit 8 at pg. 22). Dr. Edgar has never published or authored any writings relating to pain treatment (*Id.* at pg. 22, 23). He has never taught any seminars or lectured in pain treatment. (*Id.* at pg. 25). There is no evidence in the record that Dr. Edgar ever attended any seminar, lecture or other conference in relation to pain management. Dr. Edgar prefers to refer any pain patient to a pain clinic for treatment "if given the opportunity". (*Id.* at pg. 24). Although he claims to treat pain patients, there is no evidence in the record that he has any experience in prescribing or administering opioid pain medication. Rather, he has only prescribed "codeine", and when asked what he prescribed for the only two pain patients he purportedly has treated in the past two years, he stated that: "I don't know. Codeine perhaps. That's all that comes to mind." (*Id.* at pg. 28). Dr. Edgar did not know what the upper limit is for Oxycontin or MS Contin. (*Id.* at pg. 87). Perhaps that is because there simply is no upper dose limit referenced in the PDR, but Dr. Edgar did not know that either. Dr. Edgar could not testify as to what the appropriate dose of opioid was for this patient. (*Id.* at pg. 86). Dr. Edgar did not even have an up to date PDR for reference in his office. The deposition was taken on November 11, 2005 and the only PDR Dr. Edgar had available at his office was from year 2000. (*Id.* at 87-88).

Despite the complete lack of requisite qualifications and knowledge that one would certainly expect an "expert" in pain management to know, Dr. Edgar was completely unfamiliar with a fundamental and essential concept in pain treatment which is expressly referenced and defined in Fla.

Admin. Code 64B-9.013(2)(g). That fundamental concept is "pseudoaddiction". Dr. Edgar testified that he had never heard the term "pseudoaddiction". (*Id.* at pg. 30, lines 11-13). That term is defined as "a pattern of drug seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction." Dr. Edgar should not have been accepted as an "expert" in pain management and pain medicine in that he admits that he does not hold himself out as an expert in the field, completely lacks the qualifications and is completely unfamiliar with a fundamental and essential concept in pain medicine. *Gilliam v. State*, 514 So.2d 1098, 1100 (Fla. 1987). As such, the ALJ departed from the essential requirements of the law. Since the ALJ relied upon the opinions of Dr. Edgar as an expert in pain management as shown by paragraph 36 of the Recommended Order in coming to his conclusions, and the order does not differentiate upon what he relied from Dr. Edgar, the Recommended Order should properly be rejected.

Further, Petitioner stipulated that it was offering Dr. Edgar as an expert only from the aspect of psychiatry, not pain medicine. On December 1, 2005, Respondent filed a Motion to Strike Expert/Motion to Limit Experts/Motion to Compel Better Answers to Interrogatories. That Motion asserted, *inter alia*, that the addition of Dr. Worden as an expert by the Petitioner would simply be cumulative to the opinions of Dr. Edgar. In paragraph 7 of its response dated December 5, 2005, Petitioner stated that Dr. Edgar was board certified in psychiatry and will testify from the aspect of a psychiatrist while Dr. Worden would testify against Respondent from a pain management point of view. Thus, Petitioner stipulated that it was not offering Dr. Edgar as an expert in pain management, but rather as a psychiatric expert. However, the ALJ did not accept Dr. Edgar as an expert in psychiatry but rather an expert in pain management and pain medicine.

Paragraphs 44 and 45 of the Recommended Order criticize Respondent for not referring the patient to an addictionologist. This finding is inconsistent with Footnote 3 in which the ALJ determined that there was no evidence that the patient was abusing or addicted to any medication while under Respondent's care. The ALJ further accepted Respondent at paragraph 5 as having significant education and experience in diagnosing and treating addiction and substance abuse. Given

that the ALJ accepted Respondent's credentials in the area of evaluation of addiction and substance abuse issues, and given that the ALJ found that the patient was not abusing or addicted to any drug during Respondent's treatment, the conclusion that Respondent breached standard of care by failing to refer the patient to an addictionologist is simply not substantiated by the record and must be rejected. These findings completely undermine the need to refer the patient.

For the same reasoning, the criticism in paragraph 45 that Respondent should have referred the patient to a pain specialist is also unfounded and is inconsistent with the ALJ's finding that Dr. Strauss' treatment was successful in treating the pain which undermines the need to refer the patient to another pain specialist.

Paragraphs 25 through 27, 33 of the Recommended Order criticize Respondent for purportedly not having "all available medical records" concerning the patient. However, the finding by the ALJ in paragraph 34 of the Recommended Order establishes by clear and convincing evidence that Respondent had more than enough medical records from other physicians to both verify the patients claims and successfully treat the patient.

The Recommended Order finds Respondent in violation for prescribing and administering as well as standard of care with respect to the Ativan and Valium. (See paragraph 63 of the Recommended Order). First, both of Petitioner's experts agreed that they had no criticism of Respondent with respect to the Ativan. (See Petitioner's Exhibit 8 at pg. 95; December 16, 2005 record at pg. 134). Therefore, how can the ALJ possibly find against Respondent with respect to the Ativan where there was no testimony supporting same? There was simply no competent evidence on this issue against the Respondent and the Recommended Order must be rejected.

Further, Petitioner's expert, Dr. Worden, testified at hearing that he had no criticism of Respondent with respect to the Valium. (December 16, 2005 record at pg. 134). Dr. Edgar did criticize Respondent with respect to Valium. Where Petitioner's own experts disagreed with respect to the Valium, it defies logic that there can be a finding by clear and convincing evidence unless one of Petitioner's expert's opinions were completely rejected. However, the Recommended Order

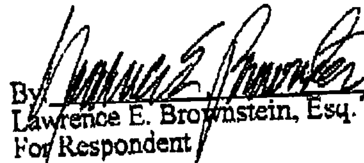
makes no mention that any opinion of Petitioner's experts was rejected. Thus, the Recommended Order with respect to this issue must be rejected.

Finally, the Recommended Order criticizes Respondent with respect to noting in the records that the patient was experiencing no side effects. (See paragraph 48 of the Recommended Order). As shown by Respondent's medical chart, he would write down "no side effects", establishing that he did frequently throughout treatment discuss side effects with the patient who was denying the existence of any side effects. According to the ALJ, that is not good enough. The Recommended Order provides that Respondent should have noted while adjusting the dosage of medication that he discussed side effects and the patient was not experiencing them. (*Id.*) There was no criticism in the record of the purported failure to "discuss" side effects with the patient. On the contrary, Respondent frequently referenced in the chart "no side effects" which clearly indicates that he was discussing side effect issues with the patient. Thus, there is no substantial competent evidence in the record to support this finding.

Based on the foregoing facts and legal authority, Respondent, ABBEY STRAUSS, M.D., respectfully submits that the Recommended Order dated April 26, 2006 should properly be rejected.

Respectfully Submitted,

Law Offices
LAWRENCE E. BROWNSTEIN
Northbridge Centre
515 N. Flagler Drive, Suite 300-Pavilion
West Palm Beach, Florida 33401



By Lawrence E. Brownstein, Esq.
For Respondent

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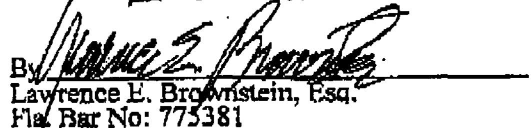
CERTIFICATE of SERVICE

I HEREBY CERTIFY that the foregoing was served via facsimile and US mail to: J. Blake Hunter, Esq., DOH- Prosecution Services Unit, 4052 Bald Cypress Way-Bin C-65, Tallahassee, Fla. 32399-3265.

Dated this 9th day of May, 2006



By: ____
Lawrence E. Brownstein, Esq.
Fla Bar No: 775381

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FILED
DEPARTMENT OF HEALTH
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CLERK Theresa McKown
DATE 4-28-06

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,

Petitioner,

v.

DOAH CASE NO. 05-3646PL
DOH CASE NO. 2002-15730

ABBEY STRAUSS, M.D.,

Respondent.

______________________________/

MOTION TO ASSESS COSTS
IN ACCORDANCE WITH SECTION 456.072(4), FLORIDA STATUTES

COMES NOW the Department of Health, by and through undersigned counsel, and moves the Board of Medicine for the entry of a Final Order assessing costs against the Respondent for the investigation and prosecution of this case in accordance with Section 456.072(4), Florida Statutes. As grounds therefore, the Petitioner states the following:

1. At its next regularly scheduled meeting, the Board of Medicine will take up for consideration the above-styled disciplinary action and will enter a Final Order therein.

2. Section 455.624(3), Florida Statutes (1997), the statute authorizing the assessment of costs that was effective on the date this incident occurred, excluded costs for attorney's time. Therefore, the Petitioner seeks an assessment of costs against the Respondent in the amount of six thousand seven hundred seventy-four

dollars and ten cents ($6,774.10), which excludes the costs associated with attorney time.

3. The investigation and prosecution of this case has resulted in costs in the total amount of six thousand seven hundred seventy-four dollars and ten cents ($6,774.10) based on the following itemized statement of costs:

a. Total costs for Complaints $82.31
b. Total costs for Investigations $921.79
c. Total costs for Legal $25,369.60
(costs associated with attorneys' time)
d. Receipted Expenditures $5,770.00

Therefore, the Petitioner seeks an assessment of costs against the Respondent in the amount of six thousand seven hundred seventy-four dollars and ten cents ($6,774.10), as evidenced in the attached affidavit. (Exhibit A).

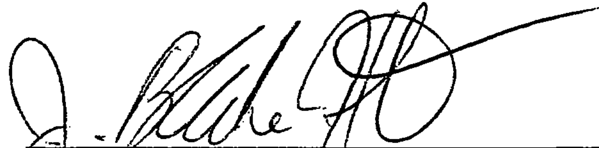
4. Should the Respondent file written objections to the assessment of costs, within ten (10) days of the date of this motion, specifying the grounds for the objections and the specific elements of the costs to which the objections are made, the Petitioner requests that the Board determine the amount of costs to be assessed based upon its consideration of the affidavit attached as Exhibit A and any timely-filed written objections.

5. Petitioner requests that the Board grant this motion and assess costs in the amount of six thousand seven hundred seventy-four dollars and ten cents ($6,774.10), as supported by competent, substantial evidence. This assessment of costs is in addition to any other discipline imposed by the Board and is in accordance

with Section 456.072(4), Florida Statutes and Section 455.624(3), Florida Statutes (1997).

WHEREFORE, the Department of Health requests that the Board of Medicine enter a Final Order assessing costs against the Respondent in the amount of six thousand seven hundred seventy-four dollars and ten cents ($6,774.10).

Respectfully submitted,



J. Blake Hunter, Assistant General Counsel
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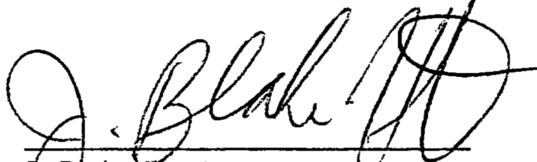
Tallahassee, FL 32317-4229
(850) 245-4640, ext. 8114
(850) 245-4682 FAX

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished via: ☑ postage-paid U.S. Mail, ☐ Hand-Delivery, ☐ E-mail and/or ☐ Facsimile Transmission to Lawrence Brownstein, Northbridge Centre, 515 N. Flagler Drive, Suite 300-Pavilion, West Palm Beach, Florida 33401, this 27th day of April, 2006.



J. Blake Hunter
Assistant General Counsel

AFFIDAVIT OF FEES AND COSTS EXPENDED

STATE OF FLORIDA
COUNTY OF LEON:

BEFORE ME, the undersigned authority, personally appeared **JAMES R. COOKSEY**, who was sworn and states as follows:

1) My name is James R. Cooksey.

2) I am over the age of 18, competent to testify, and make this affidavit upon my own personal knowledge and after review of the records at the Florida Department of Health (DOH).

3) I am a Operations Management Consultant for the Consumer Services Unit for DOH. The Consumer Services Unit is where all complaints against Florida health care licensees (e.g., medical doctors, dentists, nurses, respiratory therapists) are officially filed. I have been in my current job position for more than one year. My business address is 4052 Bald Cypress Way, Bin C-75, Tallahassee, Florida 32399.

4) As a Operations Management Consultant, my job duties include reviewing data in the Time Tracking System and verifying that the amounts correspond. The Time Tracking System is a computer program which records and tracks DOH's costs regarding the investigation and prosecution of cases against Florida health care licensees.

5) As of today, DOH's total costs for investigating and prosecuting DOH case number **2002-15730** (Department of Health V. **ABBEY STRAUSS, M.D.**) are **THIRTY-FIVE THOUSAND SIX HUNDRED NINE DOLLARS AND EIGHTY-SEVEN CENTS ($35,609.87)**

6) The costs for DOH case number **2002-15730 (**Department of Health v. **ABBEY STRAUSS, M.D.)** are summarized in Exhibit 1 (Cost Summary Report), which is attached to this document.

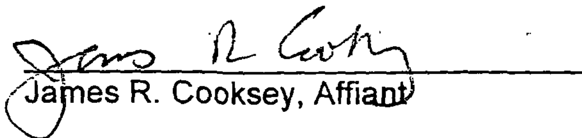
7) The itemized costs and expenses for DOH case number **2002-15730** Department of Health v. **ABBEY STRAUSS, M.D.)** are detailed in Exhibit 2 (Itemized Cost Report and Itemized Expense Report and receipts), which is attached to this document.

8) The itemized costs as reflected in Exhibit 2 are determined by the following method: DOH employees who work on cases daily are to keep track of their time in six-minute increments (e.g., investigators and lawyers). A designated DOH employee in the Consumer Services

Unit, Legal Department, and in each area office, inputs the time worked and expenses spent into the Time Tracking System. Time and expenses are charged against a state health care Board (e.g., Florida Board of Medicine, Florida Board of Dentistry, Florida Board of Osteopathic Medicine), and/or a case. If no Board or case can be charged, then the time and expenses are charged as administrative time. The hourly rate of each employee is calculated by formulas established by the Department. (See the Itemized Cost Report)

9) James R. Cooksey, first being duly sworn, states that he has read the foregoing Affidavit and its attachments and the statements contained therein are true and correct to the best of his knowledge and belief.

FURTHER AFFIANT SAYETH NOT.



James R. Cooksey, Affiant

State of Florida
County of Leon

Sworn to and subscribed before me this 27 day of April, 2006, by James R. Cooksey, who is personally known to me.

Notary Signature

Mirabel Davis
MY COMMISSION # DD221102 EXPIRES
September 7, 2007
BONDED THRU TROY FAIN INSURANCE, INC.

MIRABEL DAVIS

Name of Notary Printed

Stamp Commissioned Name of Notary Public:

Complaint Cost Summary

Complaint Number:200215730

Complainant's Name: DEPARTMENT OF INSURANCE

Subject's Name: ABBEY STRAUSS

	***** Cost to Date *****	
	Hours	Costs
Complaint:	0.90	$38.99
Investigation:	20.50	$965.11
Legal:	245.90	$25,369.60
	*********	*********
Sub Total:	267.30	$26,373.70
Expenses to Date:		$9.236.17
Prior Amount:		$0.00
Total Costs to Date:		$35,609.87

Time Tracking Report

Itemized Cost/Expense by Complaint

Complaint 200215730

Report Date: 04/27/2006

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
BUREAU OF CONSUMER COMPLAINTS							
Cost	HA38	0.40	$43.32	$17.33	07/02/2002	78	INITIAL REVIEW AND ANALYSIS OF COMPLAINT
Cost	HA38	0.20	$43.32	$8.66	07/02/2002	36	PREPARATION OR REVISION OF LETTER
Cost	HA38	1.00	$43.32	$43.32	08/07/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	HA38	0.30	$43.32	$13.00	08/09/2002	35	TELEPHONE CALLS
			SubTotal	**$82.31**			
BUREAU OF INVESTIGATIVE SERVICES							
Cost	WI31	0.50	$43.65	$21.83	08/09/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	1.50	$43.65	$65.48	08/09/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	1.00	$43.65	$43.65	08/13/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	0.50	$43.65	$21.83	08/14/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	0.50	$43.65	$21.83	08/15/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	1.00	$43.65	$43.65	08/20/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	0.50	$43.65	$21.83	09/05/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	1.50	$43.65	$65.48	09/24/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	2.50	$43.65	$109.13	09/25/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	1.50	$43.65	$65.48	09/25/2002	76	REPORT PREPARATION
Cost	WI31	1.00	$43.65	$43.65	09/26/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	1.00	$43.65	$43.65	09/26/2002	76	REPORT PREPARATION
Cost	WI31	1.00	$43.65	$43.65	09/27/2002	4	ROUTINE INVESTIGATIVE WORK
Cost	WI31	1.00	$43.65	$43.65	09/27/2002	76	REPORT PREPARATION
Cost	WI31	1.00	$43.65	$43.65	09/30/2002	76	REPORT PREPARATION
Cost	JI86	0.10	$64.47	$6.45	12/06/2005	4	ROUTINE INVESTIGATIVE WORK
Cost	JI86	0.90	$64.47	$58.02	12/06/2005	58	TRAVEL TIME
Cost	WI31	1.50	$63.55	$95.33	01/17/2006	6	SUPPLEMENTAL INVESTIGATION

Time Tracking Report

Itemized Cost/Expense by Complaint

Complaint 200215730

Report Date: 04/27/2006

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
Cost	WI31	1.00	$63.55	$63.55	01/18/2006	6	SUPPLEMENTAL INVESTIGATION
			SubTotal	**$921.79**			

BUREAU OF LEGAL SERVICES

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
Cost	HLL14A	0.20	$62.73	$12.55	06/20/2003	25	REVIEW CASE FILE
Cost	HLL14A	0.80	$62.73	$50.18	06/20/2003	25	REVIEW CASE FILE
Cost	HLL14A	1.80	$62.73	$112.91	06/24/2003	25	REVIEW CASE FILE
Cost	HLL14A	0.20	$62.73	$12.55	07/22/2003	25	REVIEW CASE FILE
Cost	HLL14A	0.20	$62.73	$12.55	07/23/2003	25	REVIEW CASE FILE
Cost	HLL14A	0.30	$62.73	$18.82	11/13/2003	25	REVIEW CASE FILE
Cost	HLL14A	0.30	$63.27	$18.98	12/16/2003	25	REVIEW CASE FILE
Cost	HLL14A	0.30	$63.27	$18.98	12/16/2003	25	REVIEW CASE FILE
Cost	HLL22B	0.50	$73.40	$36.70	06/16/2004	25	REVIEW CASE FILE
Cost	HLL22B	0.60	$73.40	$44.04	07/15/2004	25	REVIEW CASE FILE
Cost	HLL22B	0.30	$73.40	$22.02	07/22/2004	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	0.70	$73.40	$51.38	07/22/2004	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	0.50	$73.40	$36.70	07/23/2004	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL10A	0.30	$76.76	$23.03	07/26/2004	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	2.00	$73.40	$146.80	07/26/2004	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	1.50	$73.40	$110.10	08/02/2004	25	REVIEW CASE FILE
Cost	HLL22B	0.30	$73.40	$22.02	08/02/2004	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	1.30	$73.40	$95.42	09/01/2004	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL10A	0.40	$76.76	$30.70	09/13/2004	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	1.00	$73.40	$73.40	03/09/2005	25	REVIEW CASE FILE
Cost	HLL22B	0.60	$73.40	$44.04	03/09/2005	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	0.80	$73.40	$58.72	05/09/2005	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	0.30	$73.40	$22.02	07/12/2005	79	STIPULATION
Cost	HLL22B	0.30	$73.40	$22.02	07/22/2005	35	TELEPHONE CALLS
Cost	HLL28B	0.40	$73.40	$29.36	07/27/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	0.40	$73.40	$29.36	07/27/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP

Time Tracking Report

Itemized Cost/Expense by Complaint

Complaint 200215730

Report Date: 04/27/2006

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
Cost	HLL22B	0.30	$73.40	$22.02	08/09/2005	37	REVIEW LETTER
Cost	HLL22B	0.20	$73.40	$14.68	08/09/2005	35	TELEPHONE CALLS
Cost	HLL22B	0.20	$73.40	$14.68	08/09/2005	35	TELEPHONE CALLS
Cost	HLL22B	0.30	$73.40	$22.02	09/13/2005	35	TELEPHONE CALLS
Cost	HLL22B	0.30	$73.40	$22.02	09/13/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	2.00	$73.40	$146.80	10/03/2005	39	PREPARE/RESPOND TO DISCOVERY
Cost	HLL22B	0.80	$73.40	$58.72	10/04/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.20	$73.40	$14.68	10/05/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HL70A	0.20	$82.38	$16.48	10/05/2005	70	CONFERENCES WITH LAWYERS
Cost	HLL22B	0.80	$73.40	$58.72	10/06/2005	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	0.50	$73.40	$36.70	10/06/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	0.40	$73.40	$29.36	10/07/2005	35	TELEPHONE CALLS
Cost	HLL22B	0.20	$73.40	$14.68	10/07/2005	36	PREPARATION OR REVISION OF LETTER
Cost	HLL22B	0.40	$73.40	$29.36	10/07/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.40	$73.40	$29.36	10/07/2005	26	PREPARE OR REVISE MEMORANDUM
Cost	HLL22B	0.50	$73.40	$36.70	10/12/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.30	$73.40	$22.02	10/12/2005	47	TRIAL PREPARATION
Cost	HLL22B	1.00	$73.40	$73.40	10/20/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.20	$73.40	$14.68	10/21/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.70	$73.40	$51.38	10/24/2005	37	REVIEW LETTER
Cost	HLL22B	0.50	$73.40	$36.70	10/24/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.30	$73.40	$22.02	10/24/2005	35	TELEPHONE CALLS
Cost	HLL22B	0.30	$73.40	$22.02	10/24/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	0.70	$73.40	$51.38	10/25/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.50	$73.40	$36.70	10/26/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.50	$73.40	$36.70	10/27/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.30	$73.40	$22.02	10/28/2005	35	TELEPHONE CALLS
Cost	HLL22B	0.40	$73.40	$29.36	10/28/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.50	$73.40	$36.70	10/28/2005	47	TRIAL PREPARATION
Cost	HLL22B	1.90	$73.40	$139.46	10/31/2005	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	0.40	$73.40	$29.36	10/31/2005	36	PREPARATION OR REVISION OF LETTER
Cost	HLL22B	0.30	$73.40	$22.02	10/31/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP

Time Tracking Report

Itemized Cost/Expense by Complaint

Complaint 200215730

Report Date: 04/27/2006

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
Cost	HLL22B	0.80	$73.40	$58.72	10/31/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.50	$73.40	$36.70	10/31/2005	39	PREPARE/RESPOND TO DISCOVERY
Cost	HLL22B	0.50	$73.40	$36.70	11/01/2005	47	TRIAL PREPARATION
Cost	HLL22B	1.90	$73.40	$139.46	11/01/2005	28	PREPARE OR REVISE ADMINISTRATIVE COMPLAI
Cost	HLL22B	0.40	$73.40	$29.36	11/01/2005	36	PREPARATION OR REVISION OF LETTER
Cost	HLL22B	0.30	$73.40	$22.02	11/01/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	0.80	$73.40	$58.72	11/01/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.50	$73.40	$36.70	11/01/2005	39	PREPARE/RESPOND TO DISCOVERY
Cost	HLL22B	3.80	$73.40	$278.92	11/02/2005	47	TRIAL PREPARATION
Cost	HLL22B	2.00	$73.40	$146.80	11/03/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.90	$73.40	$66.06	11/03/2005	43	PREPARE FOR DEPOSITION
Cost	HLL22B	0.30	$73.40	$22.02	11/07/2005	26	PREPARE OR REVISE MEMORANDUM
Cost	HLL22B	0.80	$73.40	$58.72	11/08/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	1.10	$73.40	$80.74	11/09/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.60	$73.40	$44.04	11/10/2005	43	PREPARE FOR DEPOSITION
Cost	HLL22B	5.00	$73.40	$367.00	11/10/2005	58	TRAVEL TIME
Cost	HLL22B	5.00	$73.40	$367.00	11/11/2005	58	TRAVEL TIME
Cost	HLL22B	3.00	$73.40	$220.20	11/11/2005	44	DEPOSITIONS
Cost	HLL22B	2.00	$73.40	$146.80	11/14/2005	47	TRIAL PREPARATION
Cost	HLL22B	1.00	$73.40	$73.40	11/16/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.50	$73.40	$36.70	11/16/2005	36	PREPARATION OR REVISION OF LETTER
Cost	HLL22B	3.00	$73.40	$220.20	11/17/2005	47	TRIAL PREPARATION
Cost	HLL22B	1.00	$73.40	$73.40	11/18/2005	39	PREPARE/RESPOND TO DISCOVERY
Cost	HLL22B	0.50	$73.40	$36.70	11/18/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	0.30	$73.40	$22.02	11/18/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.40	$73.40	$29.36	11/22/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.70	$73.40	$51.38	11/28/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.80	$73.40	$58.72	11/29/2005	47	TRIAL PREPARATION
Cost	HLL22B	1.00	$73.40	$73.40	11/29/2005	43	PREPARE FOR DEPOSITION
Cost	HLL22B	0.50	$73.40	$36.70	11/30/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.50	$73.40	$36.70	11/30/2005	39	PREPARE/RESPOND TO DISCOVERY
Cost	HLL22B	0.50	$73.40	$36.70	12/01/2005	36	PREPARATION OR REVISION OF LETTER

Time Tracking Report

Itemized Cost/Expense by Complaint

Complaint 200215730

port Date: 04/27/2006

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
Cost	HLL22B	0.50	$73.40	$36.70	12/01/2005	36	PREPARATION OR REVISION OF LETTER
Cost	HLL22B	1.00	$73.40	$73.40	12/01/2005	47	TRIAL PREPARATION
Cost	HLL22B	4.00	$73.40	$293.60	12/02/2005	47	TRIAL PREPARATION
Cost	HLL22B	3.00	$73.40	$220.20	12/03/2005	47	TRIAL PREPARATION
Cost	HLL22B	2.50	$73.40	$183.50	12/04/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.50	$73.40	$36.70	12/05/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	2.00	$73.40	$146.80	12/05/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.50	$73.40	$36.70	12/06/2005	35	TELEPHONE CALLS
Cost	HLL22B	0.30	$73.40	$22.02	12/06/2005	35	TELEPHONE CALLS
Cost	HLL22B	0.20	$73.40	$14.68	12/06/2005	26	PREPARE OR REVISE MEMORANDUM
Cost	HLL22B	1.00	$73.40	$73.40	12/06/2005	47	TRIAL PREPARATION
Cost	HLL22B	2.00	$73.40	$146.80	12/06/2005	43	PREPARE FOR DEPOSITION
Cost	HL58B	0.40	$120.23	$48.09	12/06/2005	70	CONFERENCES WITH LAWYERS
Cost	HL58B	3.60	$120.23	$432.83	12/07/2005	47	TRIAL PREPARATION
Cost	HLL22B	3.00	$73.40	$220.20	12/07/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	1.80	$73.40	$132.12	12/07/2005	47	TRIAL PREPARATION
Cost	HL58B	2.00	$120.23	$240.46	12/08/2005	47	TRIAL PREPARATION
Cost	HLL22B	1.50	$73.40	$110.10	12/09/2005	44	DEPOSITIONS
Cost	HLL22B	8.00	$73.40	$587.20	12/09/2005	58	TRAVEL TIME
Cost	HLL22B	1.00	$73.40	$73.40	12/09/2005	47	TRIAL PREPARATION
Cost	HLL22B	5.00	$73.40	$367.00	12/10/2005	58	TRAVEL TIME
Cost	HLL22B	6.00	$73.40	$440.40	12/11/2005	47	TRIAL PREPARATION
Cost	HL58B	6.00	$141.12	$846.72	12/12/2005	58	TRAVEL TIME
Cost	HL58B	2.00	$141.12	$282.24	12/12/2005	44	DEPOSITIONS
Cost	HLL22B	0.40	$127.22	$50.89	12/13/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.50	$127.22	$63.61	12/13/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	2.60	$127.22	$330.77	12/13/2005	47	TRIAL PREPARATION
Cost	HL58B	4.90	$141.12	$691.49	12/13/2005	47	TRIAL PREPARATION
Cost	HL58B	1.40	$120.23	$168.32	12/14/2005	47	TRIAL PREPARATION
Cost	HL58B	1.50	$120.23	$180.35	12/14/2005	44	DEPOSITIONS
Cost	HLL22B	3.00	$127.22	$381.66	12/14/2005	47	TRIAL PREPARATION
Cost	HLL22B	1.00	$127.22	$127.22	12/14/2005	44	DEPOSITIONS

Time Tracking Report

Itemized Cost/Expense by Complaint

Complaint 200215730

Report Date: 04/27/2006

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
Cost	HLL22B	1.00	$127.22	$127.22	12/15/2005	47	TRIAL PREPARATION
Cost	HLL22B	6.00	$127.22	$763.32	12/15/2005	58	TRAVEL TIME
Cost	HL58B	4.50	$141.12	$635.04	12/15/2005	58	TRAVEL TIME
Cost	HL58B	2.50	$141.12	$352.80	12/15/2005	47	TRIAL PREPARATION
Cost	HLL22B	8.00	$127.22	$1017.76	12/16/2005	48	FORMAL HEARING
Cost	HL58B	9.00	$141.12	$1270.08	12/16/2005	48	FORMAL HEARING
Cost	HL58B	7.00	$141.12	$987.84	12/16/2005	58	TRAVEL TIME
Cost	HLL22B	6.00	$127.22	$763.32	12/17/2005	58	TRAVEL TIME
Cost	HLL22B	1.00	$127.22	$127.22	12/19/2005	47	TRIAL PREPARATION
Cost	HL58B	0.30	$141.12	$42.34	12/19/2005	26	PREPARE OR REVISE MEMORANDUM
Cost	HLL22B	1.00	$127.22	$127.22	12/19/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.40	$127.22	$50.89	12/20/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	1.70	$127.22	$216.27	12/20/2005	47	TRIAL PREPARATION
Cost	HLL22B	4.00	$127.22	$508.88	12/21/2005	47	TRIAL PREPARATION
Cost	HLL22B	0.20	$127.22	$25.44	12/22/2005	26	PREPARE OR REVISE MEMORANDUM
Cost	HLL22B	0.40	$127.22	$50.89	12/22/2005	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	0.50	$127.22	$63.61	12/27/2005	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	0.20	$127.22	$25.44	01/03/2006	40	PREPARATION OF OR REVISION OF A PLEADING
Cost	HLL22B	1.50	$127.22	$190.83	01/03/2006	46	LEGAL RESEARCH
Cost	HLL22B	0.50	$127.22	$63.61	01/03/2006	47	TRIAL PREPARATION
Cost	HLL22B	0.10	$127.22	$12.72	01/03/2006	35	TELEPHONE CALLS
Cost	HLL22B	0.50	$127.22	$63.61	01/06/2006	47	TRIAL PREPARATION
Cost	HLL22B	0.20	$127.22	$25.44	01/09/2006	26	PREPARE OR REVISE MEMORANDUM
Cost	HLL22B	0.50	$127.22	$63.61	01/11/2006	36	PREPARATION OR REVISION OF LETTER
Cost	HLL22B	0.30	$127.22	$38.17	01/11/2006	35	TELEPHONE CALLS
Cost	HLL22B	0.40	$127.22	$50.89	01/11/2006	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HL58B	0.40	$141.12	$56.45	01/18/2006	47	TRIAL PREPARATION
Cost	HL58B	0.20	$141.12	$28.22	01/18/2006	70	CONFERENCES WITH LAWYERS
Cost	HLL22B	0.20	$127.22	$25.44	01/18/2006	35	TELEPHONE CALLS
Cost	HLL22B	2.50	$127.22	$318.05	01/20/2006	47	TRIAL PREPARATION
Cost	HLL22B	0.30	$127.22	$38.17	01/20/2006	35	TELEPHONE CALLS
Cost	HLL22B	0.50	$127.22	$63.61	01/24/2006	35	TELEPHONE CALLS

Time Tracking Report

Itemized Cost/Expense by Complaint

Complaint 200215730

port Date: 04/27/2006

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
Cost	HLL22B	0.40	$127.22	$50.89	01/24/2006	47	TRIAL PREPARATION
Cost	HLL22B	2.00	$127.22	$254.44	01/25/2006	47	TRIAL PREPARATION
Cost	HLL22B	0.80	$127.22	$101.78	01/30/2006	47	TRIAL PREPARATION
Cost	HLL22B	2.50	$127.22	$318.05	01/30/2006	58	TRAVEL TIME
Cost	HLL22B	3.00	$127.22	$381.66	01/31/2006	48	FORMAL HEARING
Cost	HLL22B	0.40	$127.22	$50.89	02/07/2006	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	1.00	$127.22	$127.22	02/08/2006	47	TRIAL PREPARATION
Cost	HLL22B	2.00	$127.22	$254.44	02/08/2006	46	LEGAL RESEARCH
Cost	HLL22B	0.50	$127.22	$63.61	02/09/2006	47	TRIAL PREPARATION
Cost	HLL22B	1.00	$127.22	$127.22	02/10/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	1.50	$127.22	$190.83	02/11/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	0.30	$127.22	$38.17	02/13/2006	64	LEGAL ADVICE/DISCUSSION - BOARD OFFICE,DEP
Cost	HLL22B	0.30	$127.22	$38.17	02/15/2006	26	PREPARE OR REVISE MEMORANDUM
Cost	HLL22B	2.00	$127.22	$254.44	02/16/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	1.00	$127.22	$127.22	02/17/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	4.20	$127.22	$534.32	02/20/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	5.00	$127.22	$636.10	02/21/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	0.40	$127.22	$50.89	02/28/2006	26	PREPARE OR REVISE MEMORANDUM
Cost	HLL22B	3.00	$127.22	$381.66	03/02/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	2.00	$127.22	$254.44	03/03/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	2.00	$127.22	$254.44	03/14/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Cost	HLL22B	2.00	$127.22	$254.44	03/20/2006	49	REVIEW TRANSCRIPTS AND PREPARE RECOMMEI
Expense	HL12A			$40.00	07/02/2003	131600	LEGAL
Expense	HL12A			$430.00	05/15/2003	131600	LEGAL
Expense	HL34B			$500.00	06/23/2003	131630	EXPERT WITNESS
Expense	HL34B			$500.00	06/17/2003	131630	EXPERT WITNESS
Expense	HL34B			$1,000.00	11/18/2005	131630	EXPERT WITNESS
Expense	HL34B			$321.50	01/09/2006	131630	EXPERT WITNESS
Expense	HL34B			$312.50	01/09/2006	131630	EXPERT WITNESS
Expense	HL34B			$1,687.50	12/23/2005	131630	EXPERT WITNESS
Expense	HL34B			$250.00	01/06/2006	131630	EXPERT WITNESS
Expense	HL36B			$250.00	01/06/2006	131630	EXPERT WITNESS

Time Tracking Report
Itemized Cost/Expense by Complaint

Complaint 200215730

Report Date: 04/27/2006

Record Type	Staff Code	Activity Hours	Staff Rate	Cost/Expense Amount	Cost/Expense Date	Cost/Expense Code	Cost/Expense Code Description
Expense	HLL22B			$800.00	12/08/2005	139994	OTHER SERVICES
Expense	HLL22B			$231.82	01/31/2006	261010	TRAVEL - EMOLOYEE - IN FLA
Expense	HL34B			$306.43	12/16/2005	261010	TRAVEL - EMOLOYEE - IN FLA
Expense	HLL22B			$1,338.72	12/10/2005	261010	TRAVEL - EMOLOYEE - IN FLA
Expense	HLL22B			$334.95	11/11/2005	261010	TRAVEL - EMOLOYEE - IN FLA
Expense	HLL22B			$626.54	12/17/2005	261010	TRAVEL - EMOLOYEE - IN FLA
Expense	HL58B			$306.21	12/17/2005	261010	TRAVEL - EMOLOYEE - IN FLA
			SubTotal	**$34,605.77**			
			Total Cost/Expense	**$35,609.87**			