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BEFORE THE BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

vs.

DPR CASE NO. 0068042
DOAH CASE NO. 88-1149

CHARLES CURTIS, D.O.,

Respondent.

FINAL ORDER

Respondent, CHARLES CURTIS, D.O., is a licensed osteopathic physician in the State of Florida, having been issued licensed No. OS 0003592. Petitioner filed an Administrative Complaint seeking suspension, revocation, or disciplinary action against the licensee.

Respondent requested a formal hearing and one was held before the Division of Administrative Hearings. The Recommended Order has been forwarded to the Board pursuant to Section 120.57(1), F.S.; it is attached to and made a part of this Order.

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.

FINDINGS OF FACT

1. Findings of fact set forth in the Recommended Order, with the exception of paragraph 6, are approved and adopted and incorporated herein.

2. The Board rejects the finding of fact in paragraph 6 on the basis that it is not supported by competent substantial evidence in the record of this case.

3. There is competent substantial evidence to support the findings of fact made by the Board.

CONCLUSIONS OF LAW

1. The Board has jurisdiction of this matter pursuant to Section 120.57(1), Florida Statutes, and Chapter 459, Florida Statutes.

2. The conclusions of law set forth in the Recommended Order are approved and adopted and incorporated herein, with the exception of the last sentence of paragraph 2.

3. The Board rejects the Hearing Officer's assertion that the style of the case on the Recommended Order accurately reflects the true parties. The Board of Osteopathic Medical Examiners was not a party in this cause before the Division of Administrative Hearings.

4. There is competent substantial evidence to support the conclusions of law made by the Board.

PENALTY

WHEREFORE, IT IS HEREBY ORDERED AND ADJUDGED that Respondent's license to practice osteopathic medicine is placed on probation for a period of one year, subject to the following terms and conditions:

1. Respondent shall attend 20 hours of Category I Continuing Medical Education courses in risk management,

osteopathic recordkeeping, and hospital quality assurance. Respondent shall submit a written plan for completion of this Continuing Medical Education prior to the scheduled meeting of September 15 and 16, 1989, for approval by the Board. Said Continuing Medical Education shall be in addition to any Continuing Medical Education required for license renewal.

2. Respondent shall practice only under the indirect supervision of an osteopathic physician fully licensed under Chapter 459 and approved by Dr. Schwemmer prior to the September meeting. The responsibilities of the monitoring physician shall include:

Review 25 of Respondent's patient records selected on a random basis and submit a report in affidavit form to the Board prior to the meeting of September 15-16, 1989, and perform at least one more review and submit a report to the Board prior to the termination of probation, which termination shall not occur prior to completion of 6 months of the probationary term.

3. Respondent may request early termination of probation upon compliance with the terms and conditions set forth above.

4. Both parties agreed on the record to the penalty set forth above.

This order takes effect upon filing with the Clerk of the Department of Professional Regulation.

DONE AND ORDERED this 21ST day of August, 1989.

BOARD OF OSTEOPATHIC
MEDICAL EXAMINERS

SANDRA SCHWEMMER, D.O.
VICE CHAIRMAN

NOTICE OF RIGHT TO APPEAL

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 PROFESSIONAL REGULATION 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.

CONFIDENTIAL

CONFIDENTIAL

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF PROFESSIONAL REGULATION, BOARD OF OSTEOPATHIC MEDICAL EXAMINERS,

Petitioner,

vs. CASE NO. 88-1149

CHARLES CURTIS, D.O.,

Respondent.

RECOMMENDED ORDER

Upon due notice, this cause came on for formal hearing on December 13-14, 1989 in West Palm Beach, Florida, before Ella Jane P. Davis, a duly assigned hearing officer of the Division of Administrative Hearings.

APPEARANCES

For Petitioners: Lee Sims, Esquire
130 North Monroe Street
Tallahassee, Florida 32301

and

Peter S. Fleitman, Esquire
One Datran Center - Suite 1409
9100 Dadeland Boulevard
Miami, Florida 33156

For Respondents: Barbara W. Sonneborn, Esquire
1615 Forum Place, Suite 300
West Palm Beach, Florida 33401

and

Lawrence U. L. Chandler
Suite 800
105 So. Narcissus Avenue
West Palm Beach, Florida 33401

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BACKGROUND

The initial Administrative Complaint in this cause was filed December 15, 1987. It was thereafter amended in order to clarify the allegations against Respondent. This cause proceeded to formal hearing on Counts 1 through 4, of the Amended Administrative Complaint, alleging violations of Sections 459.015(1)(r), (n), (y), (p), F. S.

ISSUE

Respondent is charged, pursuant to Count One with a violation of Section 459.015(1)(n), (1985), now Section 459.015(1)(p), F.S., by failing to keep written medical records justifying the course of treatment of the patient, including but not limited to patient histories, examination results, and test results; pursuant to Count Two with a violation of Section 459.015(1)(t), F.S. (1985), now Section 459.015(1)(y), F.S. by gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill and treatment which is recognized as acceptable by a reasonably prudent similar osteopathic physician under similar conditions and circumstances; pursuant to Count Three, with a violation of Section 459.015(1)(l), F.S. (1985), now Section 459.015(1)(n), F.S. by making deceptive, untrue or fraudulent representations in the practice of osteopathic medicine; pursuant to Count Four, with a violation of Section 459.015(1)(o), F.S. (1985), now Section 459.015(1)(r), F.S. by exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party which shall

include but not be to limited to the promoting or selling of services, goods, appliances or drugs.

PRELIMINARY STATEMENT

Procedural and Evidentiary Matters

At Formal Hearing, Petitioner and Respondent made several motions to limit testimony of certain witnesses. Specifically, Petitioner filed a Motion in Limine to exclude the testimony of Respondent's expert, Charles Rudolph, D.O., and Respondent filed a Motion in Limine to limit the testimony of Petitioner's expert, Mark Montgomery, Ph.D.. In addition, Respondent filed a Memorandum of Law in Support of Expert Testimony of Charles Rudolph, D.O.. Petitioner's Motion in Limine regarding Dr. Rudolph was denied, it being determined that Dr. Rudolph was qualified to testify as an expert herein pursuant to Section 768.45 F.S. Respondent's Motion in Limine regarding Dr. Montgomery, who is neither a medical nor osteopathic physician, was granted. Accordingly, the testimony of Dr. Montgomery was limited so as to exclude such testimony as to the standard of care to which an osteopathic physician may be held. See, Cross v. Lakeview Center, Inc., 529 So.2d 307 (Fla. 1st DCA 1988). Dr. Montgomery's testimony was otherwise received in evidence as any other expert witness pursuant to the premises established in Wright v. Schulte, 441 So.2d 660 (Fla. 3rd DCA 1983), and Sykes v. Seaboard Coastline Railroad Co., 429 So.2d 1216 (Fla. 1st DCA 1983).

Witnesses, Exhibits and Post-Hearing Procedure

Prior to formal hearing, the parties' entered into a joint Prehearing Stipulation which has been utilized to the extent appropriate and necessary in this Recommended Order.

Although the Amended Administrative Complaint utilized only initials of the patient, Petitioner and Respondent have consistently used full names throughout discovery and hearing. Respondent has used full names in his post-hearing submittals. No motion with regard to sealing the record has been made and the transcript utilizes full names. Accordingly, no purpose would be served by reverting to initials for the patient, and her full name will be used in this recommended order.

At formal hearing, Petitioner presented the oral testimony of Christie J. Dietert, Mark R. Montgomery, Ph.D., C[redacted] M[redacted], M[redacted] M[redacted], Peter Block, and Ralph Birzon, D.O.. Petitioner offered ten exhibits of which Petitioner's Exhibits 2, 3, 4, 6, 7, 9 and 10 were admitted in evidence.

Respondent testified on his own behalf and presented the oral testimony of Douglas M. Baird, III, D.O. Respondent also filed the deposition of Charles John Rudolph, Jr., D.O., Ph.D., which was admitted in evidence as Respondent's Exhibit 6, subject to the terms of an oral order entered on the record, pursuant to which order, Petitioner's objections to the transcribed deposition of Dr. Charles Rudolph were to be filed in the form of certified questions within ten days of December 14, 1988, the last day of live testimony. By Order entered January 9, 1989, it was ruled that all such objections were deemed waived because Petitioner did not timely file any objections. In total,

Respondent offered eight (8) exhibits, of which Respondent's Exhibits 3, 4, 5, 6, [illegible] 8 were admitted in evidence.

At the close of Petitioner's case in chief, Respondent moved for involuntary dismissal of Counts Three and Four. These motions were taken under advisement and are resolved within the Conclusions of Law of this Recommended Order.

Transcript of formal hearing was duly filed and was followed by the parties' respective proposed findings of fact and conclusions of law, the findings of fact of which have been ruled upon pursuant to Section 120.59(2) F.S. in the Appendix to this Recommended Order.

Respondent's Motion to Strike Petitioner's proposals, which had been filed one day late was denied by Order entered February 15, 1989.

FINDINGS OF FACT

1. At all times material, Respondent was licensed as an osteopathic physician in the State of Florida having been issued License No. OS 0003592.

2. Respondent graduated from Kirksville College of Osteopathic Medicine and Surgery and completed a twelve month rotating internship at Suncoast Hospital in Largo, Florida in 1975. He then entered practice in Lake Park at his present address, 310 U.S. Highway One, Lake Park, Florida 33403.

3. From on or about July 22, 1985 until on or about November 27, 1985 Respondent rendered medical care and treatment to patient M[redacted] M[redacted], for a variety of complaints, including but not limited to hypertension, anxiety, depression, and hair loss.

4. This disciplinary action arises out of a mineral hair analysis test performed on Mrs. M and her treatment with chelation therapy. Ultimately, Ms. M terminated her chelation treatments after completing only 4 of the 5 treatments recommended by Respondent. Mrs. M and her husband, Charles, initiated complaints to the Department of Professional Regulation only after Medicare declined to reimburse them $65.00 per treatment for the four chelation treatments she received from Respondent. Christie J. Dietert, the Department of Professional Regulation Investigator who testified, felt her investigation had ruled out a charge of experimentation and did not pursue further investigation.

5. Upon the testimony of Respondent, Dr. Birzon, Dr. Baird, and Dr. Rudolph, it is found that although chelation therapy is not an ordinary and customary therapy, chelation therapy for heavy metal toxicity and for cardiovascular problems is used by a respectable and significant minority of physicians similar to Respondent. (See Findings of Fact 23-24) Dr. Birzon and Dr. Baird are both Florida-licensed osteopathic physicians. Dr. Birzon is not a proponent of such treatment and has little training in chelation therapy of any kind, but he is familiar with its use by respected colleagues. Dr. Baird is trained in various types of chelation therapy and uses it regularly in his practice. In his opinion, upon review of the patient's chart, laboratory reports, and the applicable superbills, he would probably have given her chelation therapy for her cardiovascular problems. He also felt that chelation therapy was the only

therapy that would address all her problems at the point in time Respondent administered it, after unsuccessfully trying other methods for each complaint.

6. Upon direct evidence adduced at formal hearing, and upon authority of the findings of fact adopted _in toto_ in the Final Order of _Department of Professional Regulation v. Roehm_, DOAH Case No. 86-2868 (Final Order entered by the Board of Medical Examiners October 13, 1988), it is clear that a respectable minority of physicians similar to Respondent also use hair mineral analysis as a diagnostic device, and that while controversial, hair mineral analysis is not experimental when used as part of the constellation of diagnostic tools available to modern science, nor is its utilization as a screening device a departure from that level of care, skill, and treatment required of a reasonably prudent similar practitioner in like circumstances.

7. Respondent participates in an average of one hundred fifty hours per year in continuing education within the field of osteopathic medicine. Although not board-certified in osteopathy, he is a member of many associations, including the American Academy of Medical Preventives and the American Academy of Medical Advancement. Since 1976, hair loss has been of special interest to Respondent and he has residency training in ear, nose and throat, and in facial plastic surgery. When Respondent became active in the American Academy of Medical Advancement, he participated in its program pertaining to hair analysis and the interpretation of hair analysis reports.

Respondent learned of chelation therapy starting in osteopathic medicine school and has had actual experience with it since 1976. Respondent has attended educational meetings at the rate of approximately one per year regarding EDTA and chelation therapy.

8. On July 22, 1985, Mrs. M[redacted] presented at the Respondent's office with symptoms of nervousness and hair loss. She told Respondent that she had previously seen Dr. Crittendon and Dr. Marchetto, both with compliants of hair loss. Both doctors had advised her that there was nothing that could be done for her hair loss, but Mrs. M[redacted] had seen and talked with a patient of Respondent's who had had good results from Respondent's treatment for hair loss, and Mrs. M[redacted] wanted to see what Respondent could do for her.

9. Upon the credible portions of the testimony of both Respondent and Mrs. M[redacted], it is found that Respondent performed only a cursory physical examination of Mrs. M[redacted] on her first visit. Respondent testified, and it is accepted, that it is his routine to examine a patient on the first visit and only note abnormal findings, not normal ones. He normally does listen to the heart, palpate the abdomen, and do a brief neurological test. If he did these on Mrs. M[redacted], they were not recorded. The fact that Respondent cannot recall with certainty if these examinations were performed and his notes cannot assist him recall this information demonstrate a significant flaw in his notes.

10. With regard to Mrs. M[redacted]' first visit, an SMAC-26, a CBC, urinalysis, and mineral hair analysis were noted by

Respondent as future tests to be performed as part of a plan for reaching a firm diagnosis of her problems and to rule out metabolic dysfunction as their cause. All tests except the hair mineral analysis were performed on her third visit, August 27, 1985, and were paid for in advance. At the same time, a thyroid test was done. Hair was removed for the hair mineral analysis on September 6, 1985.

11. Respondent's first examination of Mrs. M[redacted] was cursory, but he examined her frequently with different degrees of thoroughness on several occasions between July 22, 1985 and November 26, 1985. Respondent generally recorded only significant positive or negative findings. Frequently, the only part of the physical examination or office visit recorded in Respondent's notes was weight, blood pressure, and symptomatology. However, this information was fleshed-out on occasion with a listing on the superbills of diagnoses, and of prescriptions and injections given. Unfortunately, sometimes the dates on the superbills and the dates on the chart/notes do not dove-tail. On 9/26/85 Respondent's notes reflect the first diagnosis of hair loss and anxiety. On several occasions, Respondent also treated Mrs. M[redacted], as set forth <u>infra</u>.

12. At their initial consultation, Respondent took only a brief history because Mrs. M[redacted] informed him of her prior medical history and promised availability of medical records from the prior treating physicians. However, the brief history that was taken included the fact that Mrs. M[redacted] had major surgery at a prior unknown date and a pap smear eight months before her

first visit to Respondent. The Respondent also noted that Mrs. M[redacted] smoked two packages of cigarettes a day and drank alcohol occasionally. He further noted that she was being treated for high blood pressure (hypertension) by Dr. Marchetto. Respondent requested that the patient sign a release for her medical records from these other doctors, which she did. Nonetheless, it was agreed between them at the first visit that Mrs. M[redacted] would personally obtain her prior medical records and bring them to Respondent rather than his having to send for them. However, thereafter, she did not obtain them because, by her own testimony, she felt she did not have the time and because she unilaterally decided it was not necessary to do so.

13. Over the course of treatment, Respondent discovered that Mrs. M[redacted] drank beer, if not excessively, at least considerably, during the period he was treating her. She was also overweight and very sensitive about her hair loss. She wore wigs and hairpieces at all times, 24 hours a day, even in bed. Beyond recording her weight on each visit, Respondent did not specifically record these matters in his notes, but he did address them in discussions with Mrs. M[redacted].

14. With regard to obtaining her medical records and as set out infra, Mrs. M[redacted] was not a very cooperative patient. From observation of their candor and demeanor while testifying, as well as by assessment of the substance of their testimony, it appears that Mr. and Mrs. M[redacted] were chronic "doctor shoppers" and "treatment-shoppers" but were not fastidious about following medical directions. One or the other frequently called

Respondent's office for one reason or another and the Respondent's notes on Mrs. M[redacted] reveal he refused to advise her by telephone until she came into the office to complete the laboratory tests for diagnostic purposes. Contrary to being exploitative, the inference therefrom must be that he declined to treat or advise her until conservative diagnostic tests were performed.

15. Although the Respondent's medical notes on this patient do not reflect multiple discussions with her, as such, they do support his testimony that he reviewed laboratory results with her and warned her about drinking alcohol while on certain medications. Also, upon the credible portions of Mr. and Mrs. M[redacted]' testimony and that of Respondent, it is concluded that Respondent spent considerable time discussing symptoms, possible treatments, and probable effects with Mr. and Mrs. M[redacted] prior to suggesting chelation therapy. Respondent instructed Mrs. M[redacted] that the constant wearing of a wig, excessive use of alcohol and tobacco, and poor circulation contributed to hair loss. He contacted the University of Florida to rule out the possibility that one of her hypertensive medications was contributing to hair loss. He advised her to leave the wigs off and buy a vibrator to massage her scalp to improve circulation. He prescribed a nutritional weight loss diet, and suggested she exercise by walking. All of these suggestions constitute conservative standard treatment for high blood pressure, obesity, circulatory problems, and hair loss. He also prescribed vitamins, minerals, and a diuretic. He prescribed Kenalog to

stimulate hair growth. Neither of these treatments was shown to be clearly contrary to prevailing standards of care for this type of patient. Mrs. M[redacted] did basically what she wanted and continued to complain of hair loss and anxiety.

16. The patient's blood pressure was checked at each visit and indicated that even with medication, her blood pressure remained at the high end of the normal range. Respondent changed blood pressure medications with good results. The only faults with this procedure found by Dr. Birzon was that the prior doctors' records should have been obtained by Respondent directly, or he should have refused to treat the patient; not having the prior records, Respondent should have been more meticulous in diagnosing hypertension in the first place and in recording it; and he should have recorded his test results and diagnosis instead of just recording the medications. Medications should also have been recorded as to amount, strength, and duration, instead of as they were recorded, merely by name.

17. The patient presented at almost every office visit with symptoms of extreme nervousness, and/or anxiety. Respondent tried to refer her to a psychiatrist; she would have none of it. He prescribed tranquilizers and antidepressants. On one occasion, he prescribed lithium. No fault or failure of the standard of care was linked to these treatments, even though Respondent is not a psychiatrist, but his failure to record medications properly and his failure to record a specific diagnosis which would support use of the lithium was proven. Mr. M[redacted] flushed the lithium tablets down the toilet because he did not want his wife taking something for "crazy people."

18. Subsequent to all the tests and trials outlined above, Respondent provided Mrs. M[redacted] with a "patient's copy" of the hair mineral analysis performed by Doctor's Data Inc., a reputable hair mineral analysis laboratory. Despite some belligerent contrary assertions by Mr. M[redacted], Mrs. M[redacted] testimony, Respondent's testimony, the hair mineral analysis printout, the superbills, and the Respondent's notes on this patient are all consistent that Respondent never diagnosed Mrs. M[redacted] as having "heavy metal poisoning" or "mercury poisoning."

19. The hair mineral analysis showed a mild degree of elevation of copper and mercury, each within 1 or 2 standard deviations of normal on the heavy metals section. There was also a mild elevation of cadmium. The mercury level was within the normal range of the vast majority of the population.

20. Upon the basis of his education, training, and experience, this hair mineral analysis, and all the foregoing tests, plus his examinations and observations of, and discussions with, Mrs. M[redacted] on 7/22/85, 8/1/85, 8/27/85, 8/30/85, (when he successfully surgically removed a lesion from her leg), 9/6/85, 9/12/85, 9/26/85, and 9/30/85, Respondent diagnosed Mrs. M[redacted] as having "heavy metal toxicity" and "hypertension." He did not, however, record the diagnosis of hypertension anywhere in his records until it was first placed on the superbill for 11/5/85, and the dual diagnosis of hypertension and heavy metal toxicity is first recorded on the superbill for 11/12/85. Thereafter, the dual diagnoses appear on each superbill.

21. During her testimony, Mrs. M[redacted] first "guessed" that Respondent had told her she had mercury poisoning, lead poisoning, or heavy metal poisoning, but upon further inquiry, she could recall very few specifics about Respondent's review of her tests with her or his statements to her. Omitting repetitions and digressions in her testimony, it is found that Mrs. M[redacted]' testimony concerning Respondent's representations can be summed up as follows: Respondent had represented to her that there was mercury in her hair and in the hair analysis, that the degree of mercury "wasn't bad," that her heavy metals were light and not serious, that chelation therapy would help but not that it would take all the mercury out. Respondent related to her that the chelation therapy might bring down her high blood pressure. He told her he did not know why she was losing her hair but the chelation therapy might help her. He only used the word "poison" in a phrase like, "you need to get the poison out of your system." Mr. and Mrs. M[redacted] both agree that they were given a copy of the laboratory blood tests and the hair mineral analysis printout to take home and review outside Respondent's presence after Respondent discussed the test results with Mrs. M[redacted]. Mrs. M[redacted] also got an independent opinion from Dr. Marchetto before submitting to Respondent's chelation therapy.

22. Despite all of the foregoing, Mr. and Mrs. M[redacted] came to the conclusion that Respondent's diagnosis of "heavy metal toxicity" equated directly with "heavy metal poisoning". The consensus of the expert testimony is that these terms are not synonymous and that the standard of treatment for them is not the

same. Heavy trace metal toxicity is similar to a chronic chemical change but is not an acute poisoning. Such toxicity is subacute and subclinical, whereas mercury poisoning or other heavy metal poisoning or heavy metal intoxication is a medical emergency, requiring more extensive testing in order to discover it and requiring different chelating formulas or other treatment than Respondent used here. Mrs. M[redacted] asserted that she alone decided that something should be done about the mercury in her system.

23. Respondent recommended a course of five chelation treatments and intended to repeat the battery of standard tests afterwards to determine the treatment's effectiveness. Notwithstanding the testimony of Mark Montgomery Ph.D. and Dr. Birzon D.O., there is competent substantial evidence to show that Mrs. M[redacted] was an acceptable candidate for the type of chelation therapy Respondent administered and that although she was the first patient treated by Respondent for mercury toxicity, he could have had a reasonable belief that his method of chelation would improve circulation for treatment of hair loss, would reduce blood pressure so as to eventually reduce or eliminate medication, and possibly would provide some relief for Mrs. M[redacted]' other complaints. Dr. Birzon conceded that a low level of mercury could be causing a problem for a patient even if it did not hit the level of "heavy metal poisoning" or "toxicity." See also Dr. Baird's view, Finding of Fact 5. supra.

24. Respondent uses two chelation therapy formulas. Both formulas utilize EDTA; only one uses Heperin. Dr. Birzon

testified that the formula utilizing Heperin could have been dangerous to Mrs. M[redacted], given her cardiovascular problems, since it is a blood thinner. Respondent's records are clearly inadequate because they do not show which formula was used on Mrs. M[redacted], but there is likewise no clear evidence Mrs. M[redacted] was ever chelated with Heperin. Respondent's formulas are in accord with the recommendations of the American Academy of Medical Preventatives. Mark Montgomery, Ph.D., conceded that either formula posed little or no risk to this patient and might have actually provided some benefit, albeit a placebo effect. The complaints associated with this therapy by the Malkemuses, i.e. that the veins in Mrs. M[redacted]' face blew-up, her breasts dropped, her arms got thin, and she lost weight were not clinically documented because Mrs. M[redacted] did not report them to Respondent. Also, no witness could convincingly relate these unreported complaints to the Respondent's chelation therapy, and based upon the modicum of testimony that such symptoms beyond the weight loss could not result from this chelation therapy and having observed the candor and demeanor of the M[redacted] while testifying, the undersigned concludes that these foregoing complaints were subjective. However, Mrs. M[redacted]' complaints of foot and leg cramps were associated with the chelation therapy and were reasonably treated by the Respondent when she reported them to him.

25. Respondent failed to keep written medical records justifying the course of treatment of Mrs. M[redacted]

26. Respondent is not guilty of gross or repeated malpractice or failure to practice osteopathic medicine within that level of care, skill and treatment which is recognized by a reasonably prudent similar osteopathic physician under similar conditions and circumstances.

27. Respondent made no deceptive, untrue, or fraudulent representations in the practice of osteopathic medicine.

28. Respondent did not exercise influence on his patient or client to exploit her for his own financial gain or that of another.

CONCLUSIONS OF LAW

1. The Division of Administrative Hearings has jurisdiction of the parties and the subject matter of this cause.

2. At times during the course of these proceedings, various inaccurate styles have been utilized by the parties, court reporters, the Clerk of the Division of Administrative Hearings, and the undersigned hearing officer. It is determined that these erroneous styles have all been typographical errors, reflect no significant procedural irregularities, had no effect on actual notice, jurisdiction, or authority, and prejudiced no parties. However, the style of this cause is hereby amended as reflected above on this Recommended Orders so as to accurately reflect the true parties.

3. The Motion to Dismiss Counts Three and Four was premature at the conclusion of Petitioner's case and should have been denied at that time, however the greater weight of the credible competent substantial evidence as a whole, including

Respondent's case in chief, supports dismissal of Counts Two-Four as discussed infra.

4. Pursuant to Section 459.015(1), F.S. the Board of Osteopathic Medical Examiners is empowered to revoke, suspend or otherwise discipline the license of a physician for any of the following violations of Section 459.015(1), F.S. (1985):

> (n) in that he failed to keep written medical records justifying the course of treatment (Count I);
>
> (t) in that he practiced below the standard of care (Count II);
>
> (l) in that he made deceptive, untrue and fraudulent representations to the patient about her condition (Count III);
>
> (o) in that he exercised influence on the patient to exploit the patient for financial gain (Count IV).

5. With regard to Counts II, III, and IV, there is insufficient evidence to meet the heavy "clear and convincing" standard for the discipline of professional licenses established in Ferris v. Turlington, 510 So.2d 292 (Fla. 1987).

6. Respondent performed numerous laboratory tests and tried conservative modalities of treatment for Mrs. M[redacted] variety of complaints before instituting a very brief series of chelation therapy. Dr. Baird testified that he knew of no other treatment besides chelation which would address the entire spectrum of ailments Mrs. M[redacted] presented. There is no clear and convincing evidence this patient was, or could have been, harmed by the therapy administered by Respondent. As with every prescription, treatment and life-style change Respondent

suggested to Mrs. M[redacted] she did not complete the course of treatment. Therefore, follow-up tests could not be done.

7. Chelation therapy as administered by Respondent may be controversial and only accepted by a very small minority but that is not sufficient, without more, to render it gross or repeated malpractice or below the acceptable standard of care. Mr. and Mrs. M[redacted] believed the worst once they erroneously equated heavy metal toxicity with the controversial mercury poisoning scare. They ignored the actual words of the hair mineral analysis and ignored Respondent's assurance that the trace heavy metals were "not that bad". They resisted the idea that Mrs. M[redacted] needed to get all the poisons, including tobacco and alcohol, out of her system, and clung to the idea of "heavy metal poisoning or intoxication". Mrs. M[redacted] elected to have chelation therapy even though she consulted Dr. Marchetto first. Under these circumstances, fraud, coercion and false promises are simply non-existent.

8. With regard to Count I, however, the evidence is clear and convincing that Respondent's medical records were insufficient to justify the treatment. For the repeated failure to record physical examinations, symptomatology, interviews, laboratory test results, prescription amounts, and duration of drug use, and for failure to obtain the prior medical records as set forth in the foregoing findings of fact, and because notations on the patient's bills do not fulfill the professional standards for osteopathic record keeping, Respondent is determined to have violated Section 459.015(1)(n) F.S. (1985).

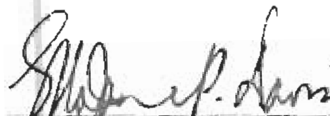
9. Petitioner argues that Respondent's use of chelation therapy poses a threat to the public but has not proved it. Petitioner also asserts that were Respondent found guilty of all four charges the appropriate penalty would be reprimand, $2,000 fine, five years' probation and 50 hours of continuing medical education courses per year of probation in toxicity and record keeping.

10. In light of the foregoing findings of fact and conclusions of law that Respondent has committed a single record-keeping violation, it is recommended that:

RECOMMENDATION

The Board of Osteopathic Medical Examiners enter a final order dismissing Counts II, III, and IV of the Amended Administrative Complaint, finding Respondent guilty of Count I thereof in that he violated Section 459.015(1)(n) F.S., reprimanding Respondent for the sole violation, and imposing a probationary period of one year, the probation to be reduced in the event Respondent demonstrates to the Board satisfactory completion of courses in osteopathic record-keeping, the courses to be selected and specified by the Board in its final order.

DONE and RECOMMENDED this 13th day of April, 1989, in Tallahassee, Leon County, Florida.



ELLA JANE P. DAVIS
Hearing Officer
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Filed with the Clerk of
the Division of
Administrative Hearings this
13th day of April, 1989.

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Tallahassee, Florida 32399-0750

APPENDIX

The following constitute specific rulings pursuant to Section 120.59(2) F.S. upon the parties' respective Proposed Findings of Fact (PFOF).

Petitioner's Proposed Findings of Fact

At the outset, it must be observed that only Petitioner's proposals 19 and 22 reference any part of the record at all and therefore are subject to rejection for that reason at alone.

1, 2, 5, 6, 7, 8, 15, 16, 17, 18 and 26 are accepted.

3 is accepted except to the extent not supported by the greater weight of the credible competent substantial evidence of record as a whole.

4, 9, and 11, are rejected as not supported by the greater weight of the credible competent substantial evidence of record as a whole; see Findings of Fact 10,18-23.

10 is accepted but not adopted as stated because as stated it is misleading and out of context.

12 This is not alleged to be experimental medicine. The proposal is accepted in part and rejected in part as subordinate and unnecessary to the facts as found.

Clause one of 13 is rejected as not supported by the credible competent substantial evidence as a whole. Clause two of 13 is rejected as subordinate to the facts as found and as irrelevant in that lack of informed consent was not alleged in the amended administrative complaint.

14 is accepted in part. The remainder is rejected as not supported by the credible competent substantial evidence as a whole.

19 is rejected as subordinate and unnecessary to the facts as found.

20, 21, 22, 25, 27 and 28, are rejected as cumulative or subordinate and unnecessary to the facts as found.

23 is accepted but immaterial since this case involves trace heavy metal toxicity.

24 is rejected in part as not supported by the greater weight of the credible competent substantial evidence of record as a whole, and in part as subordinate and unnecessary to the facts as found, and in part as mere recitation of unreconciled testimony.

29, 30, and 32 are rejected as mere recitations of testimony .

31 is rejected as mere legal argument.

33 is rejected as a mere recitation of testimony and a reiteration of an objection already ruled upon within the record. See introductory material to this Recommended Order.

Respondent's Proposed Findings of Fact

1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 18, 21, 24, 25 and 27 are accepted except where cumulative or subordinate or unnecessary to the facts as found. Legal argument therein is also rejected on that ground.

11 is accepted in part but clearly modified to conform to the greater weight of the credible competent substantial evidence of record as a whole.

13 is accepted in substance but is otherwise rejected as legal argument and mere recitation of testimony as opposed to a proposed material fact.

14, Rejected as not supported by the greater weight of the credible competent substantial evidence of record as a whole and as mere recitation of testimony and as legal argument. Moreover, many of the statements attributed to Dr. Birzon are out of context for Dr. Birzon specifically testified that a review of the superbills and other records presented him at hearing would not have modified his opinion on lack of record justification and that the superbill diagnoses did not always conform to the chart/notes. See Finding of Fact 11.

15 and 17 are accepted except where cumulative, subordinate or unnecessary to the facts as found. The legal argument in the footnotes are rejected on that ground.

16 is rejected as without record citation and as subordinate and unnecessary to the facts as found.

19, 20, and 26 are rejected as cumulative, subordinate or unnecessary to the facts as found.

22 is accepted in part. The remainder is rejected as cumulative, subordinate or unnecessary to the facts as found.

23, Rejected as mere legal argument upon objections already ruled upon within the record. Dr. Birzon's testimony has been weighed within the latitude of Wright v. Schulte, 441 So.2d 660 (Fla. .2d DCA 1983) and Sykes v. Seaboard Coastline Railroad Co. 429 So.3d 1216 (Fla. 1st DCA 1983) and is reflected appropriately within the facts as found.

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION, Petitioner, vs. CHARLES E. CURTIS, D.O., Respondent.	)	DOAH CASE NO. 88-1149 DPR CASE NO. 0068042

AMENDED ADMINISTRATIVE COMPLAINT

COMES NOW, the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner", and files this Administrative Complaint before the Board of Osteopathic Medical Examiners against Charles E. Curtis, D.O., hereinafter referred to as "Respondent", and alleges:

1. Petitioner is the state agency charged with regulating the practice of osteopathic medicine pursuant to Section 20.30, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 459, Florida Statutes.

2. Respondent is, and has been at all times material hereto, a licensed osteopathic physician in the State of Florida having been issued license number OS 0003592. Respondent's last known address is 310 U.S. Hwy. #1, Lake Park, Florida 33403.

3. From on or about July 22, 1985, until on or about November 27, 1985, Respondent rendered medical care and treatment to patient M.M., for a variety of complaints, including, but not limited to, hypertension, anxiety, depression and hair loss.

4. On or about July 22, 1985, Respondent performed a mineral hair analysis on patient M.M., so as to assess her complaint of hair loss.

5. On the aforementioned date, Respondent diagnosed patient M.M. as having heavy metal toxicity, based solely upon the aforementioned analysis.

6. The use of mineral hair analysis to confirm heavy metal toxicity is considered unreliable in itself, but may be used as a screening tool in conjunction with other diagnostic test.

7. Respondent subsequently treated patient M.M. for heavy metal toxicity with Chelation therapy.

8. Chelation Therapy may be an effective treatment for documented heavy metal intoxification when such intoxification is substantiated through extensive blood and urine test, endocrine disorders, serum levels of the intoxicants and environmental factors possibly affecting the patient.

9. Respondent failed to obtain adequate blood or urine analysis by which to properly diagnos heavy metal toxicity.

10. Respondent failed to adequately diagnose and/or treat patient M.M., for anxiety and depression.

COUNT ONE

11. Petitioner realleges and incorporates paragraphs one (1) through ten (10, above, as if fully set forth herein this Count One.

12. In his treatment of patient M.M., Respondent failed to keep written medical records, justifying this course of treatment.

13. Based upon the foregoing, Respondent has violated Section 459.015(1)(n), Florida Statutes (1985), now Section 459.015(1)(p), Florida Statutes (1986 Supp.), by failing to keep written medical records justifying the course of treatment of the patient including but not limited to patient histories, examination results and test results.

COUNT TWO

14. Petitioner realleges and incorporates paragraphs one (1) through ten (10) and twelve (12), above, as if fully set forth herein this Count Two.

15. Respondent failed to adequately examine, evaluate and treat patient M.M.

16. Based upon the foregoing, Respondent has violated Section 459.015(1)(t), Florida Statutes (1985), now Section 459.015(1)(y), Florida Statutes (1986 Supp.), by gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized as acceptable by a reasonably prudent similar osteopathic physician under similar conditions and circumstances.

COUNT THREE

17. Petitioner realleges and incorporates paragraphs one (1) through ten (10), twelve (12), and fifteen (15), above, as if fully set forth herein this Count Three.

18. Respondent made fraudulent representations in the practice of osteopathic medicine by performing a mineral hair analysis on patient M.M., while he knew or should have known of the lack of diagnostic value inherent in such test when alone applied to medical illness cases.

19. Based upon the foregoing, Respondent has violated Section 459.015(1)(l) Florida Statutes (1985), now Section 459.015(1)(n), Florida Statutes (1986 Supp.), by making deceptive, untrue or fraudulent representations in the practice of osteopathic medicine.

COUNT FOUR

20. Petitioner realleges and incorporates paragraphs one (1) through ten (10), twelve (12), fifteen (15) and eighteen (18), above as if fully set forth herein this Count Four.

21. Respondent wrongfully induced patient M.M. to undergo mineral hair analysis and subsequent Chelation therapy so as to exploit her for financial gain.

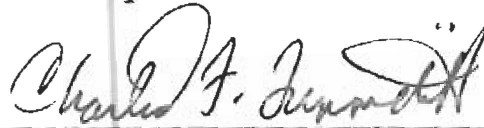
22. Based upon the foregoing, Respondent has violated Section 459.015(1)(o), Florida Statutes (1985), now Section 459.015(1)(r), Florida Statutes (1986 Supp.), by exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party which shall include but not be limited to the promoting or selling of services, goods, appliances or drugs.

WHEREFORE, the Petitioner respectfully requests the Board of Osteopathic Medical Examiners to enter an Order imposing one

or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 24th day of June, 1988.

TOM GALLAGHER
Secretary



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AGENCY CLERK
CLERK Melinda H Wagner
DATE 6/24/88

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AR/NS
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