Final Order No. DOH- 19-0712-FOI-MQA
FILED DATE -APR 2 9 2019
Department of Health
By: Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2016-24520
LICENSE NO.: ME0083911

HENRY BARTOW EHRLICH, M.D.,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57, Florida Statutes, on April 5, 2019, in West Palm Beach, Florida, for consideration of the Administrative Complaint (attached hereto as Exhibit A) in the above-styled cause pursuant to Respondent's Election of Rights. Respondent was served with the Administrative Complaint by publication. Because Respondent failed to submit an Election of Rights or otherwise dispute the facts or respond in any other way, Respondent waived the right to a hearing pursuant to Section 120.57, Florida Statutes. At the hearing, Petitioner was represented by Cynthia Nash Early, Assistant General Counsel. Respondent was not present and was not represented by counsel. The facts are not in dispute.

Upon consideration, it is ORDERED:

1. The allegations of fact set forth in the Administrative Complaint are approved and adopted and incorporated herein by reference as the findings of fact by the Board.

2. The conclusions of law alleged and set forth in the Administrative Complaint are approved and adopted and incorporated herein by reference as the conclusions of law by the Board.

3. The violations set forth warrant disciplinary action by the Board.

THEREFORE, IT IS HEREBY ORDERED AND ADJUDGED:

Respondent's license to practice medicine in the State of Florida is hereby **REVOKED.**

RULING ON MOTION TO ASSESS COSTS

At the hearing in this matter the Petitioner withdrew its Motion to Assess Costs in this matter.

(NOTE: SEE RULE 64B8-8.0011, FLORIDA ADMINISTRATIVE CODE. UNLESS OTHERWISE SPECIFIED BY FINAL ORDER, THE RULE SETS FORTH THE REQUIREMENTS FOR PERFORMANCE OF ALL PENALTIES CONTAINED IN THIS FINAL ORDER.)

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

DONE AND ORDERED this 26th day of April, 2019.

BOARD OF MEDICINE

Crystal A Kafka for

Claudia Kemp, J.D., Executive Director
For Steven Rosenberg, 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 **Certified Mail** to HENRY BARTOW EHRLICH, M.D., 1517 State Street, Suite 103, Sarasota, Florida 34236; and 1933 Whitfield Park Loop, Unit B, Sarasota, Florida 34243; by email to Allison Dudley, Assistant General Counsel, Department of Health, at Allison.Dudley@flhealth.gov; and by email to Edward A. Tellechea, Chief Assistant Attorney General, at

Ed.Tellechea@myfloridalegal.com this 29th day of

April, 2019.

Deputy Agency Clerk

Certified Article Number

9414 7266 9904 2140 1145 50

SENDER'S RECORD

Henry Bartow Ehrlich, M.D.
1517 State Street
Suite 103
Sarasota, FL 34236

Certified Article Number

9414 7266 9904 2140 1145 43

SENDER'S RECORD

Henry Bartow Ehrlich, M.D.
1933 Whitfield Park Loop
Unit B
Sarasota, FL 34243

MEMORANDUM

DATE: April 26, 2019

TO: Mark Whitten, J.D. Bureau Chief
Bureau of Health Care Practitioner Regulation

FROM: Claudia J. Kemp
Executive Director, Board of Medicine

SUBJECT: Delegation of Authority

This is to advise you that while I am out of the office Friday, April 26, 2019, the following Program Operations Administrator is delegated to serve as Acting Executive Director for the Board of Medicine.

Crystal Sanford	Program Operations Administrator	(850) 245- 4132

CK/rh
cc:
Sylvia Sanders
Staff, Board of Medicine
Board and Council Chairs

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2016-24520**

HENRY BARTOW EHRLICH, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

Petitioner Department of Health hereby files this Administrative Complaint before the Board of Medicine against Respondent Henry Bartow Ehrlich, M.D. and alleges:

1. Petitioner is the state agency 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 83911.

3. Respondent's address of record is 1517 State Street, Suite 103, Sarasota, FL 34236.

Exhibit A

4. At all times material to this Complaint, Respondent practiced at Genesis Health Care, located at 1933 Whitfield Park Loop, Sarasota, FL 34243.

5. At all times material to this Complaint, Respondent worked as a volunteer psychiatrist, providing treatment for multiple high-risk patients.

Standard of Care

6. During the treatment period, the prevailing professional standard of care required Respondent to treat each of the patient's in the following manner:

a. Adequately assess the patients' complaints and symptoms, including alleviating and/or aggravating symptoms;

b. Adequately assess the risk of abuse or diversion of the controlled substances prescribed;

c. Establish adequate treatment plans for the patients;

d. Appropriately pursue the course of treatment for the patients;

e. Obtain informed consent;

f. Adequately and consistently monitor the patients' medication use to prevent noncompliance, drug abuse, diversion of

controlled substances, and/or for the risk of substance use disorders; and/or

g. Provide alternative forms of treatments to the patients.

Facts Specific to Patient J.O.

7. From on or about November 2012, through on or about October 2016 (treatment period), Respondent treated J.O. ("Patient J.O.") a then forty-one (41) year old female, with a history and diagnoses of Major Depressive Disorder, chronic pain, and two back surgeries from vehicle accidents in 1992 and 2007.

8. During the treatment period, Respondent prescribed medications Flexeril (a muscle relaxant), citalopram (an antidepressant), Methylpred (a

corticosteroid), and controlled substances Ativan[1], Soma[2], Temazepam[3], and Alprazolam[4] to Patient J.O., on one or more occasions.

9. During the treatment period, Respondent failed to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient J.O.

10. During the treatment period, Respondent failed to document his rationale for prescribing medications and any changes or dosage adjustments.

11. During the treatment period, Respondent failed to adequately assess, or document an adequate assessment of, Patient J.O.'s complaints and symptoms, including alleviating and/or aggravating symptoms.

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[1] Ativan is the brand name for lorazepam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, lorazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

[2] Soma is the brand name for carisoprodol, a muscle relaxant commonly prescribed to treat muscular pain. According to Section 893.03(4), Florida Statutes, carisoprodol is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of carisoprodol may lead to limited physical or psychological dependence relative to the substances in Schedule III.

[3] Temazepam (brand name Restoril) is prescribed to treat insomnia. According to Section 893.03(4), Florida Statutes, temazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of temazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

[4] Alprazolam (brand name Xanax) is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

12. During the treatment period, Respondent failed to document key symptoms that were being addressed and treated during each visit.

13. During the treatment period, Respondent failed to adequately identify, or document identifying, an adequate treatment plan for Patient J.O.

14. During the treatment period, Respondent failed to appropriately pursue, or document appropriately pursuing, the course of treatment.

15. During the treatment period, Respondent did not obtain, or document obtaining, informed consent for Patient J.O.

16. During the treatment period, Respondent did not document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient J.O.

17. During the treatment period, Respondent failed to adequately and consistently monitor, or document adequately and consistently monitoring, Patient J.O.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders.

18. During the treatment period, Respondent failed to provide, or document providing, alternative forms of treatments to Patient J.O.

19. On or about January 11, 2017, Patient J.O. died from an accidental drug overdose.

20. An autopsy performed on Patient J.O. revealed the cause of death as Intoxication by the Combined Effects of Carfentanil[5] and Methadone[6].

Facts Specific to Patient A.S.

21. From on or about January 2013, through on or about July 2016 (treatment period), Respondent treated Patient A.S., a then thirty-two (32) year old male, with diagnoses of anxiety state, unspecified; nervousness; mixed disorders as reaction to stress; alcoholism; Depressive Disorder, NOS; attention or concentration deficit; Generalized Anxiety Disorder; and insomnia.

22. During the treatment period, Respondent prescribed medications Trazodone and Sertraline (antidepressants), and prescribed controlled

[5] Carfentanil (also known as carfentanyl) is an animal opioid sedative. Carfentanil is an analog of the synthetic opioid analgesic fentanyl and is one of the most potent opioids known.

[6] Methadone is prescribed to treat pain. According to Section 893.03(2), Florida Statutes, methadone is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of methadone may lead to severe psychological or physical dependence.

substances Alprazolam, Adderall[7], and Temazepam to Patient A.S., on one or more occasions.

23. During the treatment period, Respondent failed to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient A.S.

24. During the treatment period, Respondent failed to document his rationale for prescribing medications and any changes or dosage adjustments.

25. During the treatment period, Respondent failed to adequately assess, or document an adequate assessment of, Patient A.S.'s complaints and symptoms, including alleviating and/or aggravating symptoms.

26. During the treatment period, Respondent failed to document key symptoms that were being addressed and treated during each visit.

27. During the treatment period, Respondent failed to adequately identify, or document identifying, an adequate treatment plan for Patient A.S.

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[7] Adderall (brand name for amphetamine) is the brand name for a drug that contains amphetamine, commonly prescribed to treat attention deficit disorder. According to Section 893.03(2), Florida Statutes, amphetamine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of amphetamine may lead to severe psychological or physical dependence.

28. During the treatment period, Respondent failed to appropriately pursue, or document appropriately pursuing, the course of treatment.

29. During the treatment period, Respondent did not obtain, or document obtaining, informed consent for Patient A.S.

30. During the treatment period, Respondent did not document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient A.S.

31. During the treatment period, Respondent failed to adequately and consistently monitor, or document adequately and consistently monitoring, Patient A.S.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders.

32. During the treatment period, Respondent failed to provide, or document providing, alternative forms of treatments to Patient A.S.

33. On or about January 24, 2017, Patient A.S. died from accidental drug abuse.

34. An autopsy performed on Patient A.S. revealed the cause of death as Intoxication with Carfentanil and Temazepam.

Facts Specific to Patient G.S.

35. From in or about March 2014, through in or about October 2016 (treatment period), Respondent treated Patient G.S., a then thirty-two (32) year old female with diagnoses of anxiety state, unspecified; nervousness; Depressive Disorder, not elsewhere classified; mixed disorders as reaction to stress; other specified drug dependence, unspecified, Posttraumatic Stress Disorder; Agoraphobia, attention or concentration deficit; and Bipolar Disorder.

36. During the treatment period, Respondent prescribed medications zolpidem (a sedative used to treat insomnia), Fluoxetine (used primarily for treating depression), Trazodone, and controlled substances Alprazolam and Clonazepam[8] to Patient G.S., on one or more occasions.

37. During the treatment period, Respondent failed to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient G.S.

[8] Clonazepam (brand name Klonopin) is commonly prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, clonazepam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of clonazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

38. During the treatment period, Respondent failed to document his rationale for prescribing medications and any changes or dosage adjustments.

39. During the treatment period, Respondent failed to adequately assess, or document an adequate assessment of, Patient G.S.'s complaints and symptoms, including alleviating and/or aggravating symptoms.

40. During the treatment period, Respondent failed to document key symptoms that were being addressed and treated during each visit.

41. During the treatment period, Respondent failed to adequately identify, or document identifying, an adequate treatment plan for Patient G.S.

42. During the treatment period, Respondent failed to appropriately pursue, or document appropriately pursuing, the course of treatment.

43. During the treatment period, Respondent did not obtain, or document obtaining, informed consent for Patient G.S.

44. During the treatment period, Respondent did not document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient G.S.

45. During the treatment period, Respondent failed to adequately and consistently monitor, or document adequately and consistently monitoring, Patient G.S.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders.

46. During the treatment period, Respondent failed to provide, or document providing, alternative forms of treatments to Patient G.S.

47. On or about October 13, 2016, Patient G.S. died from accidental intravenous drug abuse.

48. An autopsy performed on Patient G.S. revealed the cause of death as Multi-drug Intoxication Including Alprazolam, Carfentanil and Cocaine.

Facts Specific to Patient T.T.

49. From on or about February 2013, through on or about January 2018 (treatment period), Respondent treated Patient T.T., a then forty (40) year old male, who had a history of drug and alcohol abuse, and diagnoses of ADHD and Bipolar Disorder.

50. During the treatment period, Respondent prescribed Trazodone, and the controlled substance, Adderall, to Patient T.T., on one or more occasions.

51. During the treatment period, Respondent failed to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient T.T.

52. During the treatment period, Respondent failed to document his rationale for prescribing medications and any changes or dosage adjustments.

53. During the treatment period, Respondent failed to adequately assess, or document an adequate assessment of, Patient T.T.'s complaints and symptoms, including alleviating and/or aggravating symptoms.

54. During the treatment period, Respondent failed to document key symptoms that were being addressed and treated during each visit.

55. During the treatment period, Respondent failed to adequately identify, or document identifying, an adequate treatment plan for Patient T.T.

56. During the treatment period, Respondent failed to appropriately pursue, or document appropriately pursuing, the course of treatment.

57. During the treatment period, Respondent did not obtain, or document obtaining, informed consent for Patient T.T.

58. During the treatment period, Respondent did not document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient T.T.

59. During the treatment period, Respondent failed to adequately and consistently monitor, or document adequately and consistently monitoring, Patient T.T.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders.

60. During the treatment period, Respondent failed to provide, or document providing, alternative forms of treatments to Patient T.T.

Facts Specific to Patient E.E.

61. From on or about March 2015, through on or about July 2017 (treatment period), Respondent treated Patient E.E., a then twenty-six (26) year old female, with a self-reported medical history of mental illness, anxiety, depression, and severe ADD.

62. Respondent diagnosed Patient E.E. with Bipolar Disorder and ADHD.

63. During the treatment period, Respondent prescribed Lamictal (an anticonvulsant used to treat seizures and Bipolar Disorder), and controlled substances Alprazolam and Adderall to Patient E.E., on one or more occasions.

64. On or about May 6, 2015, Respondent documented that Patient E.E. ran out of medication.

65. On or about September 16, 2015, Respondent documented that Patient E.E. had no more Adderall and she informed him that her prescription was stolen. Respondent further documented that the patient told him three different stories about her medication.

66. During the treatment period, Respondent failed to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient E.E.

67. During the treatment period, Respondent failed to document his rationale for prescribing medications and any changes or dosage adjustments.

68. During the treatment period, Respondent failed to adequately assess, or document an adequate assessment of, Patient E.E.'s complaints and symptoms, including alleviating and/or aggravating symptoms.

69. During the treatment period, Respondent failed to document key symptoms that were being addressed and treated during each visit.

70. During the treatment period, Respondent failed to adequately identify, or document identifying, an adequate treatment plan for Patient E.E.

71. During the treatment period, Respondent failed to appropriately pursue, or document appropriately pursuing, the course of treatment.

72. During the treatment period, Respondent did not obtain, or document obtaining, informed consent for Patient E.E.

73. During the treatment period, Respondent did not document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient E.E.

74. During the treatment period, Respondent failed to adequately and consistently monitor, or document adequately and consistently monitoring, Patient E.E.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders.

75. During the treatment period, Respondent failed to provide, or document providing, alternative forms of treatments to Patient E.E.

Facts Specific to Patient B.E.

76. From on or about November 2015, through on or about January 2018 (treatment period), Respondent treated Patient B.E., a then thirty-two (32) year old male, with diagnoses of Bipolar Disorder, Panic Disorder, and ADHD.

77. During the treatment period, Respondent prescribed Trazodone, Paroxetine (an antidepressant), Lithium (used to treat Bipolar and depressive disorders), Lamictal, and controlled substances, Alprazolam and Adderall, to Patient B.E., on one or more occasions.

78. During the treatment period, Respondent failed to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient B.E.

79. During the treatment period, Respondent failed to document his rationale for prescribing medications and any changes or dosage adjustments.

80. During the treatment period, Respondent failed to adequately assess, or document an adequate assessment of, Patient B.E.'s complaints and symptoms, including alleviating and/or aggravating symptoms.

81. During the treatment period, Respondent failed to document key symptoms that were being addressed and treated during each visit.

82. During the treatment period, Respondent failed to adequately identify, or document identifying, an adequate treatment plan for Patient B.E.

83. During the treatment period, Respondent failed to appropriately pursue, or document appropriately pursuing, the course of treatment.

84. During the treatment period, Respondent did not obtain, or document obtaining, informed consent for Patient B.E.

85. During the treatment period, Respondent did not document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient B.E.

86. During the treatment period, Respondent failed to adequately and consistently monitor, or document adequately and consistently monitoring, Patient B.E.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders.

87. During the treatment period, Respondent failed to provide, or document providing, alternative forms of treatments to Patient B.E.

Section 458.331(1)(t)1., F.S. (2012-2017)
Applicable to Counts I-VI

88. Section 458.331(1)(t)1., Florida Statutes (2012-2017), provides that committing medical malpractice as defined in Section 456.50, Florida Statutes, constitutes grounds for disciplinary action by the Board of Medicine. The Board shall give great weight to the provisions of Section 766.102, Florida Statutes, when enforcing Section 458.331(1)(t)1., Florida Statutes. Medical malpractice is defined in Section 456.50, Florida Statutes, as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. Section 766.102, Florida Statutes, provides that the prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

COUNT I

89. Petitioner realleges and incorporates by reference paragraphs one (1) through twenty (20), and paragraph eighty-eight (88), as if fully set forth herein.

90. Respondent failed to practice medicine with that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers in violation of Section 458.331(1)(t)1., Florida Statutes (2012-2016), in the care and treatment of Patient J.O. in one or more of the following ways:

a. By failing to adequately assess Patient J.O.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to adequately assess the risk of abuse or diversion of the controlled substances prescribed to Patient J.O.;

c. By failing to establish an adequate treatment plan for Patient J.O.;

d. By failing to appropriately pursue the course of treatment for Patient J.O.;

e. By failing to obtain informed consent from Patient J.O.;

f. By failing to adequately and consistently monitor Patient J.O.'s medication use to prevent noncompliance, drug abuse,

diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to provide alternative forms of treatments to Patient J.O.

91. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2012-2016), by committing medical malpractice.

COUNT II

92. Petitioner realleges and incorporates by reference paragraphs one (1) through six (6) and twenty-one (21) through thirty-four (34), and paragraph eighty-eight (88), as if fully set forth herein.

93. Respondent failed to practice medicine with that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers in violation of Section 458.331(1)(t)1., Florida Statutes (2013-2017), in the care and treatment of Patient A.S. in one or more of the following ways:

a. By failing to adequately assess Patient A.S.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to adequately assess the risk of abuse or diversion of the controlled substances prescribed to Patient A.S.;

c. By failing to establish an adequate treatment plan for Patient A.S.;

d. By failing to appropriately pursue the course of treatment for Patient A.S.;

e. By failing to obtain informed consent from Patient A.S.;

f. By failing to adequately and consistently monitor Patient A.S.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to provide alternative forms of treatments to Patient A.S.

94. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2013-2017), by committing medical malpractice.

COUNT III

95. Petitioner realleges and incorporates by reference paragraphs one (1) through six (6) and thirty-five (35) through forty-eight (48), and paragraph eighty-eight (88), as if fully set forth herein.

96. Respondent failed to practice medicine with that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers in violation of Section 458.331(1)(t)1., Florida Statutes (2014-2016), in the care and treatment of Patient G.S. in one or more of the following ways:

a. By failing to adequately assess Patient G.S.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to adequately assess the risk of abuse or diversion of the controlled substances prescribed to Patient G.S.;

c. By failing to establish an adequate treatment plan for Patient G.S.;

d. By failing to appropriately pursue the course of treatment for Patient G.S.;

e. By failing to obtain informed consent from Patient G.S.;

f. By failing to adequately and consistently monitor Patient G.S.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to provide alternative forms of treatments to Patient G.S.

97. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2014-2016), by committing medical malpractice.

COUNT IV

98. Petitioner realleges and incorporates by reference paragraphs one (1) through six (6) and forty-nine (49) through sixty (60), and paragraph eighty-eight (88), as if fully set forth herein.

99. Respondent failed to practice medicine with that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers in violation of Section 458.331(1)(t)1., Florida Statutes

(2012-2017), in the care and treatment of Patient T.T. in one or more of the following ways:

a. By failing to adequately assess Patient T.T.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to adequately assess the risk of abuse or diversion of the controlled substances prescribed to Patient T.T.;

c. By failing to establish an adequate treatment plan for Patient T.T.;

d. By failing to appropriately pursue the course of treatment for Patient T.T.;

e. By failing to obtain informed consent from Patient T.T.;

f. By failing to adequately and consistently monitor the Patient T.T.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to provide alternative forms of treatments to Patient T.T.

100. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2012-2017), by committing medical malpractice.

COUNT V

101. Petitioner realleges and incorporates by reference paragraphs one (1) through six (6) and sixty-one (61) through seventy-five (75), and paragraph eighty-eight (88), as if fully set forth herein.

102. Respondent failed to practice medicine with that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers in violation of Section 458.331(1)(t)1., Florida Statutes (2014-2017), in the care and treatment of Patient E.E. in one or more of the following ways:

a. By failing to adequately assess Patient E.E.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to adequately assess the risk of abuse or diversion of the controlled substances prescribed to Patient E.E.;

c. By failing to establish an adequate treatment plan for Patient E.E.;

d. By failing to appropriately pursue the course of treatment for Patient E.E.;

e. By failing to obtain informed consent from Patient E.E.;

f. By failing to adequately and consistently monitor Patient E.E.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to provide alternative forms of treatments to Patient E.E.

103. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2014-2017), by committing medical malpractice.

COUNT VI

104. Petitioner realleges and incorporates by reference paragraphs one (1) through six (6) and seventy-six (76) through eighty-eight (88), as if fully set forth herein.

105. Respondent failed to practice medicine with that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers in violation of Section 458.331(1)(t)1., Florida Statutes (2015-2017), in the care and treatment of Patient B.E. in one or more of the following ways:

a. By failing to adequately assess Patient B.E.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to adequately assess the risk of abuse or diversion of the controlled substances prescribed to Patient B.E.'s;

c. By failing to establish an adequate treatment plan for Patient B.E.;

d. By failing to appropriately pursue the course of treatment for Patient B.E.;

e. By failing to obtain informed consent from Patient B.E.;

f. By failing to adequately and consistently monitor Patient B.E.'s medication use to prevent noncompliance, drug abuse,

diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to provide alternative forms of treatments to Patient B.E.

106. Based on the foregoing, Respondent violated Section 458.331(1)(t)1., Florida Statutes (2015-2017), by committing medical malpractice.

Section 458.331(1)(m), F.S. (2012-2017) and/or
Section 458.331(1)(nn), F.S. (2012-2017)
Applicable to Counts VII-XII

107. Section 458.331(1)(m), Florida Statutes (2012-2017), subjects a licensee to discipline for 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.

108. Section 458.331(1)(nn), Florida Statutes (2012-2017), provides that violating any provision of this Chapter 458 or Chapter 456, or any rules adopted pursuant thereto constitutes grounds for disciplinary action by the Board of Medicine.

109. Rule 64B8-9.003(3), Florida Administrative Code, provides that the medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

COUNT VII

110. Petitioner re-alleges and incorporates by reference the allegations in paragraphs one (1) through five (5), seven (7) through twenty (20), and one hundred seven (107) through one hundred nine (109), as if fully set forth herein.

111. During Patient J.O.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient J.O., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient J.O.;

b. By failing to document his rationale for prescribing medications and any changes or dosage adjustments; and/or

c. By failing to document key symptoms that were being addressed and treated during each visit.

112. In the alternative to the allegations set forth in subsections (a) through (g) of paragraph ninety (90) above, during Patient J.O.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient J.O., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document an adequate assessment of Patient J.O.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to document an adequate treatment plan for Patient J.O.;

c. By failing to appropriately document pursuing the course of treatment;

d. By failing to document obtaining informed consent from Patient J.O.;

e. By failing to document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient J.O.;

f. By failing to document adequately and consistently monitoring Patient J.O.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to document providing alternative forms of treatments to Patient J.O.

113. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2012-2016), and/or Section 458.331(1)(nn), Florida Statutes (2012-2016), by violating Rule 64B8-9.003 F.A.C.

COUNT VIII

114. Petitioner re-alleges and incorporates by reference the allegations in paragraphs one (1) through five (5), twenty-one (21) through thirty-four (34), and one hundred seven (107) through one hundred nine (109), as if fully set forth herein.

115. During Patient A.S.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient A.S., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient A.S.;

b. By failing to document his rationale for prescribing medications and any changes or dosage adjustments; and/or

c. By failing to document key symptoms that were being addressed and treated during each visit.

116. In the alternative to the allegations set forth in subsections (a) through (g) of paragraph ninety-three (93) above, during Patient A.S.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient A.S., and/or failed to satisfy the

requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document an adequate assessment of Patient A.S.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to document an adequate treatment plan for Patient A.S.;

c. By failing to document appropriately pursuing the course of treatment;

d. By failing to document obtaining informed consent from Patient A.S.;

e. By failing to document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient A.S.;

f. By failing to document adequately and consistently monitoring Patient A.S.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to document providing alternative forms of treatments to Patient A.S.

117. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2013-2017), and/or Section 458.331(1)(nn), Florida Statutes (2013-2017), by violating Rule 64B8-9.003 F.A.C.

COUNT IX

118. Petitioner re-alleges and incorporates by reference the allegations in paragraphs one (1) through five (5), thirty-five (35) through forty-eight (48), and one hundred seven (107) through one hundred nine (109), as if fully set forth herein.

119. During Patient G.S.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient G.S., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient G.S.;

b. By failing to document his rationale for prescribing medications and any changes or dosage adjustments; and/or

c. By failing to document key symptoms that were being addressed and treated during each visit.

120. In the alternative to the allegations set forth in subsections (a) through (g) of paragraph ninety-six (96) above, during Patient G.S.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient G.S., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document an adequate assessment of Patient G.S.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to document an adequate treatment plan for Patient G.S.;

c. By failing to appropriately document pursuing the course of treatment;

d. By failing to document obtaining informed consent from Patient G.S.;

e. By failing to document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient G.S.;

f. By failing to document adequately and consistently monitoring Patient G.S.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to document providing alternative forms of treatments to Patient G.S.

121. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2014-2016), and/or Section 458.331(1)(nn), Florida Statutes (2014-2016), by violating Rule 64B8-9.003 F.A.C.

COUNT X

122. Petitioner re-alleges and incorporates by reference the allegations in paragraphs one (1) through five (5), forty-nine (49) through sixty (60), and one hundred seven (107) through one hundred nine (109), as if fully set forth herein.

123. During Patient T.T.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient T.T., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient T.T.;

b. By failing to document his rationale for prescribing medications and any changes or dosage adjustments; and/or

c. By failing to document key symptoms that were being addressed and treated during each visit.

124. In the alternative to the allegations set forth in subsections (a) through (g) of paragraph ninety-nine (99) above, during Patient T.T.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient T.T., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document an adequate assessment of Patient T.T.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to document an adequate treatment plan for Patient T.T.;

c. By failing to appropriately document pursuing the course of treatment;

d. By failing to document obtaining informed consent from Patient T.T.;

e. By failing to document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient T.T.;

f. By failing to document adequately and consistently monitoring Patient T.T.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to document providing alternative forms of treatments to Patient T.T.

125. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2012-2017), and/or Section 458.331(1)(nn), Florida Statutes (2012-2017), by violating Rule 64B8-9.003 F.A.C.

COUNT XI

126. Petitioner re-alleges and incorporates by reference the allegations in paragraphs one (1) through five (5), sixty-one (61) through seventy-five (75), and one hundred seven (107) through one hundred nine (109), as if fully set forth herein.

127. During Patient E.E.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient E.E., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient E.E.;

b. By failing to document his rationale for prescribing medications and any changes or dosage adjustments; and/or

c. By failing to document key symptoms that were being addressed and treated during each visit.

128. In the alternative to the allegations set forth in subsections (a) through (g) of paragraph one hundred two (102) above, during Patient E.E.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient E.E., and/or failed to satisfy the

requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document an adequate assessment of Patient E.E.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to document an adequate treatment plan for Patient E.E.;

c. By failing to appropriately document pursuing the course of treatment;

d. By failing to document obtaining informed consent from Patient E.E.;

e. By failing to document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient E.E.;

f. By failing to document adequately and consistently monitoring Patient E.E.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to document providing alternative forms of treatments to Patient E.E.

129. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2014-2017), and/or Section 458.331(1)(nn), Florida Statutes (2014-2017), by violating Rule 64B8-9.003 F.A.C.

COUNT XII

130. Petitioner re-alleges and incorporates by reference the allegations in paragraphs one (1) through five (5), seventy-six (76) through eighty-seven (87), and one hundred seven (107) through one hundred nine (109), as if fully set forth herein.

131. During Patient B.E.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient B.E., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document the effectiveness and/or ineffectiveness of the medications prescribed to Patient B.E.;

b. By failing to document his rationale for prescribing medications and any changes or dosage adjustments; and/or

c. By failing to document key symptoms that were being addressed and treated during each visit.

132. In the alternative to the allegations set forth in subsections (a) through (g) of paragraph one hundred five (105) above, during Patient B.E.'s treatment period, Respondent failed to keep legible medical records which justified the course of treatment of Patient B.E., and/or failed to satisfy the requirements of Rule 64B8-9.003 F.A.C., in one or more of the following ways:

a. By failing to document an adequate assessment of Patient B.E.'s complaints and symptoms, including alleviating and/or aggravating symptoms;

b. By failing to document an adequate treatment plan for Patient B.E.;

c. By failing to appropriately document pursuing the course of treatment;

d. By failing to document obtaining informed consent from Patient B.E.;

e. By failing to document an adequate assessment of the risk of abuse or diversion of the controlled substances prescribed to Patient B.E.;

f. By failing to document adequately and consistently monitoring Patient B.E.'s medication use to prevent noncompliance, drug abuse, diversion of controlled substances, and/or for the risk of substance use disorders; and/or

g. By failing to document providing alternative forms of treatments to Patient B.E.

133. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2015-2017), and/or Section 458.331(1)(nn), Florida Statutes (2015-2017), by violating Rule 64B8-9.003 F.A.C.

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 22nd day of October, 2018.

Celeste Philip, MD, MPH
State Surgeon General and Secretary of Health

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DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK
DATE OCT 22 2018

PCP Date: October 19, 2018

PCP Members: Jorge Lopez, M.D.; Stephanie Haridopolos, M.D.; Andre Perez

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. A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.

Mediation under Section 120.573, Florida Statutes, is not available to resolve this Administrative Complaint.

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.