STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2001-04256
DOAH CASE NO.: 07-3396PL
LICENSE NO.: ME0059702

JAMES SCOTT PENDERGRAFT, IV, M.D.,

Respondent.
_____/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(1), Florida Statutes, on August 7, 2010, in Orlando, Florida, for the purpose of considering the Administrative Law Judge's Recommended Order and Respondent's Exceptions to the Recommended Order, Petitioner's Response to Respondent's Exceptions, (copies of which are attached hereto as Exhibits A, B, and C, respectively) in the above-styled cause. Petitioner was represented by Diane Kiesling, Assistant General Counsel. Respondent was not present but an appearance was made on his behalf by Kenneth J. Metzger, Esquire.

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

RULING ON EXCEPTIONS

The Board reviewed and considered the Respondent's Exceptions to the Recommended Order and the Petitioner's Response to the Respondent's Exceptions and ruled as follows:

1. The Board denied Respondent's Findings of Fact Exception 1 to Paragraph 12 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions and based on the fact that in paragraphs 21, 24, and 25, of the Recommended Order the ALJ refers to the Respondent's own testimony and his own entries in the recreated medical records to support the factual finding set forth in the last sentence of paragraph 12 of the findings of fact. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 12 of the Recommended Order.

2. The Board denied Respondent's Findings of Fact Exception 2 to Paragraph 13 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's. There is competent substantial evidence in the

record to support the Administrative Law Judge's finding in Paragraph 13 of the Recommended Order.

3. The Board denied Respondent's Findings of Fact Exception 3 to Paragraphs 27 and 28 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraphs 27 and 28 of the Recommended Order.

4. The Board denied Respondent's Findings of Fact Exception 4 to Paragraph 32 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 32 of the Recommended Order.

5. The Board denied Respondent's Findings of Fact Exception 5 to Paragraph 33 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 33 of the Recommended Order.

6. The Board denied Respondent's Findings of Fact Exception 6 to Paragraph 29 of the Recommended Order for the reasons stated in Petitioner's written and oral response to

Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 29 of the Recommended Order.

7. The Board denied Respondent's Findings of Fact Exception 7 to Paragraphs 35 and 37 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraphs 35 and 37 of the Recommended Order.

8. The Board denied Respondent's Findings of Fact Exception 8 to Paragraph 36 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 36 of the Recommended Order.

9. The Board denied Respondent's Findings of Fact Exception 9 to Paragraph 40 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 40 of the Recommended Order.

10. The Board rejected Respondent's Conclusions of Law Exception 1 to paragraphs 53 and 54 of the Recommended Order and

denies the exception based upon the Petitioner's written and oral responses. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraphs 53 and 54 of the Recommended Order.

11. The Board denied Respondent's Conclusions of Law Exception 2 to Paragraph 56 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 56 of the Recommended Order.

12. The Board denied Respondent's Conclusions of Law Exception 3 to Paragraph 59 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions but does not adopt the Petitioner's suggested revised language for the first two sentences of paragraph 59 of the Recommended Order. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 59 of the Recommended Order.

13. The Board denied Respondent's Conclusions of Law Exception 4 to Paragraph 59 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial

evidence in the record to support the Administrative Law Judge's finding in Paragraph 59 of the Recommended Order.

14. The Board denied Respondent's Conclusions of Law Exception 5 to Paragraph 66 of the Recommended Order for the reasons stated in Petitioner's written and oral response to Respondent's Exceptions. There is competent substantial evidence in the record to support the Administrative Law Judge's finding in Paragraph 66 of the Recommended Order.

FINDINGS OF FACT

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

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

CONCLUSIONS OF LAW

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

2. The conclusions of law set forth in the Recommended Order are approved and adopted and incorporated herein by reference with the exception of the first two sentences of Paragraph 59 of the Conclusions of Law which is replaced by the following language:

> The Respondent, and the ALJ in his ruling on this finding, is incorrect when it contends that *Rogers v. Department of Health*, 920 So. 2d 27 (Fla. 1st DCA 2005) requires an element of illicitness for a determination that the prescription or administration of a legend drug is not in the "course of the physician's professional practice." *Waters, M.D. v. Department of Health, Board of Medicine*, 962 So. 2d 1011 (Fla. 3rd DCA 2007); *See also, Scheininger, M.D. v. Department of Professional Regulation, Board of Medical Examiners, 443 So. 2d 387 (Fla. 1st DCA 1983) Nonetheless, even if one accepts the ALJ's finding regarding the Rogers* case, Section 458.331(1)(e) supplies the element of illicitness.

For the reasons set forth above, this conclusion of law is as reasonable or more reasonable than that found by the administrative law judge.

PENALTY

Although Respondent filed a written exception to the penalty recommended by the Administrative Law Judge, counsel for Respondent orally withdrew this exception at the hearing. Upon a complete review of the record in this case, the Board determines that the penalty recommended by the Administrative Law Judge be MODIFIED. The Board bases its modification of the penalty on the Administrative Law Judge's findings of a violation of Section 458.331(1)(m), F.S., with regard to Respondent's failure to keep adequate medical records; and a violation of Section 458.331(1)(q), F.S., with regard to

Respondent's inappropriate prescribing. WHEREFORE, IT IS HEREBY ORDERED AND ADJUDGED:

1. Respondent shall pay an administrative fine in the amount of $10,000.00 to the Board within 30 days from the date this Final Order is filed.

2. Respondent's license to practice medicine in the State of Florida is hereby SUSPENDED for a period of one (1) year.

3. Following the period of suspension, Respondent shall be placed on PROBATION for a period of three (3) years subject to the following terms and conditions:

a. Respondent shall appear before the Probationer's Committee at the first meeting after said probation commences, at the last meeting of the Probationer's Committee preceding termination of probation, quarterly and at such other times requested by the committee. Respondent shall be noticed by Board staff of the date, time and place of the Board's Probationer's Committee whereat Respondent's appearance is required. Failure of the Respondent to appear as requested or directed shall be considered a violation of the terms of probation, and shall subject the Respondent to disciplinary action.

b. Respondent shall not practice except under the **indirect supervision** of a board-certified physician fully licensed under

Chapter 458 to be approved by the Board's Probationer's Committee. Absent provision for and compliance with the terms regarding temporary approval of a monitoring physician set forth below, Respondent shall cease practice and not practice until the Probationer's Committee approves a monitoring physician. Respondent shall have the monitoring physician present at the first probation appearance before the Probationer's Committee. Prior to approval of the monitoring physician by the committee, the Respondent shall provide to the monitoring physician a copy of the Administrative Complaint and Final Order filed in this case. A failure of the Respondent or the monitoring physician to appear at the scheduled probation meeting shall constitute a violation of the Board's Final Order. Prior to the approval of the monitoring physician by the committee, Respondent shall submit to the committee a current curriculum vitae and description of the current practice of the proposed monitoring physician. Said materials shall be received in the Board office no later than fourteen days before the Respondent's first scheduled probation appearance. The attached definition of a monitoring physician is incorporated herein. The responsibilities of a monitoring physician shall include:

(1) Submit reports, in affidavit form, which shall include:

(A) Brief statement of why physician is on probation.

(B) Description of probationer's practice.

(C) Brief statement of probationer's compliance with terms of probation.

(D) Brief description of probationer's relationship with monitoring physician.

(E) Detail any problems which may have arisen with probationer.

(2) Be available for consultation with Respondent whenever necessary, at a frequency of at least once per month.

(3) Review 25 percent of Respondent's patient records selected on a random basis at least once every month. In order to comply with this responsibility of random review, the monitoring physician shall go to Respondent's office once every month. At that time, the monitoring physician shall be responsible for making the random selection of the records to be reviewed by the monitoring physician.

(4) Report to the Board any violations by the probationer of Chapter 456 and 458, Florida Statutes, and the rules promulgated pursuant thereto.

c. In view of the need for ongoing and continuous monitoring or supervision, Respondent shall also submit the curriculum vitae and name of an alternate supervising/monitoring physician who shall be approved by Probationer's Committee.

Such physician shall be licensed pursuant to Chapter 458, Florida Statutes, and shall have the same duties and responsibilities as specified for Respondent's monitoring/supervising physician during those periods of time which Respondent's monitoring/supervising physician is temporarily unable to provide supervision. Prior to practicing under the indirect supervision of the alternate monitoring physician or the direct supervision of the alternate supervising physician, Respondent shall so advise the Board in writing. Respondent shall further advise the Board in writing of the period of time during which Respondent shall practice under the supervision of the alternate monitoring/supervising physician. Respondent shall not practice unless Respondent is under the supervision of either the approved supervising/monitoring physician or the approved alternate.

d. CONTINUITY OF PRACTICE

(1) TOLLING PROVISIONS. In the event the Respondent leaves the State of Florida for a period of 30 days or more or otherwise does not or may not engage in the active practice of medicine in the State of Florida, then certain provisions of the requirements in the Final Order shall be tolled and shall remain in a tolled status until Respondent returns to the active practice of medicine in the State of Florida. **Respondent shall**

notify the Compliance Officer 10 days prior to his/her return to practice in the State of Florida. Unless otherwise set forth in the Final Order, **the following requirements and only the following requirements** shall be tolled until the Respondent returns to active practice:

(A) The time period of probation shall be tolled.

(B) The provisions regarding supervision whether direct or indirect by the monitor/supervisor, and required reports from the monitor/supervisor shall be tolled.

(2) ACTIVE PRACTICE. In the event that Respondent leaves the active practice of medicine for a period of one year or more, the Respondent may be required to appear before the Board and demonstrate the ability to practice medicine with reasonable skill and safety to patients prior to resuming the practice of medicine in the State of Florida.

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

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

RULING ON MOTION TO ASSESS COSTS

The Petitioner's Motion to Assess Costs was withdrawn prior to the Board's consideration of the Motion.

(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.)

DONE AND ORDERED this 25 day of AUGUST, 2010.

BOARD OF MEDICINE

Larry McPherson, Jr., Executive Director
For Michael Chizner, M.D., Vice-Chair

NOTICE OF RIGHT TO JUDICIAL REVIEW

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

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to JAMES

SCOTT PENDERGRAFT, IV, M.D., 1103 Lucerne Terrace, Orlando, Florida 32806; by email to Kenneth J. Metzger, Esquire, Strawn, Monaghan, & Metzger, P.A., at kmetzger@metzgerandassociates.com; to Robert E. Meale, Administrative Law Judge, Division of Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-3060; and by interoffice delivery to Veronica Donnelly, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 27 day of August, 2010.

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DEPARTMENT OF HEALTH,

PETITIONER,

v. CASE NO.: 2001-04256

JAMES S. PENDERGRAFT, IV, M.D.,

RESPONDENT.

AMENDED ADMINISTRATIVE COMPLAINT

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

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

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number 59702.

3. Respondent's address of record is 1103 Lucerne Terrace, Orlando, Florida 32806.

4. Respondent is board certified in Obstetrics and Gynecology.

5. At all times material to this case, Respondent owned and operated Orlando Women's Center (OWC), Inc., a clinic specializing in abortions

6. M.W., a 31 year-old female, was a patient of the Respondent and also an employee of OWC. However, Patient M.W. was not a Florida licensed health care provider.

7. Patient M.W.'s duties at OWC included assisting in patient preparation, administering medications, cleaning equipment, ordering supplies, and remaining overnight with Patients to administer pain medications, such as Demerol, a Schedule II controlled substance. Respondent authorized Patient M.W., an unlicensed practitioner, to administer narcotics to Patients without supervision.

8. In 1997, Patient M.W.'s duties expanded to ordering controlled substances for OWC under Respondent's Drug Enforcement Administration (DEA) Registration Certificate, Number BP3000875.

9. Respondent's medical records for Patient M.W. indicate that in or about November of 1998, Patient M.W. informed Respondent that she wanted to become a wrestler, body builder and requested he prescribe anabolic steroids

for that purpose. There was no medical justification for prescribing anabolic steroids for Patient M.W.

10. In or about November of 1998, Respondent allowed Patient M.W. to use his DEA number to order anabolic steroids (specifically, Winstrol, Depo-testosterone, and Stanozolol) for her personal use.

11. Under Section 893.03, Florida Statutes, an anabolic steroid is defined as a Schedule III controlled substance and is any drug or hormonal substance chemically or pharmacologically related to testosterone that promotes muscle growth.

12. Respondent failed to order laboratory studies, such as liver function tests, to monitor the effects of the steroids he authorized for Patient M.W.

13. Respondent failed to document his monitoring of the effects of the steroids prescribed for Patient M.W. in the medical records.

14. In or about March of 1999, Patient M.W. was found unconscious on the floor at OWC. In speaking with Respondent regarding the incident, Patient M.W. admitted that she had abused Cocaine, a Schedule II controlled substance, and Heroin, a Schedule I controlled substance. Respondent made no attempt to treat Patient M.W.'s drug addiction or to refer her to an addiction specialist.

15. In or about April of 1999, Patient M.W. was again found unconscious on the floor at OWC.

16. On or about August 23, 1999, Respondent ordered a drug profile on Patient M.W. that was positive for Benzodiazepines (a chemically similar group of psychotropic drugs with potent hypnotic and sedative action used predominantly as anti-anxiety and sleep-inducing drugs), and Cocaine Metabolites (a Class II controlled substance and classified as a drug of abuse when used for non-medical purposes; but when used in medicine, to numb mucous membranes).

17. On or about September 22, 1999, Patient M.W. expired from acute pulmonary edema and respiratory compromise due to acute bronchitis with persistent airway obstruction. According to the coroner, Patient M.W.'s death was due to natural causes.

18. Rule 64B8-9.003, Florida Administrative Code, (November 1998-September 1999), is a Rule adopted by the Florida Board of Medicine which elaborates on the standard of care as regards medical records.

COUNT ONE

19. Petitioner realleges and incorporates paragraphs one (1) through seventeen (17) as if fully set forth herein.

20. Section 458.331(1)(t), Florida Statutes (1996-1999), provides that gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances constitutes grounds for disciplinary action by the Board of Medicine.

21. Respondent committed gross or repeated malpractice or failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances by one or more of the following:

a. Prescribing anabolic steroids for Patient M.W. when there were no medical indications to justify giving these drugs;

b. Failing to order laboratory tests for Patient M.W. to monitor the effects of the prescribed anabolic steroids;

c. Failing to treat Patient M.W.'s known drug addiction or to refer her to an addiction specialist;

d. Employing Patient M.W. in a position that gave her full access to narcotics to maintain her drug addiction;

e. Allowing Patient M.W., an unlicensed practitioner, to administer narcotics to Patients without supervision;

f. Allowing Patient M.W. to use Respondent's DEA number to order controlled substances;

g. Maintaining inadequate medical records that would justify the course of treatment. Some standards for the adequacy of

medical records are set forth in Rule 64B8-9.003, Florida Administrative Code, (November 1998-September 1999).

22. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (1996-1999), by gross or repeat malpractice or failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

COUNT TWO

23. Petitioner realleges and incorporates paragraphs one (1) through seventeen (17) as if fully set forth herein.

24. Section 458.331(1)(m), Florida Statutes (1996-1999), sets forth grounds for disciplinary action by the Board of Medicine for failing to keep legible medical records that justify the course of treatment, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

25. Respondent failed to justify the course of Patient M.W.'s medical treatment by failing to adequately document the monitoring of the effects of the prescribed anabolic steroids on Patient M.W.

26. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (1996-1999), by failing to keep legible medical records that justify the course of Patient M.W.'s medical treatment.

COUNT THREE

27. Petitioner realleges and incorporates paragraphs one (1) through seventeen (17) as if fully set forth herein.

28. Section 458.331(1)(w), Florida Statutes (1996-1999), sets forth grounds for disciplinary action by the Board of Medicine for delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

29. Respondent delegated professional responsibilities to Patient M.W., an unlicensed practitioner, when he knew or has reason to know that Patient M.W. was not qualified by training, experience, or licensure to perform them, by one or more of the following ways:

a. Allowing Patient M.W. to administer controlled drugs and narcotics to patients;

b. Allowing Patient M.W., who had a known drug addiction, to utilize Respondent's DEA number to order controlled substances.

30. Based on the forgoing, Respondent has violated Section 458.331(1)(w), Florida Statutes (1996-1999), by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

COUNT FOUR

31. Petitioner realleges and incorporates paragraphs one (1) through seventeen (17) as if fully set forth herein.

32. Section 458.331(1)(q), Florida Statutes (1996-1999), sets forth grounds for disciplinary action by the Board of Medicine for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice.

33. Respondent prescribed, or allowed to be purchased using his DEA number, anabolic steroids for Patient M.W. without a medical indication and/or justification.

34. Based on the foregoing, Respondent has violated Section 458.331(1)(q), Florida Statutes (1996-1999), by prescribing a controlled substance other than in the course of the physician's professional practice.

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.

CERTIFICATE OF SERVICE

The undersigned certifies that a true and correct copy of the foregoing has been furnished as a PDF document by electronic mail (k.metzger@mgfblaw.com), and by U.S. Mail to Kenneth J. Metzger, Metzger, Grossman, Furlow & Bayó, LLC, 1408 North Piedmont Way, Tallahassee, FL 32308, Counsel for Respondent, this 9th day of September, 2009.

GREG S. MARR

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE, Petitioner, vs. JAMES F. PENDERGRAFT, IV, M.D., Respondent.	)	Case No. 07-3396PL

RECOMMENDED ORDER

Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing in Orlando, Florida, on January 11-13, 2010.

APPEARANCES

For Petitioner: Gregg S. Marr
Assistant General Counsel
Department of Health
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265

For Respondent: Kenneth J. Metzger
Metzger & Associates, P.A.
1637 Metropolitan Boulevard, Suite C-2
Tallahassee, Florida 32308

Sharon B. Roberts
Strawn & Monaghan, P.A.
54 Northeast Fourth Avenue
Delray Beach, Florida 33483

STATEMENT OF THE ISSUES

The issues are whether Respondent deviated from the applicable standard of care, failed to keep medical records justifying the course of treatment, improperly delegated professional responsibilities, or prescribed, dispensed or administered controlled substances other than in the course of his professional practice; and, if so, what penalty should be imposed.

PRELIMINARY STATEMENT

By Administrative Complaint dated September 2, 2005, Petitioner alleged that Respondent is a licensed Florida physician, holding license number 59702. The Administrative Complaint alleges that Respondent owned and operated the Orlando Women's Center, which employed M. W., who was also a patient of Respondent.

The Administrative Complaint alleges that M. W., who was not a licensed health care provider, assisted in patient preparation, administered medications, cleaned equipment, ordered supplies, and remained overnight with patients to administer pain medications, such as Demerol, which is a controlled substance. The Administrative Complaint alleges that Respondent authorized M. W. to administer pain medications without his supervision. The Administrative Complaint alleges that, in 1997, M. W.'s duties expanded to ordering controlled

substances for the Orlando Women's Center using Respondent's Drug Enforcement Agency registration certificate (DEA number).

The Administrative Complaint alleges that, in November 1998, M. W. informed Respondent that she wanted to become a wrestler and bodybuilder and asked that he prescribe anabolic steroids for these purposes. However, the Administrative Complaint alleges that there was no medical justification for prescribing anabolic steroids to M. W.

The Administrative Complaint alleges that, in November 1998, Respondent allowed M. W. to use his DEA number to order anabolic steroids--specifically, Winstrol, depo-testosterone, and Stanozolol--for her personal use. The Administrative Complaint alleges that Chapter 893, Florida Statutes, defines an anabolic steroid as a Schedule III controlled substance and is any drug or hormonal substance chemically or pharmacologically related to testosterone that promotes muscle growth.

The Administrative Complaint alleges that Respondent failed to order laboratory studies, such as liver function tests, to monitor the effect of the steroids that he authorized for M. W. Futher, the Administrative Complaint alleges that Respondent failed to document his monitoring of the effects of the steroids in his medical records.

The Administrative Complaint alleges that, in March 1999, M. W. was found unconscious on the floor of the Orlando Women's

Center. She allegedly told Respondent that she had abused cocaine, a Schedule II controlled substance, and heroin, a Schedule I controlled substance. Respondent allegedly made no effort to treat M. W.'s drug addiction or to refer her to an addiction specialist.

The Administrative Complaint alleges that, in April 1999, M. W. was again found unconscious on the floor of the Orlando Women's Center. On August 23, 1999, Respondent allegedly ordered a drug profile on M. W., which was positive for benzodiazepines, a group of psychotropic drugs with potent hypnotic and sedative action used predominantly as anti-anxiety and sleep-inducing drugs, and cocaine metabolites, a Class II controlled substance that is a drug of abuse when used for nonmedical purposes, but is used medically to numb mucous membranes.

The Administrative Complaint alleges that, on September 22, 1999, M. W. expired from acute pulmonary edema and respiratory compromise due to acute bronchitis with persistent airway obstruction. The medical examiner allegedly stated that her death was due to natural causes.

These paragraphs of the Administrative Complaint are realleged in each of the four counts of the pleading.

Count One of the Administrative Complaint alleges that Section 458.331(1)(t), Florida Statutes, authorizes discipline

for failing to practice medicine with that level of skill, care, and treatment that is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances (Standard of Care). Count One alleges that Respondent violated the Standard of Care by:

a. Prescribing anabolic steroids for M. W. when there were no medical indications to justify giving these drugs.

b. Failing to order laboratory tests for M. W. to monitor the effects of the prescribed anabolic steroids.

c. Failing to treat M. W.'s known drug addiction or to refer her to an addiction specialist.

d. Employing M. W. in a position that gave her full access to narcotics to maintain her drug addiction.

e. Allowing M. W., an unlicensed practitioner, to administer narcotics to patients without supervision.

f. Allowing M. W. to use Respondent's DEA number to order controlled substances.

g. Maintaining inadequate medical records that would justify the course of treatment.

Count Two alleges that Section 458.331(1)(m), Florida Statutes, authorizes discipline for failing to keep legible medical records justifying the course of treatment, including patient histories, examination results, test results, records of drugs prescribed, dispensed or administered, and reports of consultations or hospitalizations. Count Two alleges that

Respondent committed a medical records violation by failing to justify the course of treatment when he did not adequately document the monitoring of the effects of the anabolic steroids.

Count Three alleges that Section 458.331(1)(w), Florida Statutes, authorizes discipline for delegating professional responsibilities to a person the licensee knows or has reason to know is not qualified by training, experience, or licensure to perform them. Count Three alleges that Respondent violated this provision by: a) allowing M. W. to administer controlled drugs and narcotics to patients and b) allowing M. W., who had a known drug addiction, to use Respondent's DEA number to order controlled substances.

Count Four alleges that Section 458.331(1)(q), Florida Statutes, authorizes discipline for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's practice. Count Four alleges that Respondent violated this provision by prescribing or allowing to be purchased, with his DEA number, anabolic steroids for M. W. without a medical indication or justification.

By Motion to Amend Administrative Complaint filed August 20, 2009, Petitioner requested leave to amend paragraph 7, above, of Count One, which alleges medical records as a Standard of Care violation, to add a reference to Florida

Administrative Code Rule 64B8-9.003. By Order entered September 3, 2009, this request was granted.

Petitioner transmitted the file to the Division of Administrative Hearings on July 23, 2007. The case was first set for hearing on January 7-11, 2008. The hearing was repeatedly continued, most often due to problems in obtaining discovery from the Drug Enforcement Administration (DEA).[1] Prior to the assignment of the case to the undersigned Administrative Law Judge in late October 2009, the case had been assigned to three Administrative Law Judges, two of whom had disqualified themselves.

At the hearing, ruling on Respondent's Motion to Dismiss filed December 30, 2009, the Administrative Law Judge struck paragraph g, above, of Count One, based on Board of Dentistry v. Barr, 954 So. 2d 668 (Fla. 1st DCA 2007), and limited paragraphs d, e, and f, above, of Count One to alleged breaches of the Standard of Care with respect to the practice of medicine as to M. W., as a patient, based on the final order in DOAH Case No. 08-4197PL (requirement of a DEA registration to prescribe certain medications is not a standard-of-care requirement). These matters are discussed in the conclusions of law. Petitioner voluntarily dismissed paragraph b of Count Three at the start of the hearing.

At the hearing, Petitioner called seven witnesses and offered into evidence seven exhibits: Petitioner Exhibits 1-3, 5, 9, and 11-12. Petitioner Exhibit 1 is limited to pages 4-6 and A and B. Petitioner Exhibit 9 is admitted for penalty, not liability. Respondent called seven witnesses and offered into evidence eight exhibits: Respondent Exhibits 1-4, 7, and 8. Respondent Exhibit 7 is the following pages of Petitioner Exhibit 1: 11-20 and 22-32. Respondent Exhibit 8 is Petitioner Exhibits 7 and 8. All exhibits were admitted.

The parties received the Transcript prior to its filing with the Division of Administrative Hearings. The parties filed their Proposed Recommended Orders on March 22, 2010, and the court reporter filed the transcript on March 31, 2010.

FINDINGS OF FACT

1. Respondent is a licensed physician in Florida, holding license number 59702. He has been licensed in Florida since 1991. Respondent is Board-certified in obstetrics and gynecology. His last certification was in November 2009.

2. Respondent received his bachelor of science degree from the University of North Carolina at Chapel Hill in 1978. He received his doctor of medicine degree from Meharry Medical College in Nashville in 1982. He performed a surgical internship from 1982-83 with the Madigan Army Medical Center in Tacoma, an obstetrics and gynecology residency from 1987-91 at

the Harbor Hospital Center in Baltimore, and a maternal fetal medicine fellowship from 1991-93 at the University of South Florida.

3. During the residency, Respondent completed a six-week rotation in the mental evaluation, diagnosis, and treatment of transgendered patients. The training took place on the campus of Johns Hopkins University, which was one of the first medical schools to offer training in the diagnosis and treatment of transgendered patients. During this rotation, Respondent assumed responsibility for the care of about 30 patients, a little over half transitioning from female to male.

4. From 1991-93, Respondent performed obstetrics and gynecology at several medical facilities in Florida, Maine, and Missouri. From 1993-96, Respondent was the Chief of Perinatology, Healthy Start Program, at the D.C. General Hospital/Howard University in Washington.

5. In 1996, Respondent started the Orlando Women's Center (OWC) in Orlando, which he still owns and operates. He opened a second women's clinic in Orlando the following year. Respondent also participated in the starting of women's clinics in Ocala in 1998, Fort Lauderdale in April 1999, and Tampa in October 1999.

6. In October 1996, about six months after opening, OWC hired M. W. as a medical assistant. She had nearly completed the coursework to become a licensed practical nurse, but at no

time material to this case was she ever a licensed health care provider. M. W. was employed by OWC until 1999.

7. M. W. was a diligent employee. Her initial duties were answering the telephone and working in the lab. However, her enthusiasm, intelligence, dedication, and discretion earned M. W. a promotion. In January 1997, Respondent promoted M. W. to a trusted position in which she would care for patients undergoing abortions during the second trimester of pregnancy.

8. Working conditions required M. W. to be on-call nearly all of the time, as certain patients demanded to be admitted during nights or weekends to preserve confidentiality. The work was stressful because some patients bore fetuses with abnormalities, and protestors regularly demonstrated outside the clinic. M. W.'s new duties allowed Respondent himself to observe her work and determine that M. W. had the psychological stability to perform her job well.

9. M. W. demonstrated her trustworthiness by dealing with patients' valuables, opening and closing the clinic, ordering supplies and stocking five surgical rooms, and drawing controlled substances for administration by Respondent. At the end of 1997, Respondent promoted M. W. to ordering and stocking the clinic's medical supplies, which include controlled substances. For Schedule II drugs, which includes narcotics, and Schedule III drugs, which includes steroids, M. W. had to

fill out a DEA Form 222, using Respondent's DEA number to place the order.

10. When OWC received Schedule III drugs, M. W. matched the order with the shipment. She then recorded the information in the OWC drug log. M. W. would place the drugs in a locked cabinet, if they were not needed for immediate use in the clinic.

11. After nearly one year of ordering supplies, toward the end of 1998, M. W. approached Respondent to discuss a personal matter. At this point, the material disputes between the parties emerge. Respondent testified that M. W. discussed with him the possibility of undergoing transgender therapy, as well as treatment for an injured shoulder. According to Petitioner, M. W. discussed with Respondent the possibility of using anabolic steroids to improve her bodybuilding and weightlifting. The parties do not dispute that M. W. had participated in bodybuilding and weightlifting for several years prior to her employment with OWC. The Administrative Law Judge credits Petitioner's version of the purpose of treatment.

12. Respondent testified that M. W. told him that she had thought about changing genders for several years. She did not like or want her breasts. She did not like the shape of her hips and thighs. She had decided that she did not want children and did not want to undergo menstruation. Although M. W. may

have told Respondent that she did not like her body shape, she did not tell him that she wanted to change into a man.

13. As discussed below, M. W. is not available to confirm or deny Respondent's version of events, and Respondent does not have any medical records documenting his care and treatment of M. W. Assigning a secondary reason for the treatment--healing a long-injured shoulder--is an awkward fit with Respondent's version of events, given the unlikelihood that someone considering a decision as major as changing genders would bother assigning a secondary reason for the decision. This secondary reason for the treatment is a better fit with Petitioner's version of events, although treatment of an injured shoulder was, at most, a very minor factor in the steroid treatment because the reconstructed medical records, discussed below, mention strength and bodybuilding, not recovery from a shoulder injury.

14. The most important reason to credit Petitioner's version of the purpose of the steroid treatment over Respondent's version is that Petitioner's version conforms to Respondent's initial description of the purpose of the treatment. In other words, this is not a case of Respondent's word against contrary inferences drawn by Petitioner; this is a case of Respondent's later word against Respondent's earlier word.

15. The parties do not dispute that, after the initial meeting to discuss the personal matter, Respondent agreed to allow M. W. to order anabolic steroids using his DEA number and at the discounted price charged to OWC. The drugs that Respondent expressly allowed M. W. to order--and which he prescribed for her--were Winstrol and, a short while later, depo-testosterone. Respondent prescribed for M. W. Winstrol orally at the rate of 2 mg per day, increasing to 10 mg per day at the end of six weeks, and depo-testosterone by intramuscular injection, which Respondent administered initially at the rate of 50 mg every two weeks, increasing to 200 mg every two weeks.

16. The parties do not contest that, in early summer 2009, M. W. ordered through OWC sufficient Winstrol and Deca-Durabolin for her weightlifting father and brother, with whom she lived, to complete one six-week bodybuilding cycle each with these two anabolic steroids. For her brother, the evidence establishes that M. W. ordered through OWC additional Winstrol and sufficient depo-testosterone for him to complete a second six-week cycle. The evidence is undisputed that M. W. administered the injections of Deca-Durabolin and depo-testosterone to her brother, Deca-Durabolin to her father, and Deca-Durabolin to herself. M. W. probably took additional Winstrol at home. The evidence is also clear that, in addition to ordering the Winstrol and depo-testosterone in quantities in excess of the

amount that she was authorized to order and Deca-Durabolin without any authority whatsoever, M. W. also ordered--without authorization--Xanax, an anti-anxiety drug, and Soma, a muscle relaxant, possibly for her own use. Petitioner contends that Respondent knew or reasonably should have known of these unauthorized orders, but the evidence that Respondent knew is nonexistent, and the evidence that he should have known is insubstantial.

17. There is little, if any, dispute that, unknown to Respondent, M. W. was using cocaine and heroin--by her own admission since early 1998. In late July 1999, Respondent was informed that M. W. had passed out at work. When Respondent spoke with her about this incident, M. W. admitted to the use of cocaine and heroin, most recently a couple of weeks earlier. Respondent immediately withdrew his authorization of M. W. to order supplies and medications for OWC and immediately discontinued further steroid treatment.

18. Acting as M. W.'s employer, not physician, Respondent ordered M. W. to submit to a drug screen for Demerol, which had been missing from OWC,[2] Valium, and cocaine. Three weeks later, he received the results, which were positive for cocaine. After giving M. W. an opportunity to discontinue illegal drug use, Respondent ordered M. W. to submit to another drug screen for

Demerol, Valium, fentanyl, cocaine, and heroin, and the report, received in late August, was positive for cocaine and Valium.

19. On September 22, 1999, M. W. was found dead in her home by her father. The first law enforcement officers responding to the 911 call reported that they had found a lifeless male dressed in woman's panties; this mistaken observation was based on M. W.'s muscularization and shadowy presence of facial hair. A homicide detective conducting an initial investigation found large quantities of syringes and prescription drugs, mostly steroids, in M. W.'s bedroom. He also found shipping labels and receipts with the names of OWC and Respondent.

20. The parties have stipulated that the death was unrelated to steroid use. M. W.'s death was classified as a natural death. She was 30 years old.

21. In resolving the major factual dispute--i.e., the purpose of the treatment--the Administrative Law Judge has assigned considerable weight to Respondent's earlier responses to law enforcement and regulatory inquiries. In these responses, Respondent never mentioned transgender treatment or gender identity disorder, but instead admitted that the treatment was to enhance athletic performance and to facilitate bodybuilding.

22. In a written reconstruction of the medical records done prior to the commencement of this case, Respondent stated that he was "unable to locate [M. W.'s] chart so I will reconstruct her chart from memory. Last time chart was seen was June [19]99 which was given to [her]."

23. The reconstructed chart shows three office visits: November 7, 1998, March 20, 1999, and June 26, 1999. None of the reconstructed notes mentions anything about lab work being ordered, the results of any lab work, or anything about an injured shoulder and whether it was healing.

24. The entry for November 7 starts: "[Patient] request being placed on testosterone for body building. States she . . . is considering Pro-Wrestling." The notes indicate blood pressure of 118 over 64, pulse of 72, and nothing remarkable from a basic physical examination. The notes state: "Wants to body build; requests steroids." The notes report that Respondent prescribed Winstrol in 2 mg doses and explained the side effects, and Respondent was going to allow M. W. to order her steroid medication from the clinic's vendors. This entry concludes with a note for a followup visit in three months.

25. The entry for March 20, 1999, states that M. W. had no complaints, reported getting stronger, and was happy with "bench," meaning bench-pressing, a form of weightlifting. This note states that M. W. denied experiencing any side-effects and

wanted to add a second steroid: "Request to add Depo-Testosterone."

26. The entry for June 26, 1999, notes that M. W. "feels good about herself and her outlook on life is much improved" and is "continuing to [increase] strength [with] weights." This note contains findings of a physical exam, including blood pressure of 124 over 78 and pulse of 72, and the note concludes that M. W. was doing well and Respondent planned to continue the same steroid regime.

27. The other time that Respondent discussed the purpose of the treatment was when he was interviewed by a law enforcement officer on March 10, 2000, in the presence of Respondent's attorney. Respondent did not say anything about transgender treatment or gender identity disorder, and he was evasive when asked if he were M. W.'s physician. When asked if M. W. were ever a patient or just an employee, Respondent responded by referring to the incident when she passed out at work: "She now when you say she would ah the only time when she and I were upstairs that day. . . . And when she had the overdose." The law enforcement officer asked, "And that's like in August [1999]?" Respondent replied, "Yeah. . . . The question was and I and I still haven't been able to define that because she asked me not to tell anybody about her problem with her drug habits and this type of scenario. So the question is

whether or not she was a, whether or not honestly she was a patient of mine at that particular point in time."[3]

28. Shortly after this exchange, the law enforcement officer asked Respondent if the steroids that Respondent allowed M. W. to order through the OWC were for competitive purposes, such as weightlifting. Respondent replied, "we had a discussion about her wanting to . . . make it so that her, that she could work out harder because she was having some problems with her shoulders and these type of things . . . . ."[4]

29. These reconstructed records and statements to a law enforcement officer were not casual statements uttered in an informal setting. This was information that Respondent provided to assist in the investigation of the circumstances surrounding the death of this 30-year-old woman. Except for mention of a shoulder injury in the last-cited statement--an effort by Respondent to convert the treatment objective from pure enhancement of athletic performance to a mix of enhancement of athletic performance and therapy for some undiagnosed shoulder injury--the information consistently implies that the treatment objective was to improve M. W.'s efforts in bodybuilding and weightlifting. And the mention of the shoulder injury suggests only that its healing was subordinate to the weightlifting and bodybuilding. The failure of the reconstructed records to contain any diagnostic information or progress reports on the

injured shoulder precludes a finding that the treatment objective was to heal a shoulder injury.

30. Respondent testified about the importance of confidentiality for his patients, especially M. W., as she was undergoing "gender transformation." But patient confidentiality is not an end in itself; it is a means to assuring that the patient will trust the physician with all relevant information necessary for diagnosis and treatment. Respondent implied that the requirement of patient confidentiality somehow trumped the duty not to affirmatively frustrate investigations into the death of his employee and patient. This makes no sense. Respondent's strained "explanation" for creating a misleading set of medical records yields to the simpler explanation that Respondent told the truth in these reconstructed records and in the police interview: Respondent was treating M. W. with steroids for bodybuilding and wrestling, not for gender transformation and not for an injured shoulder.

31. These findings are supported by the fact that the first drug that Respondent prescribed M. W. was Winstrol. The anabolic effect of a steroid promotes muscularization, and the androgenic effect of a steroid promotes masculinization. Because Winstrol produces more anabolic than androgenic effect, it was long favored by females who wanted to produce muscle mass, such as for bodybuilding, without masculinization.

Initiating treatment with Winstrol and following with depo-testosterone is a conventional example of the cyclical use of steroids for muscularization, not masculinization.

32. One of Respondent's expert witnesses made an interesting observation based on the misidentification of the gender of the body of M. W. by the first responders. He testified that, if Respondent had been ordering the anabolic steroids for weightlifting and bodybuilding, M. W. must have been seriously dissatisfied with the masculinization that she had undergone. However, this observation overlooks the fact that M. W., without Respondent's knowledge, had administered to herself unknown quantities of the prescribed anabolic steroids and Deca-Durabolin. Like Winstrol, Deca-Durabolin is more anabolic, or muscle-making, than androgenic, or masculinizing--which is consistent with M. W.'s intent to enhance her athletic performance and bodybuilding, not change her gender. Although the first responders observed some facial hair, in addition to muscularization, nothing in the record suggests that M. W. could take all of these anabolic steroids in unknown quantities without experiencing some masculinization, or that she expected no such masculinization side effects. Under these circumstances, M. W. could not legitimately have confronted Respondent over the incidental masculinization that she had experienced, while self-administered steroids whose main effect

was muscularization, without running the risk that he would detect her unauthorized ordering of steroids.

33. As noted above, there are no available medical records. Respondent testified that he gave M. W.'s medical chart and drug log "VIP" treatment to preserve confidentiality: Respondent allowed M. W. to keep her medical records and the drug log pertaining to her medications. Each time M. W. presented to Respondent, such as for an injection, she brought with her these files, according to Respondent. Petitioner contends that these records never existed, and, therefore, Respondent failed to document that he monitored the effects of the anabolic steroids that he ordered for M. W. The Administrative Law Judge credits Petitioner's version of the situation regarding medical records.

34. At the hearing, Respondent characterized as a mere "sampling" the medical records that he had initially called a reconstruction. He implied that the reconstructed medical records were illustrative of what the records originally contained. This probably explains how he could reconstruct blood pressure readings of 118 over 64 and 126 over 78 taken six and nearly twelve months prior to the reconstruction of the records. Likely, he recalled that the values were normal and inserted these readings merely to illustrate his recollection.

35. However, as noted above, these reconstructed records are significant for their omission of any similar illustrative reconstructions of an SBC for blood chemistry, SMAC 18 for electrolytes and kidney and liver function, and lipids for cholesterol and triglycerides. This lab work is essential, at the start of a course of treatment with anabolic steroids and periodically during treatment, to ensure the safety of any patient, especially when orally ingested anabolics--here, Winstrol--are administered, due to the possibility of liver damage. Respondent testified at the hearing that the lab results were normal, but, unlike his addition of illustrative, normal values for blood pressure and pulse, Respondent never added illustrative, normal values for this lab work. This is because he never ordered such lab work.

36. These lab tests are common in a variety of circumstances, so they did not require the "VIP treatment" that Respondent claimed was required for the transgender treatment plan. However, Respondent never produced medical records or even lab paperwork, such as test results or invoices, documenting that these tests had been done. Also, if such records had existed and Respondent had allowed M. W. to keep them, one obvious place for them would have been in M. W.'s room at her home, but Respondent never sent anyone there to look for them after her death.

37. As to the Standard of Care allegations, Petitioner has thus proved first, that Respondent prescribed steroids for M. W. both for muscle building (not to treat an injured muscle) and for enhancement of athletic performance; and, second, that Respondent did not order lab work to monitor the effects of the steroids that he prescribed for M. W.

38. The evidence fails to establish that Respondent ever undertook the treatment of M. W.'s drug addiction (despite his statement to the contrary, which has been discredited). The evidence fails to establish the circumstances out of which a duty to treat could have arisen, especially within the brief time frame between Respondent's discovery of her drug problems and her death.

39. Any evidence relevant to the remaining allegations within Count One involves the employer-employee relationship, not the physician-patient relationship, between Respondent and M. W.

40. As to the medical records violation, Petitioner has proved that Respondent's medical records failed to adequately document the monitoring of the effects of anabolic steroids that Respondent prescribed for M. W. The evidence establishes the necessity of lab work, at the start and during steroid treatment, to ensure the safety of the patient. Without this

lab work, documented in the medical records, the course of steroid treatment is not justified.

41. The evidence fails to establish that Respondent delegated responsibilities to a person whom Respondent knew or reasonably should have known was not qualified by training, experience, or licensure to administered controlled substances to patients. Drug addiction is not a deficit in training, experience, or licensure. Even if drug addiction fell within one of these statutory categories, the evidence fails to establish any improprieties in M. W.'s administration of controlled substances to patients, and, even if the evidence proved such improprieties, the evidence fails to establish that Respondent knew of M. W.'s drug addiction at a point to have timely relieved her of her duties, or that Respondent reasonably should have known of M. W.'s drug addiction in time to do anything about it. To the contrary, Respondent's termination of these responsibilities of M. W. appears to have been timely.

42. Petitioner has proved that Respondent prescribed and administered controlled substances--i.e., anabolic steroids--for muscle building, not the treatment of an injured muscle, and for enhanced athletic performance.

43. Respondent has previously been disciplined. By Final Order entered on December 18, 2007, in DOAH Case No. 06-4288PL, the Board of Medicine imposed one year's suspension, a $10,000

fine, and three years' probation for failing to perform a third-trimester abortion in a hospital and failing to obtain the written certifications of two physicians of the necessity for the procedure; committing an associated medical-records violation; and committing a Standard of Care violation for failing to perform a third-trimester abortion in a hospital. Respondent's acts and omissions occurred in 2005. The Fifth District Court of Appeal affirmed the Final Order in Pendergraft v. Department of Health, Board of Medicine, 19 So. 3d 392 (Fla. 5th DCA 2009).

44. By Final Order entered on January 28, 2010, in DOAH Case No. 08-4197PL, the Board of Medicine imposed two years' suspension, a $20,000 fine, and three years' probation for committing a Standard of Care violation for failing to a advise subsequent treating physicians that he had removed a portion of a patient's fetus and an associated medical-records violation. Respondent's acts and omissions occurred in 2006.

45. Although Respondent has been disciplined prior to this recommended order, the acts and omissions in this case took place several years prior to the acts and omissions in the two cases described immediately above.

CONCLUSIONS OF LAW

46. The Division of Administrative Hearings has jurisdiction over the subject matter. §§ 120.569 and 120.57(1), Fla. Stat. (2009).

47. Petitioner must prove the material allegations by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern and Company, Inc., 670 So. 2d 932 (Fla. 1996) and Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

48. Section 458.331(1), Florida Statutes (1998), provides, in relevant part:

> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
>
> * * *
>
> (m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.
>
> * * *
>
> (q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any

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

* * *

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. . . . As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

* * *

(w) Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

* * *

> (ee) Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. For the purposes of this subsection, the term "muscle building" does not include the treatment of injured muscle. . . .

49. As noted above, the Administrative Law Judge limited the Standard of Care allegations in two respects. First, the allegation in paragraph g of Count One attempts to recast a medical records violation as a Standard of Care violation. This interpretation of these two statutory subsections was rejected, in the context of the practice of dentistry, in Barr v. Department of Health, Board of Dentistry, 954 So. 2d 668 (Fla. 1st DCA 2007).

50. Second, the Administrative Law Judge limited the scope of proof that would be admissible to prove the allegations in paragraphs d, e, and f of Count One because a Standard of Care violation applies only to the practice of medicine and not to other acts and omissions of the licensee. Section 458.305(3), Florida Statutes (1998), provides: "'Practice of medicine' means the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition." In this case, the evidence supporting these three paragraphs of Count One pertained exclusively to Respondent's employment or managerial practices involving M. W.

as an employee, not the practice of medicine with respect to M. W. as a patient, so Petitioner has failed to prove the Standard of Care violations alleged in these three paragraphs.

51. As to paragraph a of Count One, Petitioner has proved that Respondent prescribed anabolic steroids to M. W. without medical indication. Section 458.331(1)(ee) prohibits the use of anabolic steroids to build muscle, except to treat injured muscle, or to enhance athletic performance. Any prescription of anabolic steroids in violation of this statute thus cannot be medically indicated. The exception applies to building muscle, not athletic performance. To the extent that M. W. sought anabolic steroids for weightlifting, which is athletic performance, not muscle building, the injured-muscle exception is unavailable to Respondent. However, as noted in the findings of fact, Petitioner proved that Respondent did not prescribe anabolic steroids to heal an injured muscle.

52. The problem with paragraph a of Count One is that is it mispleaded, under Barr. The prescription of anabolic steroids under these circumstances violates Section 458.331(1)(ee), so it does not constitute a Standard of Care violation under the reasoning of Barr.

53. As to paragraph b of Count One, Petitioner has proved that the failure to order lab work to monitor the effects of the anabolic steroids is a Standard of Care violation. Respondent

testified that he ordered the lab work, and he was treating M. W. for gender identity disorder. The Administrative Law Judge is free to disbelieve unrebutted testimony of a physician. Fox v. Department of Health, 994 So. 2d 416 (Fla. 1st DCA 2008) (dictum). But see Reich v. Department of Health, 973 So. 2d 1233 (Fla. 4th DCA 2008) (Administrative Law Judge's discrediting of physician's testimony describing additional medical records reversed due to lack of competent substantial evidence). In this case, as noted above, Respondent himself provided contrary evidence, prior to the commencement of this case, that is consistent with Petitioner's version of events.

54. The failure to order lab work is distinct from the medical records violation discussed below because a practitioner could order the lab work, but fail to document it. In this case, though, where the physician fails to order and document the lab work, there is considerable overlap between the offenses, which must be considered when determining the appropriate penalty.

55. As to paragraph c of Count One, the evidence has failed to prove that Respondent violated the Standard of Care by failing to treat M. W.'s drug addiction for the reasons stated above.

56. As to Count Two, Petitioner has proved a medical records violation because Respondent failed to document

adequately the effects of the anabolic steroids--specifically, by failing to document the results of the lab work that must be performed when administering anabolic steroids under these circumstances. This is a failure to justify the course of the steroid treatment that Respondent pursued with M. W.

57. As to Count Three, the evidence fails to establish an improper delegation of professional responsibilities to M. W. for the reasons stated above.

58. As to Count Four, Petitioner has proved that Respondent prescribed and administered anabolic steroids without medical indication because he did so for building muscles and enhancing athletic performance. The question is whether Respondent prescribed and administered these controlled substances other than in the course of his professional practice.

59. As Respondent contends, Rogers v. Department of Health, 920 So. 2d 27 (Fla. 1st DCA 2005), requires an element of illicitness for a determination that the prescription or administration is not in the course of the physician's professional practice. Section 458.331(1)(ee) supplies this element. The holding in Barr does not require a contrary result. Here, Section 458.331(1)(ee) has supplied the element of illicitness necessary to find a violation of Section 458.331(1)(q). The illicit nature of an act or omission may be

derived from any statute, so this situation is different from merely recasting a medical record violation as Standard of Care violation, at least where Petitioner has not pleaded a Section 458.331(1)(ee) violation.

60. Section 458.331(2), Florida Statutes (1998), states:

> When the board finds any person guilty of any of the grounds set forth in subsection (1), . . . it may enter an order imposing one or more of the following penalties:
>
> * * *
>
> (b) Revocation or suspension of a license.
> (c) Restriction of practice.
> (d) Imposition of an administrative fine not to exceed $5,000 for each count or separate offense.
> (e) Issuance of a reprimand.
> (f) Placement of the physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, to attend continuing education courses, to submit to reexamination, or to work under the supervision of another physician.
> (g) Issuance of a letter of concern.
> (h) Corrective action.
> (i) Refund of fees billed to and collected from the patient.
>
> In determining what action is appropriate, the board must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the physician. All costs associated with compliance with orders issued under this subsection are the obligation of the physician.

61. Legislation raising the maximum fine from $5000 to $10,000, became effective July 1, 1999.[5] However, absent an explicit provision in the new legislation for retroactive application, courts will not retroactively apply a new penalty. McGann v. Florida Elections Commission, 803 So. 2d 763 (Fla. 1st DCA 2001). Thus, in this case, the statute authorizes a fine of no more than $5000 per count or offense.

62. As in effect from May 14, 1998, through December 26, 1999, Florida Administrative Code Rule 64B8-8.001 provides:

> (1) Purpose. Pursuant to Section 2, Chapter 86-90, Laws of Florida, the Board provides within this rule disciplinary guidelines which shall be imposed upon . . . licensees whom it regulates under Chapter 458, F.S. The purpose of this rule is to notify . . . licensees of the ranges of penalties which will routinely be imposed unless the Board finds it necessary to deviate from the guidelines for the stated reasons given within this rule. The ranges of penalties provided below are based upon a single count violation of each provision listed; multiple counts of the violated provisions or a combination of the violations may result in a higher penalty than that for a single, isolated violation. Each range includes the lowest and highest penalty and all penalties falling between. The purposes of the imposition of discipline are to punish the . . . licensees for violations and to deter them from future violations; to offer opportunities for rehabilitation, when appropriate; and to deter other . . . licensees from violations.

63. Former Florida Administrative Code Rule 64B8-8.001(2)(m) punishes a medical records violation with a

reprimand to two years' suspension followed by probation and a fine of $250-$5000. Former Florida Administrative Code Rule 64B8-8.001(2)(q) punishes inappropriate prescribing with one year's probation to revocation and a fine of $250-$5000. Former Florida Administrative Code Rule 64B8-8.001(2)(t)3. punishes a Standard of Care violation with two years' probation to revocation and a fine of $250-$5000.

64. Former Florida Administrative Code Rule 64B8-8.001(3) establishes various aggravating and mitigating circumstances, such as the degree of exposure of the patient or public to injury or death, the legal status of the licensee at the time of the offenses, the number of counts or separate offenses proved, the number of times the same offenses have been committed by the licensee previously, the licensee's disciplinary history, and any pecuniary benefit inuring to the licensee.

65. Based on Respondent's entire disciplinary record, these are his first offenses. At least six years after these offenses, Respondent committed the acts and omissions in 2005 and 2006 that resulted in the disciplinary proceedings described above. To treat the 1998 and 1999 offenses as subsequent offenses strains the notion of notice mentioned in the above-cited portion of Former Rule 64B8-8.001(1). Petitioner selected the order in which to prosecute these three cases, and its choice does not transform the acts and omissions of 1998 and

1999 into a third offense. Cf. Department of Public Safety v. Mitchell, 152 So. 2d 764 (Fla. 3d DCA 1963). A disciplinary rule must be construed against the agency due to the penal nature of the disciplinary proceeding. Colbert v. Department of Health, 890 So. 2d 1165 (Fla. 2004). However, the language of the rule permits consideration of Respondent's disciplinary history, as distinguished from the number of times he has committed the same offenses, as an aggravating factor, so the other discipline is an aggravating factor, even though the present offenses must be considered a first offense.

66. Although M. W.'s drug addiction and death cannot be linked in any way to the acts and omissions of Respondent, the potential for injury to M. W. was at least moderate when Respondent prescribed anabolic steroids for bodybuilding and weightlifting without ordering lab work. On these facts, as noted above, the failure to document the lab results is essentially duplicative of the Standard of Care violation arising from the failure to order these tests, so, in determining an appropriate penalty, Respondent is essentially guilty only of a Standard of Care violation and a violation of the inappropriate prescription of steroids.

67. If this were a case in which increasingly serious discipline had failed to produce corrective behavior, the Administrative Law Judge would recommend revocation, but a less

harsh penalty is indicated due to the first-offense status of these acts and omissions. On the other hand, the risk of injury and, somewhat contradictorily, the disciplinary history require a significant penalty.

RECOMMENDATION

It is

RECOMMENDED that the Board of Medicine enter a Final Order finding Respondent guilty of violations of Section 458.331(1)(m), (t), and (q), Florida Statutes (1998), and suspending his license for one year followed by three years' probation, imposing a fine of $10,000, and assessing costs as provided by law.

DONE AND ENTERED this 8th day of June, 2010, in Tallahassee, Leon County, Florida.

ROBERT E. MEALE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of June, 2010.

ENDNOTES

1. After setting the case for final hearing January 7-11, 2008, the first Administrative Law Judge disqualified herself by Order entered December 7, 2007. On December 27, 2007, the new Administrative Law Judge granted a motion for continuance filed by Respondent, and reset the hearing for April 22-25, 2008. On April 1, 2008, Respondent filed a Motion to Continue Formal Hearing due to the need for more time for discovery, and Petitioner supported the motion. On April 3, 2008, the second Administrative Law Judge abated the case.

Based on joint status reports filed May 2, 2008, and June 27, 2008, the Administrative Law Judge extended the abatement. By joint status report filed October 2, 2008, Petitioner objected to Respondent's claim that the abatement needed to be extended a third time. After a conference call, the Administrative Law Judge extended the abatement 30 days. On November 7, 2008, the parties filed another joint status report, disagreeing again on whether the case was ready to be set for hearing. After a conference call, the Administrative Law Judge extended the abatement about five weeks and transferred the case to a third Administrative Law Judge.

On December 12, 2008, the parties filed a joint status report, in which Petitioner reported that the prior delays were due to the inability of the parties to obtain the cooperation of the U.S. Department of Justice, Drug Enforcement Administration, which had recently responded to a subpoena. Respondent claimed that the case was not ready for hearing because the Drug Enforcement Administration had not agreed to a deposition of any of its agents or investigators.

After a conference call on January 12, 2009, the Administrative Law Judge scheduled the case for final hearing on June 16-19, 2009. On May 28, 2009, Petitioner filed a Motion to Reschedule Final Hearing, and Respondent joined in the motion. After a conference call on June 1, 2009, the Administrative Law Judge continued the hearing to September 15-18, 2009. On September 1, 2009, Respondent filed a Motion for Brief Continuance, based on problems in arranging a deposition of a Drug Enforcement Administration agent. On September 2, 2009, the Administrative Law Judge conducted a conference call, and, the next day, issued an Order continuing the final hearing to December 8-11, 2009.

On October 26, 2009, Respondent filed a Motion to Disqualify the Administrative Law Judge on the ground that he had issued a recommended order on September 21, 2009, in a different disciplinary case involving Respondent and had rejected certain testimony of Respondent as not credible. On the same day, the

Administrative Law Judge granted the motion and the undersigned Administrative Law Judge was assigned the case at that time.

On November 20, 2009, Respondent filed an Unopposed Motion for Continuance due to discovery problems. After a conference call on November 23, 2009, the Administrative Law Judge issued an Order Granting Continuance on November 24, 2009, and reset the final hearing for January 11-15, 2010.

2. By stipulation, there is no evidence that M. W. took the Demerol from OWC.

3. Petitioner Exhibit 5, p. 71.

4. Petitioner Exhibit 5, p. 72.

5. Chap. 99-397, Laws of Fla. § 99. This provision became effective July 1, 1999. Chap. 99-397 Laws of Fla. § 208.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,

Petitioner,

v.

DOAH CASE NO. 07-3396PL
DOH CASE NO. 2001-04256

JAMES S. PENDERGRAFT, IV, M.D.,

Respondent.

_____/

RESPONDENT'S EXCEPTIONS TO THE RECOMMENDED ORDER

Respondent, James S. Pendergraft, IV, M.D., ("Respondent" or "Dr. Pendergraft"), by and through his undersigned counsel, and pursuant to Section 120.57(l)(k), Florida Statutes, and Rule 28-106.217(1), Florida Administrative Code, files his written Exceptions to the Recommended Order of the Administrative Law Judge issued on June 8, 2010, as follows:

The Board's Review Requirements Under Chapter 120, Florida Statutes

In considering the Recommended Order and penalty recommendations of the Administrative Law Judge herein, the Board of Medicine is confined solely to the review of the record as established at the formal hearing, Ong v. Department of Professional Regulation, 565 So. 2d 1384, 1387 (Fla. 5th DCA 1990). Thus, the Board is not authorized to receive additional evidence other than that already presented and considered by the Administrative Law Judge. *Id.* Nor can the Board discipline a licensee for matters not charged in the Administrative Complaint. See Trevisani v. Dep't of Health, 936 So. 2d 790, 795 (Fla. 1st DCA 2006); Ghani v. Dep't of Health, 714 So. 2d 1113, 1114 (Fla. 1st DCA 1998).

Standard of Review of a Recommended Order

In reviewing a Recommended Order of an Administrative Law Judge, the Board of Medicine ("the Board") must evaluate the individual findings of fact and conclusions of law under a "competent, substantial evidence" standard. §120.57(1)(1), Florida Statutes. Competent substantial evidence is defined as that evidence supporting an ultimate finding which is sufficiently relevant and material such that a reasonable mind would accept as adequate to support the conclusions reached. DeGroot v. Sheffield, 95 So. 2d 912, 916 (Fla. 1959). In keeping with the requirement of a "competent, substantial evidence" review, the Legislature has authorized the Board to reject any finding of fact set forth in a Recommended Order, when upon its review of the entire record before the Administrative Law Judge, the Board determines that there is a lack of competent, substantial evidence upon which to base the particular finding of fact. *Id.*; see also Heifetz v. Department of Business Regulation, 475 So. 2d 1277, 1281-1282 (Fla. 1st DCA 1985); Gross v. Department of Health, 819 So. 2d 997, 1000-1001 (Fla. 1st DCA 2002). In so doing, however, the Board may not reweigh the evidence presented, may not judge the credibility of the witnesses, and may not otherwise interpret the evidence to fit its desired ultimate conclusion. Heifetz, *supra*; Gross, *supra*.

In addition, the Board is authorized to reject or modify the conclusions of law over which it has substantive jurisdiction and to reject or modify interpretation of administrative rules over which it has substantive jurisdiction. §120.57(1)(1), Florida Statutes.

> When rejecting or modifying such conclusion of law or interpretation of administrative rule, the agency must state with particularity its reasons for rejecting or modifying such conclusions of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was

rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejections or modification of findings of fact.

Id. (Emphasis added).

Respondent's Exceptions to Findings of Fact

Finding of Fact Exception 1: Respondent takes exception to a portion of the last sentence of Finding of Fact 12 at pages 11-12 of the Recommended Order because a portion of that finding is not supported by competent, substantial evidence.

Respondent takes exception to a portion of the last sentence of paragraph 12 of the Recommended Order. This exception is addressed to the underscored portion of the Administrative Law Judge's statement reading as follows: "Although MW may have told Respondent that she did not like her body shape, she did not tell him that she wanted to change into a man." The basis for this exception is that there is no competent, substantial evidence in the record to support the underscored statement. The only people with first-hand knowledge of what Patient MW did or did not tell the Respondent in this regard were MW and the Respondent. MW did not testify at the hearing because she passed away more than ten years ago. The only witness who did testify on this subject was the Respondent. The best and clearest examples of his testimony about MW's treatment goals are at page 397 of the hearing transcript, which includes the following:

> Q. And what were [M.W.]'s expressed desires for treatment?
> A. Her expressed desires for treatment were that she wanted to use -- she wanted to transgender from female to male. And essentially she then -- she had thought about for several years that she wanted to make the transition. She was very uncomfortable with her body which is the other criteria in that she didn't like her breasts and she didn't want any breasts. She didn't like her hips and she didn't like her thighs. She didn't want to have any children and she didn't want to have any menses. And so after assessing all of that, her request was that she wanted to transgender from female to male.

At several places in the Recommended Order the Administrative Law Judge made it clear that he did not believe the Respondent's testimony to the effect that he was treating MW for gender identity disorder. Obviously, because the Administrative Law Judge did not believe the Respondent's testimony on that issue, the Administrative Law Judge did not make any findings of fact consistent with the testimony quoted above. It is well within the ALJ's discretion to disbelieve unrebutted testimony of a physician, Fox v. Department of Health, 994 So.2d 416(Fla. 1st DCA 2008), but such disbelief does not provide a basis for a finding of fact that is essentially the opposite of the disbelieved testimony. Where unrebutted evidence is disbelieved, the ALJ's disbelief does not give rise to proof of the opposite of what was disbelieved. Rather, as a result of the disbelief there is no persuasive evidence regarding the disbelieved testimony, and in the absence of persuasive evidence that is no basis for a finding of fact one way or the other. Accordingly, the underscored portion of the last sentence of Paragraph 12 of the Recommended Order should be stricken.

Finding of Fact Exception 2: Respondent takes exception to all of Finding of Fact 13 at page 12 because it is not a finding of fact about any fact at issue in this case, but appears to be an effort by the Administrative Law Judge to discuss or explain the basis for some of his findings of fact yet to come.

Respondent takes exception to all of paragraph 13 of the Recommended Order. The basis for this exception is that nothing in paragraph 13 of the recommended Order appears to be a finding of fact about any material fact at issue in this case. Paragraph 13 of the Recommended Order reads as follows:

> 13. As discussed below, M. W. is not available to confirm or deny Respondent's version of events, and Respondent does not have any medical records documenting his care and treatment of M. W. Assigning a secondary reason for the treatment--healing a long-injured shoulder--is an awkward fit with Respondent's version of

> events, given the unlikelihood that someone considering a decision as major as changing genders would bother assigning a secondary reason for the decision. This secondary reason for the treatment is a better fit with Petitioner's version of events, although treatment of an injured shoulder was, at most, a very minor factor in the steroid treatment because the reconstructed medical records, discussed below, mention strength and bodybuilding, not recovery from a shoulder injury.

The language quoted immediately above appears to be intended as an introduction or explanation or clarification of findings yet to come; the type of material one more frequently sees in endnotes. But such language does not appear to include a finding of fact about any material fact at issue in this case. Because the language in paragraph 13 does not appear to contain any material finding of fact and because that language appears to add more confusion than conclusion to the findings of fact, it should be stricken, or at least relegated to endnote explanatory status.

Finding of Fact Exception 3: Respondent takes exception to Finding of Fact 27 and 28 at pages 17 and 18 of the Recommended Order because there is no competent, substantial evidence to support any of the facts asserted in paragraphs 27 and 28 of the Recommended Order.

All of the findings contained in paragraphs 27 and 28 of the Recommended Order are based solely on information contained in Petitioner's Exhibit 5. For the reasons which follow, Petitioner's Exhibit 5 is not competent, substantial evidence and cannot lawfully be the basis for any finding of fact in this case.

The Respondent respectfully submits that Petitioner's Exhibit 5, a copy of the typed transcript of a tape-recorded interview of the Respondent by Detective Moyers, is unreliable evidence that should not have been admitted in evidence, and is, in any event, an insufficient basis for making findings of fact in this case. The main reason Pet. Ex. 5 should not have been admitted in evidence is that counsel for Petitioner did not intend to offer it in evidence. Rather,

in an abundance of candor, Petitioner's counsel stated: ". . . Petitioner is not going to be able to overcome the objection to authentication. So we're not going to offer it in evidence." (Emphasis added.) T: 193-194. And further down Petitioner's counsel continues: ". . . we're not able to regenerate that statement by a custodian of records that can testify." T. 194. With such being the position of Petitioner's counsel, there was no reason to discuss whether there might be some other way to establish the authenticity of Pet. Ex. 5, but nevertheless such a discussion ensued.

During the course of that discussion, at two different places Detective Moyer testified that if he were to read the subject exhibit he would be able to "testify that it is in a substantially unaltered form." T. 197 and T. 198. But the answer to the question is meaningless unless and until the witness actually reads the document in front of him and it is pure speculation and conjecture for the witness to predict the nature of the contents of a photocopy of a document he has not yet read. Even if the original transcription of the Respondent's statement to Detective Moyer was correct in all material details, there is no evidence in the record of this case that the document before the witness is a true and correct copy of the original transcript. (And we know from colloquy during the hearing that at least some of the copies were not true and correct. T: 199-201, 203-204.) For the foregoing reasons it has not been established that the document is trustworthy and the evidence regarding the document does not make out "a prima facie showing of compliance with the relevant evidentiary criteria."

Relying on Detective Moyer's assertion that if he were to read the exhibit he could testify that "it is in substantially unaltered form," Petitioner's counsel stated: "Well, given that predicate, we would offer this into evidence as recollection recorded." (T: 200-201) After objection and argument Pet. Ex. 5. was admitted in evidence with the observation by the

Administrative Law Judge that ". . . in terms of admissibility of the document, what we're looking for is merely whether there's a prima facie showing of compliance with the relevant evidentiary criteria. I mean, it looks that way to me. So on the basis of the testimony of the witness, I'll admit Petitioner No. 5."

Respondent respectfully submits that there was no compliance with the relevant evidentiary criteria. A key element in considering whether an exhibit should be admitted in evidence is whether the exhibit is trustworthy. An important part of determining the trustworthiness of a document is whether there is evidence that it is authentic and accurate. The sponsoring witness testified that a document he proofread ten years ago was accurate, but there is no testimony by the sponsoring witness or anyone else that vouches for the accuracy or the authenticity of the photocopy of the document that was admitted as Pet. Ex. 5.

Respondent further argues that even if it were to be concluded that Pet. Ex. 5 meets the criteria to be admitted in evidence, Pet. Ex. 5 is a hearsay document that does not come within any of the exceptions to the hearsay rule. At the time of offering Pet. Ex. 5 in evidence, Petitioner's counsel offered it as "recollection recorded" (T: 200-201), apparently in reliance on section 90.803(5), Florida Statutes, which creates an exception to the hearsay rule for documents described in the statute as "recorded recollection." Section 90.803(5) reads as follows:

> 90.803(5) RECORDED RECOLLECTION.--A memorandum or record concerning a matter about which a witness once had knowledge, but now has insufficient recollection to enable the witness to testify fully and accurately, shown to have been made by the witness when the matter was fresh in the witness's memory and to reflect that knowledge correctly. A party may read into evidence a memorandum or record when it is admitted, but no such memorandum or record is admissible as an exhibit unless offered by an adverse party.

Pet. Ex. 5 was not made by the witness. Therefore, Pet. Ex.. 5 does not come within the statutory definition of "recorded recollection" and is not an exception to the hearsay rule within the meaning of section 90.803(5), Florida Statutes. Because it is a hearsay document that would not be admissible over objection in a civil action, Pet. Ex. 5 cannot be an independent basis for making any finding of fact. Sec. 120.57(1)(c), Fla. Stat. For all of the foregoing reasons, all of paragraphs 27 and 28 of the Recommended Order should be stricken.

Finding of Fact Exception 4. Respondent takes exception to the findings in the last two sentences of Finding of Fact 32 at page 20 of the Recommended Order because the statements in those two sentences are not supported by competent, substantial evidence.

Respondent takes exception to the statements in the last two sentences of paragraph 32 of the Recommended Order, which read as follows:

> Although the first responders observed some facial hair, in addition to muscularization, nothing in the record suggests that M. W. could take all of these anabolic steroids in unknown quantities without experiencing some masculinization, or that she expected no such masculinization side effects. Under these circumstances, M. W. could not legitimately have confronted Respondent over the incidental masculinization that she had experienced, while self-administered steroids whose main effect was muscularization, without running the risk that he would detect her unauthorized ordering of steroids.

There is no competent, substantial evidence anywhere in the record of this case to support the statements quoted immediately above. It is not even clear whether those statements are findings of fact or are merely opinions and conjectures of the Administrative Law Judge. If these statements are findings of fact, they are findings of irrelevant and immaterial facts. Whichever they may be, there is no competent, substantial evidence to support the statements in the last two sentences of paragraph 32, and those statements should be stricken.

Finding of Fact Exception 5. Respondent takes exception to portions of Finding of Fact 33 at page 21 of the Recommended Order because a portion of that finding is not supported by competent, substantial evidence.

Respondent takes exception to the last two sentences of Paragraph 33 of the Recommended Order. The entire paragraph reads as follows, with underscoring of the parts to which exception is taken.

> 33. As noted above, there are no available medical records. Respondent testified that he gave M. W.'s medical chart and drug log "VIP" treatment to preserve confidentiality: Respondent allowed M. W. to keep her medical records and the drug log pertaining to her medications. Each time M. W. presented to Respondent, such as for an injection, she brought with her these files, according to Respondent. Petitioner contends that these records never existed, and, therefore, Respondent failed to document that he monitored the effects of the anabolic steroids that he ordered for M. W. The Administrative Law Judge credits Petitioner's version of the situation regarding medical records.

The basis for this exception is that there is no competent, substantial evidence to support the underscored portion of paragraph 33. The Respondent is the only person with actual knowledge of whether he did or did not create contemporaneous medical records of his treatment of Patient MW. If such records were created, the Respondent is the only person with actual knowledge of the contents of any such contemporaneously created records. At the final hearing in this case the Respondent testified that he did create contemporaneous medical records of his treatment of MW. He also testified at length about the contents of those records. No witness testified that the Respondent failed to create contemporaneous medical records of his treatment of MW. There is no document in evidence that states that the Respondent failed to create such records.

It is clear that the Administrative Law Judge did not believe the Respondent's testimony about the creation of contemporaneous medical records of his treatment of MW. Obviously, because the Administrative Law Judge did not believe the Respondent's testimony on that issue, the Administrative Law Judge did not make any findings of fact consistent with the Respondent's testimony that he had, in fact, created such records. It is well within the ALJ's discretion to disbelieve unrebutted testimony of a physician, Fox v. Department of Health, 994 So.2d 416(Fla. 1st DCA 2008), but such disbelief does not provide a basis for a finding of fact that is essentially the opposite of the disbelieved testimony. Where unrebutted evidence is disbelieved, the ALJ's disbelief does not give rise to proof of the opposite of what was disbelieved. Rather, as a result of the disbelief, there is no persuasive evidence regarding the disbelieved testimony, and in the absence of persuasive evidence supporting a finding of some other version of the fact at issue, there is no basis for a finding of fact one way or the other as to the fact at issue because there is no persuasive evidence supporting any version of the fact at issue.

Stated otherwise, the only evidence as to whether the Respondent created the original medical records during the course of his treatment of MW is the Respondent's testimony that he did create the records, but that the Respondent was unable to find those records following the death of MW. The ALJ has apparently chosen not to believe the Respondent's testimony on this subject. Such being the case, the Respondent's testimony is not competent substantial evidence because the ALJ did not believe the Respondent's testimony on this issue. There is no other testimony by anyone with personal knowledge as to whether the Respondent did or did not create the subject medical records. Under these circumstances the most that can be said is that there is no competent, substantial evidence one way or the other as to whether the Respondent created the subject medical records. With the burden of proof resting on the Petitioner on all factual

issues raised by the Petitioner, it is not the Respondent's burden to prove that he created the records. Rather, it is the Petitioner's burden to come forward with clear and convincing proof that the Respondent did not create the subject records. There is no competent, substantial evidence of a failure to create the subject medical records; there is only a void in the evidence on this issue. Accordingly, the findings in the last two sentences of paragraph 33 of the Recommended Order should be stricken.

Finding of Fact Exception 6. Respondent takes exception to all of Finding of Fact 29 at pages 18-19 because it is not a finding of fact about any fact at issue in this case, but appears to be an effort by the Administrative Law Judge to discuss or explain the basis for some of his findings of fact yet to come.

Respondent takes exception to all of paragraph 29 of the Recommended Order. The basis for this exception is that nothing in paragraph 29 of the Recommended Order appears to be a finding of fact about any material fact at issue in this case. Paragraph 29 of the Recommended Order reads as follows:

> 29. These reconstructed records and statements to a law enforcement officer were not casual statements uttered in an informal setting. This was information that Respondent provided to assist in the investigation of the circumstances surrounding the death of this 30-year-old woman. Except for mention of a shoulder injury in the last-cited statement--an effort by Respondent to convert the treatment objective from pure enhancement of athletic performance to a mix of enhancement of athletic performance and therapy for some undiagnosed shoulder injury--the information consistently implies that the treatment objective was to improve M. W.'s efforts in bodybuilding and weightlifting. And the mention of the shoulder injury suggests only that its healing was subordinate to the weightlifting and bodybuilding. The failure of the reconstructed records to contain any diagnostic information or progress reports on the injured shoulder precludes a finding that the treatment objective was to heal a shoulder injury.

The language quoted immediately above appears to be intended as an introduction or explanation or clarification of findings yet to come; the type of material one more frequently sees in endnotes. But such language does not appear to include a finding of fact about any material fact at issue in this case. Because the language in paragraph 29 does not appear to contain any material finding of fact and because that language appears to add more confusion than conclusion to the findings of fact, it should be stricken, or at least relegated to endnote explanatory status.

Finding of Fact Exception 7: Respondent takes exception to a portion of the last sentence of Finding of Fact 35 at page 22 of the Recommended Order because a portion of that finding is not supported by competent, substantial evidence. And for exactly the same reasons, Respondent takes exception to the latter part of the one-sentence Finding of Fact 37 at page 23 of the Recommended Order.

With regard to paragraph 35, Respondent takes exception to all of the last sentence of paragraph 35 at page 22 of the Recommended Order. The specific language of paragraph 35 to which this exception is addressed reads as follows: "This is because he [Respondent] never ordered such lab work."

With regard to paragraph 37, Respondent takes exception to the underscored portion of the following language in the one-sentence Finding of Fact in paragraph 37 of the Recommended Order:

> 37. As to the Standard of care allegations, Petitioner has thus proved first . . . and, second, that Respondent did not order lab work to monitor the effects of the steroids that he prescribed for MW."

The basis for the exceptions to the specified portions of paragraphs 35 and 37 is that there is no competent, substantial evidence in the record to support the quoted statements in either paragraph. The Respondent was the only witness at the final hearing with first-hand knowledge

of whether the Respondent actually ordered the pre-treatment lab tests and the follow-up lab tests. At the final hearing the Respondent testified without hesitation or qualification that he ordered the necessary lab tests. No witness testified to having personal knowledge that the subject lab tests were not ordered. No document received in evidence states that the subject lab tests were not ordered. The best and clearest examples of his testimony about ordering the necessary lab tests are at pages 417-419 of the hearing transcript, which includes the following:

> Q. Now, in order to address these issues of possible adverse effects of the drugs and any other side effects, did you order laboratory tests to ensure that she was not having any of these negative effects as you proceeded through her therapy?
> A. Yes. But in addition to that, in addition to the ones that I've described, which is the CBC, the SMAC-20, lipid panel, I also ordered a testosterone to make sure that the testosterone was in the male range anywhere between 300 and 900 versus higher than that which would put it in the range of body building if it's over 1000 or higher. As long as you keep it within the range of the three to 700 range, then you're within the normal range of what it is that males have and you should get a very beautiful effect on the transgender aspect of this.
> Q. And then I was asking you as you're proceeding through the six weeks of administration of Winstrol, do you do any continuing liver function or kidney function tests?
> A. And I did answer the question.
> Q. And the answer is, sir?
> A. The answer is that I drew the same labs over again, including a testosterone level and to make sure that the testosterone level is between the 300 and 900 nanogram range and not out of that range higher than that range because you want to keep it within that certain range to make sure that you are in the transgender area for the medications that you're using.
> ADMINISTRATIVE LAW JUDGE MEALE: When did you draw those labs over with the testosterone level.
> THE WITNESS: I'm sorry.
> ADMINISTRATIVE LAW JUDGE MEALE: When, relative to the six-week administration.
> THE WITNESS: At the end of the six weeks.
> ADMINISTRATIVE LAW JUDGE MEALE: Okay.
> THE WITNESS: Yes, sir.
> BY MR. METZGER:

Q. And what were those findings as best you recall?
A. In the 500 nanogram level.
Q. Which would be what? Would that be --
A. Which would be normal for male levels.

At several places in the Recommended Order the Administrative Law Judge stated that he did not believe the Respondent's testimony to the effect that the Respondent ordered the appropriate pre-treatment and follow-up lab tests. Obviously, because the Administrative Law Judge did not believe the Respondent's testimony on that issue, the Administrative Law Judge did not make any findings of fact consistent with the testimony quoted above. It is well within the ALJ's discretion to disbelieve unrebutted testimony of a physician, Fox v. Department of Health, 994 So.2d 416 (Fla. 1st DCA 2008), but such disbelief does not provide a basis for a finding of fact that is essentially the opposite of the disbelieved testimony. Where unrebutted evidence is disbelieved, the ALJ's disbelief does not give rise to proof of the opposite of what was disbelieved. Rather, as a result of the disbelief, there is no persuasive evidence regarding the disbelieved testimony, and in the absence of persuasive evidence supporting a finding of some other version of the fact at issue, there is no basis for a finding of fact one way or the other as to the fact at issue because there is no persuasive evidence supporting any version of the fact at issue.

Stated otherwise, the only evidence as to whether the Respondent ordered the necessary lab tests during the course of his treatment of MW is the Respondent's testimony that he did order those tests, and that the orders for the lab tests and the results of the lab tests were included in the original records he created of his treatment of MW, but that the Respondent was unable to find those records following the death of MW. The ALJ has apparently chosen not to believe the

Respondent's testimony on this subject. Such being the case, the Respondent's testimony is not competent, substantial evidence because the ALJ did not believe the Respondent's testimony on this issue. There is no other testimony by anyone with personal knowledge as to whether the Respondent did or did not order the subject lab tests and did or did not make note of the order and the results of the subject lab tests in the original medical records of his treatment of MW. Under these circumstances the most that can be said is that there is no competent, substantial evidence one way or the other as to whether the Respondent ordered the subject lab tests. With the burden of proof resting on the Petitioner on all factual issues raised by the Petitioner, it is not the Respondent's burden to prove that he ordered the subject lab tests. Rather, it is the Petitioner's burden to come forward with clear and convincing proof that the Respondent did not order the subject lab tests. There is no competent, substantial evidence of a failure to order the subject lab tests; there is only a void in the evidence on this issue.

The findings in paragraphs 35 and 37 to the effect that the Respondent did not order the necessary lab work are also inconsistent with the logical observation of the Administrative Law Judge in paragraph 54 of the Recommended Order where he states: "The failure to order lab work is distinct from the medical records violation discussed below because a practitioner could order the lab work, but fail to document it." On the issue of whether the Respondent did or did not order the subject lab tests, the evidence in this case is equally balanced and is equally consistent with either a finding that the Respondent did not order the tests or that the Respondent ordered the tests but failed to document having done so. Where the evidence is consistent with either finding of fact, the evidence is insufficient to support a finding that one version of the facts is more likely than the other. And if the evidence fails to show that one version is more likely than the other, then there is no preponderance of the evidence for either finding. And it logically

follows that if the evidence is insufficient to demonstrate even a preponderance of the evidence, then it is certainly insufficient to prove the fact at issue by clear and convincing evidence. In a case of this nature, in the absence of clear and convincing evidence of a fact at issue, there can be no finding of fact one way or the other. Such is the case here and, accordingly, the specified portions of paragraph 35 and paragraph 37 of the Recommended Order should be stricken.

Finding of Fact Exception 8: Respondent takes exception to a portion of the last sentence of Finding of Fact 36 at page 22 of the Recommended Order because a portion of that finding is not supported by competent, substantial evidence.

Respondent takes exception to a portion of the last sentence of paragraph 36 of the Recommended Order. This exception is addressed to the underscored portion of the Administrative Law Judge's statement reading as follows: "Also, if such records had existed and Respondent had allowed MW to keep them, one obvious place for them would have been in MW's room at her home, but Respondent never sent anyone there to look for them after her death." The basis for this exception is that there is no competent, substantial evidence in the record to support the underscored portion of the quoted statement. The only statement that even comes close to supporting the underscored finding is in the rebuttal testimony of Frank White at page 650 of the hearing transcript in which Mr. White testified as follows:

> ADMINISTRATIVE LAW JUDGE MEALE: So you can answer if you know. Who is Janet Rainer?
> THE WITNESS: Yeah. She was a coworker of my daughter's.
> ADMINISTRATIVE LAW JUDGE MEALE: Okay.
> BY MR. MARR:
> Q. And what is her current status or whereabouts?
> A. I'm told that she'd [sic] deceased.
> Q. Okay. And did Ms. Rainer or anyone else from the Orlando Women's Center ever go to your house in an attempt to locate a missing medical file?
> A. Not while I was there. (Emphasis added.)

To fully comprehend the insignificance of Mr. White's statement quoted above, one must consider other testimony by Mr. Frank White to the effect that at the time in question he spent very little time at his home. For example, at page 45 of the hearing transcript Mr. Frank White stated:

> Q. In the six months prior to M.W.'s passing, how often did you see her?
> A. Almost daily. And the reason there's any exception at all is because I was helping my mother who had broken her hip rehab. So at the time, I was spending the afternoons and evenings at my mother's house. I would say during the last two months of M.W.'s life, that's where I was.

The most reasonable inferences to be drawn from the testimony quoted above is that, although no one came to Mr. White's home to look for medical records while he was there, he was away from home so often that there was ample opportunity for someone to come to his home when he was not there. In sum: Although Mr. White knows no one came while he was home, he has no knowledge as to whether anyone came when he wasn't home, and he was frequently not at home. This is by no means sufficient evidence to support a finding that "Respondent never sent anyone there to look for them [medical records] after her death." And Mr. Frank White's insufficient testimony is even further diminished when considered in context of other testimony on this issue. For example, at pages 450-451, the Respondent testified as follows about efforts to find the missing medical records:

> A. We looked all over the office, including the place where it was supposed to be. I asked Janet to look in [M.W.]'s car. I also asked Janet to look -- to call the Whites and go over to the house to see if they could find -- if she could find [M.W.]'s chart at her house along with the drug logs because the drug log was missing also.

Q. And Janet made a search for the medical records at [M.W.]'s house?
A. I believe she did.
Q. And she did that under your instructions?
A. I don't know if I asked her or if I asked Heidi to do it, to talk to Janet. I can't remember exactly. But I do know that somebody asked Janet to go look for [M.W.]'s chart at her house.
Q. And what was the result of that search?
A. We couldn't find the chart.
Q. Was it reported back to you that Janet's efforts to locate the medical chart at [M.W.]'s house were unsuccessful?
A. Yes.

From the foregoing it appears that the Respondent clearly instructed someone on his office staff to go to MW's home to look for the medical records, although, admittedly, from the testimony quoted immediately above it is not clear the extent to which the Respondent's instructions were carried out. Such being the case, this is another disputed issue of material fact on which there is insufficient evidence to support a finding either way as to whether there was or was not a search of MW's home for the missing medical records. In such circumstances where there is no competent substantial evidence to support either version of the disputed fact and no finding can be made, the underscored portion of the last sentence of paragraph 36 should be stricken.

Finding of Fact Exception 9: Respondent takes exception to the first sentence of Finding of Fact 40 at page 23 of the Recommended Order because that sentence is either ambiguous or is not supported by competent, substantial evidence.

Respondent takes exception to the first sentence in paragraph 40 of the Recommended Order. This exception is addressed to the underscored portion of that sentence, which reads as follows:

> As to the medical records violation, Petitioner has proved that Respondent's medical records failed to adequately document the monitoring of the effects of anabolic steroids that Respondent prescribed for MW.

The finding quoted immediately above is ambiguous in ways that are similar to the ambiguities in the allegations of the Respondent's conduct that are alleged to constitute a violation of section 458.331(1)(m), Florida Statutes. Those ambiguous allegations are found in paragraph 25 of Count Two of the Amended Administrative Complaint, which reads as follows:

> 25. Respondent failed to justify the course of Patient MW's medical treatment by failing to adequately document the monitoring of the effects of the prescribed anabolic steroids on Patient MW.

The above-quoted allegation in the Amended Administrative Complaint, like the substantially identical allegation in Trevisani v. Dept. of Health, 908 So.2d 1108 (Fla 1st DCA 2005), is ambiguous because one cannot tell from reading the allegation whether the alleged documentation failure refers to the information contained in the "reconstructed" records (Pet. Ex. 1) or to the information contained in the Respondent's original medical records of his treatment of MW—the records that could not be found after MW's death. Similarly, the finding in paragraph 40 of the Recommended Order which is challenged in this exception is so ambiguous that one cannot tell whether the Administrative Law Judge is making a finding about the information contained in the "reconstructed" records (Pet. Ex. 1) or whether the alleged documentation failure refers to the information contained in the Respondent's original medical records of his treatment of MW—the records that could not be found after MW's death. A Respondent in a case of this nature cannot be found guilty of a violation on the basis of an ambiguous allegation or on the basis of an ambiguous finding of fact. Because the ambiguities in both allegations and findings of fact must be resolved in favor of the Respondent, the

ambiguities in the first sentence of paragraph 40 of the Recommended Order should be stricken because they cannot form the basis for a conclusion that the Respondent is guilty of the ambiguous allegation in paragraph 25 of the Amended Administrative Complaint.

Respondent's Exceptions to Conclusions of Law

Conclusions of Law Exception 1. The Respondent takes exception to the conclusions of law and the explanations of the conclusions of law in Paragraphs 53 and 54 at pages 29 and 30 of the Recommended Order because the evidence is insufficient to support the conclusion that there was a violation.

Respondent takes exception to the conclusion of law in paragraph 53 that reads: "As to paragraph b of Count One, Petitioner has proved that the failure to order lab work to monitor the effects of the anabolic steroids is a Standard of Care violation." The basis for the exception to the quoted conclusion, and to the Administrative Law Judge's explanations of the subject conclusion is that, as argued earlier in the Findings of Fact portion of these exceptions, there is no competent substantial evidence that the Respondent failed to order lab work to monitor the effects of the anabolic steroids. The most that could be said on the record of this case is that the Respondent failed to retain original medical records showing that the tests were ordered and showing the results of any of the tests, or that the Respondent failed to make any mention of ordering the lab work in the "reconstructed" records he created. But, as explained in detail earlier in this document at Respondent's Finding of Fact Exception 7, there is no competent, substantial evidence that the Respondent never ordered the tests.

The finding that Respondent never ordered the tests appears to be based on nothing more than an unwarranted inference by the Administrative Law Judge to the effect that if the Respondent had ordered the tests the Respondent would have told Detective Moyer about the tests when the detective interviewed the Respondent. There are many reasons the Respondent

might not have mentioned the tests to the detective, including the fact that the tests and their results would not have been relevant to the cause of death of MW, which is what the detective was investigating. Further there is no evidence that the detective asked about the monitoring tests. (The detective did ask about the tests to determine if MW was using unauthorized controlled substances and in due course he was provided with the results of those tests.) Because there is no competent, substantial evidence that the Respondent failed to order the subject lab work, there can be no finding of fact to that effect. And without that finding of fact, there is no factual foundation for the conclusions of law in paragraphs 53 and 54 of the Recommended Order. Accordingly, the conclusions of law in paragraphs 53 and 54 should be stricken.

Conclusions of Law Exception 2. The Respondent takes exception to the conclusions of law in Paragraph 56 at pages 30 and 31 of the Recommended Order because the conclusions of law at Paragraph 56 are legally insufficient, the facts they rely on are insufficient and the allegations underlying the alleged medical records violation are legally insufficient.

Respondent takes exception to the conclusion of law in paragraph 56 that reads:

> As to Count Two, Petitioner has proved a medical records violation because Respondent failed to document adequately the effects of the anabolic steroids—specifically, by failing to document the results of the lab work that must be performed when administering anabolic steroids under these circumstances. This is a failure to justify the course of the steroid treatment that Respondent pursued with MW.

The reasons for this exception include (a) the conclusion of law in paragraph 56 is predicated on a fact that was not proved, and (b) the allegations that underlie the conclusion of law are legally insufficient for the reasons set forth in Trevisani v. Dept. of Health, 908 So.2d 1108 (Fla. 1st DCA 2005), and similar cases. Turning first to the insufficiencies in the factual foundation for this conclusion of law, the material fact on which this conclusion of law rests is, in the words of the Administrative Law Judge, that "...Respondent failed to document

adequately the effects of the anabolic steroids--specifically, by failing to document the results of the lab work..." (Emphasis added.) As explained in detail earlier in this document at Respondent's Finding of Fact Exception 5 and at Respondent's Conclusion of Law Exception 1, there is no competent, substantial evidence that the Respondent failed to document the results of the lab work in his original medical records of his care of MW. Because there is no competent, substantial evidence of a documentation failure, there can be no finding of fact to that effect. And without that finding of fact, there is no factual foundation for the conclusion of law in paragraph 56 of the Recommended Order. Accordingly, the conclusion of law in paragraph 66 should be stricken.

At this point we wish to address attention to insufficiencies in the quality of Petitioner's allegations regarding the medical records, because the record-keeping allegations in this case suffer from the same legal insufficiencies as the allegations that brought about the reversal of the Board of Medicine's final order is Trevisani v. Department of Health, 908 So.2d 1108 (Fla. 1st DCA 2005). Due process prohibits an agency from taking disciplinary action against a licensee based upon conduct not specifically alleged in the charging instrument. Stated otherwise, an agency seeking to take disciplinary action must allege the specific act or failure to act which is the basis for the violation(s) charged in the Administrative Complaint. For the reasons mentioned below, specificity is missing from the allegations that are stated to be the factual foundation for the violation charged in Count Two.

In Trevisani the court described the nature of the issues before it and the disposition of those issues in the following words:

> The ALJ found that the complaint only alleged that Appellant had failed to create certain medical records. The ALJ accepted Appellant's testimony as credible that he had created these

documents, even though they were not contained in the patient's medical records. Based on this finding, the ALJ dismissed the count charging Appellant with a violation of section 458.331(1)(m), Florida Statutes; however, the Board of Medicine rejected this finding and concluded that Appellant was charged not only with failure to create certain medical records, but also with failure to retain possession of those documents. The Board of Medicine found that there was competent, substantial evidence in the record to support a finding that Appellant failed to retain possession of the medical records, and it imposed an administrative fine and placed Appellant's license on probation for two years.

A physician may not be disciplined for an offense not charged in the complaint. Ghani v. Dep't of Health, 714 So.2d 1113 (Fla. 1st DCA 1998); Willner v. Dep't of Prof'l Reg., Bd. of Med., 563 So.2d 805 (Fla. 1st DCA 1990). In this case, the complaint charged Appellant with failing to properly document certain records and failing to create or complete certain documents. The complaint did make reference to section 458.331(1)(m), Florida Statutes, but it did not contain any specific factual allegations that Appellant failed to retain possession of the medical records. The single reference to the statute without supporting factual allegations was not sufficient to place Appellant on notice of the charges against him. Cottrill v. Dep't of Ins., 685 So.2d 1371 (Fla. 1st DCA 1996) (partly reversing Department's final order and remanding for reconsideration of penalty, where administrative complaint merely cited statutes but failed to allege any act or omission in violation of statutes allegedly violated by licensee, thereby denying licensee reasonable notice of facts or of conduct warranting disciplinary action). Even if the administrative complaint could be read to assert a charge that Appellant failed to retain possession of the medical records, we could not affirm such a finding because Appellant was no longer employed at the health care facility in question and did not have possession of the medical records. Accordingly, we reverse the final order with directions to dismiss the complaint against Appellant.

The extent to which the insufficient allegations of an "(m)" violation in the instant case are substantially identical to the insufficient allegations that were before the court in Trevisani, is best shown in the recommended order in that case at Department of Health, Board of Medicine v.

Thomas P. Trevisani, M.D., DOAH Case No. 03-1952PL (RO issued December 31, 2003), at paragraphs 69 through 73, which read as follows

> 69. Count Two of the Amended Administrative Complaint charges Respondent with having violated Section 458.331(1)(m), Florida Statutes (Supp. 1996). In this regard, paragraph 16 of the Amended Administrative Complaint charges the following:
>
> > 16. Respondent failed to keep written medical records that justify the course of treatment of Patient F. V. in one or more of the following ways: (a) By failing to properly document Patient F. V.'s pre-operative consultation; (b) By failing to properly document a post-operative report of the procedures; (c) By failing to complete or create an appropriate operative report for the procedures.
>
> 70. Directing attention first to the allegations in subparagraph (a) of paragraph 16, there is a certain amount of ambiguity in the allegations that Respondent failed to keep written medical records that justify the course of treatment of Patient F. V. "[b]y failing to properly document Patient F. V.'s pre-operative consultation." The failures alleged in paragraph 16 and its subparagraphs could come about in either of two ways: (1) Petitioner could be alleging that Respondent at one time prepared sufficient medical records during the course of treating the patient, but later failed to "keep" those records because he did not "retain" the records and could not produce them upon request, or (2) Petitioner could be alleging that Respondent failed to ever prepare sufficient medical records and, therefore, never had any sufficient records to keep. Following careful consideration of the language of the three subparagraphs of paragraph 16, it appears that the most logical interpretation of those subparagraphs is to interpret them as allegations that Respondent failed to ever prepare sufficient medical records of the types described in each of the three subparagraphs of paragraph 16.
>
> 71. Subparagraph (a) of paragraph 16, alleges that Respondent failed to properly document Patient F. V.'s preoperative consultation. That allegation has not been established by clear and convincing evidence. To the contrary, the greater weight of the evidence is to the effect that promptly following Respondent's pre-operative consultation with Patient F. V., he dictated an adequate pre-operative consultation note. That note is presently missing from the patient's chart, but there is no evidence in the record of this case upon which to attribute the absence of the missing

document to any act or omission of Respondent. Therefore, so much of Count Two as relies on the allegations in subparagraph (a) of paragraph 16 should be dismissed for lack of sufficient proof.

72. Turning next to the allegations in subparagraph (b) of paragraph 16, there is no clear and convincing evidence in the record of this case that Respondent failed to keep written medical records that justify the course of treatment of Patient F. V. "[b]y failing to properly document a post-operative report of the procedures." To the contrary, the greater weight of the evidence is to the effect that shortly after the surgery on June 6, 1997, Respondent dictated a detailed operative report. That note is presently missing from the patient's chart, but there is no evidence in the record of this case upon which to attribute the absence of the missing document to any act or omission of Respondent. Therefore, so much of Count Two as relies upon the allegations in subparagraph (b) of paragraph 16 should be dismissed for lack of sufficient proof.

73. And, finally, attention is directed to the allegations in subparagraph (c) of paragraph 16, which allege that Respondent failed to keep written medical records that justify the course of treatment of Patient F. V. "[b]y failing to complete or create an appropriate operative report for the procedures." The allegations in subparagraph (c) of paragraph 16 appear to use different words to allege what appears to be the same violation that is alleged in subparagraph (b) of paragraph 16. Inasmuch as the violation alleged in subparagraph (c) appears to be indistinguishable from the violation alleged in subparagraph (b), the two alleged violations should be disposed of in the same manner for the same reasons. Therefore, so much of Count Two as relies upon the allegations in subparagraph (c) of paragraph 16 should be dismissed for lack of sufficient proof.

Endnote 20 of the Trevisani RO also noted: "In this regard it is also important to remember that in penal proceedings any ambiguities must be construed in favor of the licensee." See Lester v. Department of Professional and Occupations Regulations, 348 So. 2d 923 (Fla. 1st DCA 1977) and Elmariah v. Department of Professional regulation, Board of Medicine, 574 So.2d (Fla 1st DCA 1990. Although Lester and Elmariah both involved ambiguities in the language of disciplinary statutes, the same principles apply equally to ambiguities in the

language of the charging document. See Department of Health, Board of Pharmacy v. RX Network of South Florida, LLC, and Gwyneth M. Gordon, R.Ph., DOAH Case Nos. 02-2976-77, 02-2978PL and 02-2980PL, RO issued January 10, 2003, in which the ALJ states at paragraph 13: "The ALJ has ruled that any ambiguity in the factual allegation must be construed in favor of the licensee because this is a license discipline proceeding." (Emphasis added.) By reason of the insufficiencies in the allegations of the factual basis for the violation charged in Count Two, the Respondent has been deprived of the specific notice to which he is entitled under well-settled case law. Accordingly, Count Two of the Administrative Complaint should be dismissed in its entirety on due process grounds.

If not dismissed on due process grounds, the records-keeping violation alleged in Count Two should be dismissed because the Respondent reasonably interpreted the allegations in Count Two as an assertion that he never created any records that would "adequately document the monitoring of the effects of the anabolic steroids on Patient M.W.," as opposed to an assertion that he once had records (perhaps sufficient records), but had failed to keep or retain such records so they could be produced at a later date. In this regard it is instructive to note that the facts alleged in paragraph 25 to be the basis of the violation charged do not include either the word "keep" or the word "retain." As in Trevisani, the allegations in Count Two are ambiguous and are susceptible to being interpreted in more than one way. Respondents in license discipline cases are not required to, at their peril, guess what a regulatory body might have had in mind when it wrote an ambiguous allegation. Rather, as noted in Lester v. Department of Professional and Occupational Regulation, 348 So.2d 923, 925 (Fla. 1st DCA 1977), ". . . if there are any ambiguities included such must be construed in favor of the applicant or licensee."

For all of the foregoing reasons, the conclusions of law in paragraph 56 of the Recommended Order should be dismissed.

Conclusions of Law Exception 3. The Respondent takes exception to the conclusions of law in Paragraph 59 at pages 31 and 32 of the Recommended Order because the conclusions of law at Paragraph 59 are legally insufficient and those conclusions are in conflict with decisional law.

Respondent takes exception to the underscored portion of the conclusion of law in paragraph 59 that reads:

> 59. As Respondent contends, Rogers v. Department of Health, 920 So.2d 27 (Fla. 1st DCA 2005), requires an element of illicitness for a determination that the prescription or administration is not in the course of the physician's professional practice. Section 458.331(1)(ee) supplies this element. The holding in Barr does not require a contrary result. Here, Section 458.331(1)(ee) has supplied the element of illicitness necessary to find a violation of Section 458.331(1)(q). The illicit nature of an act or omission may be derived from any statute, so this situation is different from merely recasting a medical record violation as [a] Standard of Care violation, at least where Petitioner has not pleaded a Section 458.331(1)(ee) violation.

As noted by the Administrative Law Judge, Rogers v. Department of Health is the controlling interpretation of how section 458.331(1)(q), Florida Statutes, should be applied. And as also noted by the ALJ, Rogers requires an element of illicitness to prove a violation of 458.331(1)(q). In this case the element of illicitness has been neither alleged nor proved. (The absence of allegation or proof is addressed at further length in the exception which follows.) The Administrative Law Judge purports to discover the element of illicitness in the language of section 458.331(1)(ee), Florida Statutes, but that discovery is misplaced because if it were to be applied in the manner described by the ALJ, it would run afoul of fundamental notions of due process. The bottom line of the ALJ's legal analysis in paragraph 59 is that the Respondent has violated section 458.331(1)(q) because some of the Respondent's conduct violated section

458.331(1)(ee). But the Respondent was never charged with a violation of section 458.331(1)(ee), nor was he placed on notice by anything in the Amended Administrative Complaint that section 458.331(1)(ee) would be brought into play in any way in this case. In fact, section 458.331(1)(ee) is not mentioned a single time anywhere in the Amended Administrative Complaint. A long line of well-established case law prohibits finding a Respondent guilty of violating a statute that is not even mentioned in the charging document.

It is also noted that when the Rogers interpretation of section 458.331(1)(q) is applied to the allegations in this case, the violations of section 458.331(1)(q) asserted in this case must be dismissed because it is clear from the allegations in paragraphs 33 and 34 of Count Four that those allegations relate to the Respondent's care and treatment of Patient MW and do not relate to any conduct of the Respondent "other than in the course of the physician's professional practice." As of today, Rogers is the only appellate opinion interpreting section 458.331(1)(q), and unless and until the holding in Rogers is modified or reversed the Board of Medicine must follow and apply that interpretation. See Costarell v. Florida Unemployment Appeals Commission, 916 So.2d 778 (Fla. 2005), Mikolsky v. Unemployment Appeals Commission, 721 So.2d 738, 740 (Fla. 5th DCA 1998), State v. Hayes, 333 So.2d 51 (Fla. 4th DCA 1976), Bunn v. Bunn, 311 So.2d 387, 389 (4th DCA Fla.1975).) There is nothing in the allegations or in the evidence that indicates the Respondent did anything with any legend drug or controlled substance in any manner "other than in the course of the physicians' professional practice."

Because there is neither sufficient allegation nor sufficient evidence that the Respondent violated section 458.331(1)(q), the legal conclusion in paragraph 59 of the Amended Administrative Complaint should be stricken. Additional reasons for striking paragraph 59 are set forth in the exception which follows.

Conclusions of Law Exception 4. The Respondent takes further exception to the conclusions of law in Paragraph 59 at pages 31 and 32 of the Recommended Order because the factual and legal analysis underlying the conclusions of law at Paragraph 59 are in irreconcilable conflict with the factual and legal analysis of the other paragraphs in which the Administrative Law Judge concludes that the Respondent has violated other provisions of section 458.331(1), Florida Statutes.

The Respondent takes further exception to the Administrative Law Judge's conclusion in paragraph 59 that the Respondent has violated Section 458.331(1)(q), Florida Statutes, on the grounds that a necessary element of a violation of section 458.331(1)(q) is proof that a physician made a legend drug or controlled substance available to another person at a time and circumstance "other than in the course of the physician's professional practice," and that element has been neither alleged herein nor proved in this case. Simple logic and the common and ordinary meaning of words leads to the conclusion that when a physician is acting "other than in the course of the physician's professional practice," such actions by the physician are not the practice of medicine. It would be nothing less than absurd to contend that by performing a specific act – specifically the act of providing a legend drug or a controlled substance to a person – a physician was simultaneously engaged in the practice of medicine and also acting "other than in the course of the physician's professional practice." Each time a physician makes a legend drug or a controlled substance available to another person the act of making the drug available has to be either within or without the practice of medicine; it cannot logically be both.

The allegations in the Amended Administrative Complaint indicate that the Petitioner seems to view the matter otherwise. In each of the following paragraphs of the Amended Administrative Complaint it is alleged or inferred that the Respondent is a physician or that the Respondent was practicing medicine: 2, 4, 9, 12, 13, 16, 21, 22, 25, 26, 33. In each of the following paragraphs of the Amended Administrative Complaint it is alleged or inferred that

MW was a "patient" of the Respondent: 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17, 21, 25, 26, 33. But nowhere in the Amended Administrative Complaint is there an allegation of fact to the effect that the Respondent provided any drugs to MW "other than in the course of the physician's professional practice." Similarly, there is no testimony by any fact witness or by any expert witness to the effect that the Respondent provided any drugs to MW "other than in the course of the physician's professional practice." The only place in the Amended Administrative Complaint that states that the Respondent made a drug available to MW "other than in the course of the physician's professional practice" is in paragraph 34. Paragraph 34 is not a factual allegation. Rather, it is a statement of the Petitioner's legal conclusion that the facts alleged in other paragraphs of the Amended Administrative Complaint constitute a violation of Section 458.331(1)(q), Florida Statutes.

Where there is no allegation of fact to the effect that the Respondent acted "other than in the course of the physician's professional practice," and where there is no testimony to that effect by either a fact witness or an expert witness, the Respondent cannot be found guilty of an act that was neither alleged nor proved. Not only is there no proof that the Respondent at any time acted "other than in the course of the physician's professional practice," throughout the record in this case the evidence is clear and convincing that at all times material the Respondent was a physician, MW was his patient, and everything that the Respondent did for MW was within the course and scope of his professional practice. If a physician-patient relationship existed between the Respondent and MW at all material times, there is simply no basis upon which to conclude that the Respondent provided drugs to MW "other than in the course of the physician's professional practice." While the parties obviously have their differences as to the quality and

sufficiency of the professional services the Respondent provided to MW, all of those services were provided during the course of a legal and proper physician-patient relationship.

It should also be noted that if the Respondent was providing medical treatment to MW for a medical condition that required treatment then he was engaged in the practice of medicine, which is a necessary element of proving a 458.331(1)(t) standard of care violation or a 458.331(1)(m) medical records violation. And if the Respondent was practicing medicine when he made drugs available to MW then it cannot logically be concluded that he was acting "other than in the course of the physician's professional practice," which is a necessary element of a violation of section 458.331(1)(q), Florida Statutes. Similarly, if it is found or concluded that the Respondent was acting "other than in the course of the physician's professional practice" when he made drugs available to MW, in that event the Respondent would not have been practicing medicine when he made drugs available to MW, and his provision of those drugs would not have been during the course of practicing medicine, which is a required element of proving a 458.331(1)(t) standard of care violation or a 458.331(1)(m) medical records violation.

For the reasons set forth in this exception, if the Board of Medicine concludes that the Respondent was practicing medicine during the period when he was making steroids available to MW, then the Board must dismiss the allegations that the Respondent violated section 458.331(1)(q). Alternatively, if the Board of Medicine concludes that the Respondent was acting "other than in the course of the physician's professional practice" when he was making steroids available to MW, then the Board must dismiss the allegations that the Respondent violated sections 458.331(1)(m) (medical records) and 458.331(1)(t) (standard of care) because a

necessary element of an "(m)" or a ("t") violation is that the acts occur during the course of the practice of medicine.

Conclusion of Law Exception 5. The Respondent takes exception to the conclusion of law in Paragraph 66 at page 35 of the Recommended Order because that conclusion of law is based on a factual predicate for which there is no competent substantial evidence.

Respondent takes exception to paragraph 66 of the Recommended Order because the conclusion of law set forth in that paragraph is predicated on a fact that was not proved. The material fact on which this conclusion of law rests is, in the words of the Administrative Law Judge, that "Respondent prescribed anabolic steroids for body building and weight lifting without ordering lab work." (Emphasis added.) As explained in detail earlier in this document at Respondent's Finding of Fact Exception 7, and at Respondent's Conclusions of Law Exception 1, there is no competent, substantial evidence that the Respondent prescribed steroids for MW "without ordering lab work." Because there is no competent substantial evidence that the respondent failed to order the subject lab work, there can be no finding of fact to that effect. And without that finding of fact, there is no factual foundation for the conclusion of law in paragraph 66 of the Recommended Order. Accordingly, the conclusion of law in paragraph 66 should be stricken.

Exception To The Proposed Penalty And Request For Reduction

In accordance with the foregoing Exceptions and the resultant modifications to the Findings of Fact and Conclusions of Law of the Administrative Law Judge, this Board should consistently reduce the recommended penalty commensurate with those modifications made.

Exception To The Proposed Penalty And Request For Reduction

In accordance with the foregoing Exceptions and the resultant modifications to the Findings of Fact and Conclusions of Law of the Administrative Law Judge, this Board should consistently reduce the recommended penalty commensurate with those modifications made.

WHEREFORE, Respondent respectfully requests that the foregoing Exceptions to the Recommended Order be granted and that modifications to the Findings of Fact, Conclusions of Law, and Recommended Penalty of the Administrative Law Judge be made in accordance with the arguments herein.

Respectfully submitted this 23rd day of June, 2010.

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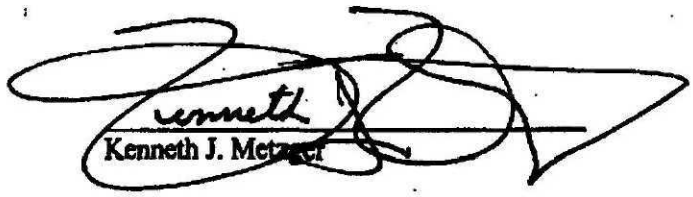
ATTORNEYS FOR RESPONDENT

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that the original of the foregoing Exceptions to Recommended Order was forwarded by hand delivery for filing to R. Sam Power, Clerk, Department of Health, 4052 Bald Cypress Way, Bin C-01, Tallahassee, Florida 32399-3201 and was forwarded by hand delivery to the clerk of the Division of Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-3060 and by hand delivery to Greg Marr, Esquire, Assistant General Counsel, at Department of Health, Prosecution Services Unit, 4052 Bald Cypress Way, Bin C-65, Tallahassee, Florida 32399-3265, with a hard copy to follow by United States mail delivery, the 23rd day of June, 2010.



Kenneth J. Metzger

Tab 21

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Sandra Soto
DATE JUL 06 2010

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO.: 2001-04256**

JAMES S. PENDERGRAFT, IV, M.D.,

RESPONDENT.

_____/

PETITIONER'S RESPONSES TO RESPONDENT'S EXCEPTIONS TO THE RECOMMENDED ORDER

Petitioner, Department of Health (Department), pursuant to Section 120.57(1), Florida Statutes, and Florida Administrative Code Rule 28-106.217, files the following Responses to Respondent's Exceptions, filed June 23, 2010, to the Recommended Order (RO) issued by Administrative Law Judge (ALJ) Robert E. Meale, on June 8, 2010, and in support thereof, states as follows:

RESPONSE TO EXCEPTIONS

Respondent set out nine exceptions to the findings of fact, five exceptions to the conclusions of law, and one exception to the proposed penalties in the Recommended Order. The following is

Tab 21

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Sandra Soto
DATE JUL 06 2010

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

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JAMES S. PENDERGRAFT, IV, M.D.,

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RESPONSE TO EXCEPTIONS

Respondent set out nine exceptions to the findings of fact, five exceptions to the conclusions of law, and one exception to the proposed penalties in the Recommended Order. The following is

Petitioner's response to the correspondingly numbered Respondent's exceptions:

Findings of Fact

1. Respondent takes exception to a portion of the last sentence of paragraph 12 on pages 11 and 12 of the Recommended Order in which the Administrative Law Judge (ALJ) finds that Patient M. W. (hereinafter MW) did not tell Respondent that she wanted to change into a man.

This is the first of many instances, to follow, where the ALJ disbelieved the testimony of Respondent.

Respondent admits in this exception that the ALJ is well within his discretion to disbelieve his unrebutted testimony as a physician, but then, without legal support, goes on to claim that that disbelief cannot justify believing that the opposite of his testimony is the truth. This exception makes no sense. MW either did or she did not tell Respondent she wanted to take steroids to transgender into a man. There are no shades in between. You cannot disbelieve one without believing the other. These are, by definition, opposites.

The record is replete with substantial, credible evidence in support of the side of this equation the ALJ chose as being the truth, particularly the testimony of two of Petitioner's expert witnesses (Jones and Greenwald) who testified that the steroids MW purchased were for body building and not transgender treatment.

This exception should be denied.

2. Respondent takes exception to paragraph 13 on page 12 of the Recommended Order in which the ALJ finds that healing a long-injured shoulder was not a secondary reason for allowing MW's access to steroids. Respondent takes exception to this paragraph because it does not relate directly to a fact at issue in this case.

This paragraph touches on several central themes of this case—medical records, gender reassignment vs. body building, Respondent's credibility—that are the subject of many findings to come. Does Respondent propose we not allow the ALJ to write a Recommended Order as he sees fit? Exceptions are for findings of fact and conclusions of law, not literary style.

This exception should be denied.

3. Respondent takes exception to paragraphs 27 and 28 on pages 17 and 18 of the Recommended Order in which the ALJ finds MW's use of steroids was for body building and not gender reassignment. Respondent claims that this finding rests solely on an Exhibit of Petitioner's that allegedly was inadmissible. In reality, this finding is supported by other competent, substantial evidence in the record such as Petitioner's Exhibit 1, and the testimony of Petitioner's expert pharmacokinetics witness who opined that the steroids MW purchased were tailored for body building, and the testimony of Petitioner's expert gender reassignment witness who opined that the steroids MW purchased were not tailored for sex change therapy.

Additionally, as to the issue of the admissibility of proffered evidence, the Board should defer to the ALJ on making such decisions because this issue is not within the Board's substantive jurisdiction. See Barfield v. Dep't of Health, Bd. Of Dentistry, 805 So. 2d 1008 (Fla 1st DCA 2001).

This exception should be denied.

4. Respondent takes exception to the last two sentences of paragraph 32 on page 20 of the Recommended Order in which the

ALJ finds that MW's physical appearance was consistent with the steroids she had access to, but that she could not remark to Respondent about her muscularization without tipping him off to the whole panoply of steroids she was acquiring and using.

The best explanation for the ALJ's statement of these findings would appear to be to summarize and to explain the bodily changes MW was experiencing and Respondent's lack of knowledge of what MW was self-administering. These remarks are based upon a number of sources of substantial, competent evidence, including Respondent's own expert witness (as stated in this paragraph), the police officer's testimony that MW's deceased body looked manly, the steroid purchase records, and the testimony of MW's father and brother.

This exception should be denied.

5. Respondent takes exception to portions of paragraph 33 on page 21 of the Recommended Order in which the ALJ finds that no medical record was made contemporaneous with the treatment of MW; therefore, Respondent failed to document his treatment of MW.

Respondent testified that he made a medical record on MW including monitoring the effects of the steroids, and explained that he dispatched someone to her house after her death to retrieve the record after it came up missing at the clinic. That assertion was contradicted by rebuttal testimony of MW's father. The ALJ, as is his prerogative, chose not to believe Respondent.

This exception should be denied.

6. Respondent takes exception to paragraph 29 on pages 18 and 19 of the Recommended Order in which the ALJ summarizes evidence from several sources—the investigating police officer, Respondent's reconstructed medical records, and Respondent's testimony—apparently to explain why he was not crediting Respondent's version of events in this case. This is but one of several instances in the Recommended Order where the ALJ makes findings that Respondent's testimony was not credible. This exception is, again, merely critical of the ALJ's literary style.

This exception should be denied.

7. Respondent takes exception to a portion of the last sentence of paragraph 35 on page 22 of the Recommended Order in

which the ALJ finds that Respondent never ordered the lab work that he claimed to have ordered. This is another instance of the ALJ simply disbelieving Respondent's testimony, even when that testimony is unrebutted. The ALJ sets forth a substantial, credible basis for this finding by making reference to the omission of lab values from Respondent's reconstructed medical record where he did in fact document other pertinent information.

This exception should be denied.

8. Respondent takes exception to a portion of the last sentence of paragraph 36 on page 22 of the Recommended Order in which the ALJ finds that Respondent, contrary to his claim, did not send someone to MW's house to look for her allegedly missing medical file after MW's demise.

In support of this exception, Respondent quotes from the testimony of MW's father. This quote stops one question and one answer short of this witness's entire rebuttal testimony which does, in its totality, constitute competent, substantial evidence for the ALJ's finding of fact.

This exception should be denied.

9. Respondent takes exception to the first sentence of paragraph 40 on page 23 of the Recommended Order in which the ALJ finds that Respondent's medical record on MW did not adequately document his monitoring the effects of the steroids that MW was taking. The claim is that Respondent was ambiguously charged in the Amended Administrative Complaint by there not being a clear distinction between the original medical record and the record that Respondent claims to have reconstructed to aid the police in their investigation into MW's death.

What Respondent fails to acknowledge in this exception is that the ALJ found that there was **no** medical record maintained by Respondent concerning his alleged care and treatment of MW. If there was no record (and Respondent would have to have known this) where could there possibly be an ambiguity? Respondent failed to justify his course of treatment of MW, as charged, because he was not maintaining a medical record on this treatment.

This exception should be denied.

Conclusions of Law

1. Respondent takes exception to the Conclusion of Law in paragraphs 53 and 54 on pages 29 and 30, of the Recommended Order, that reads: "As to paragraph b of Count One, Petitioner has proved that the failure to order lab work to monitor the effects of the anabolic steroids is a Standard of Care violation," asserting that the evidence is not sufficient to support this conclusion.

At paragraph 23, 34 and 35, of the Recommended Order, the ALJ clearly set forth his basis for disbelieving Respondent as to whether he had lab tests performed to monitor the effects of the steroids on MW. These tests are crucial and had there been any they would have been included in the allegedly reconstructed medical records where reference to such tests was conspicuous by its absence.

This exception should be denied.

2. Respondent takes exception to the Conclusion of Law in paragraph 56 on pages 30 and 31, of the Recommended Order, that reads: "As to Count Two, Petitioner has proved a medical records violation because Respondent failed to document adequately the

effects of the anabolic steroids—specifically, by failing to document the results of the lab work that must be performed when administering anabolic steroids under these circumstances. This is a failure to justify the course of the steroid treatment that Respondent pursued with M. W." Respondent asserts that the evidence is not sufficient to support this conclusion and that the charging document was so ambiguous as to negate due process.

These issues were dealt with under the Responses to Exceptions to Findings of Fact number 5 and 9, above. In sum, there is in the record substantial, credible evidence to support the conclusion that there was no contemporaneous medical record on MW, so there obviously was a failure to document lab work done, and, as to whether the alleged violation related to original records or reconstructed records, Respondent knew there were no original records and thus was on notice that the deficiency alleged in the Amended Administrative Complaint related to the absence of such a record.

This exception should be denied.

3. Respondent takes exception to the Conclusion of Law in paragraph 59 on pages 31 and 32, that reads: "As Respondent contends, Rogers v. Department of Health, 920 So. 2d 27 (Fla. 1st DCA 2005), requires an element of illicitness for a determination that the prescription or administration is not in the course of a Physician's professional practice. Section 458.331(1)(ee) supplies this element. The holding in Barr does not require a contrary result. Here, Section 458.331(1)(ee) has supplied the element of illicitness necessary to find a violation of Section 458 (1)(q). The illicit nature of an act or omission may be derived from any statute, so this situation is different from mere recasting a medical record violation as Standard of Care violation, at least where Petitioner has not pleaded a Section 458.331(1)(ee) violation."

Respondent takes exception to everything except the first sentence; however, it is the first sentence which is incorrect as a matter of law. This Board has substantive jurisdiction over the conclusion of law of whether a violation under section 458.331(q), Florida Statutes requires illicit conduct, and this Board has specifically found that it does not, and the Board's interpretation of the statute

was upheld on appeal as within the agency's delegated range of discretion. See Waters v. Dep't of Health, Bd. of Med., 962 So. 2d 1011, 1012-13 (Fla. 3d DCA 2007).

The Respondent argues Rogers v. Dep't of Health, 920 So. 2d 27, 31-32 (Fla. 1st DCA 2005), applies, and that it is the "only appellate opinion interpreting section 458.331(1)(q)..." However, the District Court of Appeal did not interpret section 458.331(1)(q), in Rogers. In Rogers, an ALJ had entered a Recommended Order recommending dismissal of a charge of violating section 458.331(1)(q), for two reasons: 1) the ALJ found that to establish guilt under section 458.331(1)(q), the Department had to prove that the accused doctor was not practicing medicine, but instead was engaged in an illicit (and probably criminal) activity; and 2) the ALJ found that there was not clear and convincing evidence to support the Department's claims that the Respondent in that case failed to document patient history and the Department did not prove that the Respondent failed to conduct a physical examination before prescribing narcotics. See id. at 29-31. The Board rejected the ALJ's interpretation of section 458.331(1)(q), Florida Statutes. The case

was reversed on appeal; however, the case was not reversed because of the agency's interpretation of section 458.331(1)(q), as the Respondent in the present case claims. Instead, the case was reversed because the court found that the Board reweighed the evidence presented to the ALJ and came to a different result, which was reversible error. See id. at 31. The court specifically stated as follows:

> The Department argues on appeal that the prescriptions were inappropriate because they were not preceded by focused medical examinations. Without affirming the Department's view of subsection (q) that inappropriate dispensing occurs when a prescription is given without a physical examination, we find the Department's argument to be without evidentiary support. As noted previously, the ALJ did not find that Dr. Rogers failed to undertake an appropriate examination before prescribing medication. Such a finding was supplied by the Board when it rejected the ALJ's findings and conclusions regarding count I, and we have already found the Board's action in reweighing the evidence relating to count I to be reversible error. Accordingly, the Board may not premise a violation of count III on its erroneous ruling as to count I.

Id. (emphasis added). Thus, the reversal in Rogers was because of a lack of evidence, not because of the interpretation of the Board.

Subsequently, in Waters, the Third District Court of Appeal specifically addressed the Board's interpretation of section 458.331(1)(q). As in Rogers, an ALJ had found that 458.331(1)(q), required illicit conduct, and once again, the Board disagreed with that interpretation, and the Board rejected the ALJ's conclusion of law on that issue. Id. at 1012. In upholding the Board's final order, the Third District Court of Appeal held as follows: "Further, we hold that the Department's rejection of the law judge's interpretation of the requirements of subsection (q) is within the agency's delegated range of discretion." Waters, 962 So. 2d at 1013. Thus, the court specifically held that this interpretation was within the discretion of the Board.

The Board's ruling Waters is controlling. A physician violates section 458.331(1)(q), Florida Statutes, if the physician prescribes inappropriately or excessively, and the conduct does not have to include illicit activity. In the present case, the Respondent prescribed inappropriately because building muscles and enhancing athletic performance is not a justified medical indication for prescribing steroids.

In addition, the prescribing was inappropriate because under section 458.331(1)(ee), Florida Statutes, a physician may be disciplined for "prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance." The ALJ found that Respondent prescribed anabolic steroids to MW for the purpose of weight lifting. (RO, paragraph 51). Although the Board has found that illicit conduct in prescribing is not required to find a violation of section 458.331(1)(q), it is additional proof that Respondent's prescribing was inappropriate because it specifically violated section 458.331(ee).

The Board should adopt the following revised language for the first two sentences of paragraph 59 of the RO: Respondent is incorrect when he contends Rogers v. Department of Health, 920 So. 2d 27 (Fla. 1st DCA 2005), requires an element of illicitness for a determination that the prescription or administration is not in the course of the physician's professional practice. Nonetheless, Section 458.331(1)(ee) supplies this element.

Otherwise, this exception should be denied.

4. Respondent takes further exception to the Conclusion of Law in paragraph 59 on pages 31 and 32, of the Recommended Order, claiming, essentially, that violations of Sections 458.331(1)(t), (standard of care) and of 458.331(1)(q), (improper prescribing) F.S., are mutually exclusive because (t) must, by definition, involve the practice of medicine, while (q) includes the language "other than in the course of the physician's professional practice." Respondent cites no legal authority for this proposition.

The Board should rely on the holding in Scheininger v. Department of Professional Regulation, Board of Medical Examiners, 443 So.2d 387 (Fla. 1st DCA 1983) wherein the court acknowledged that the physician was practicing medicine when prescribing drugs to patients. The Scheininger case supports the position that when prosecuting physicians for violating Section 458.331(1)(q), the Department is not obligated to prove that the physician was not practicing medicine when he prescribed the drugs. The more reasonable interpretation calls for the Department to show that the physician prescribed legend drugs inappropriately to a patient. Such

would be considered "other than in the course of the physician's professional practice."

Moreover, Waters v. Dep't of Health, Bd. of Med., 962 So. 2d 1011, 1012-13 (Fla. 3d DCA 2007), stands for the proposition that "... the requirements of subsection (q) is within the agency's delegated range of discretion."

Thus, this exception should be denied.

5. Respondent takes exception to the Conclusion of Law in paragraph 66 on page 35, of the Recommended Order, which reads in pertinent part as follows: "...without ordering lab work." Respondent claims there is not substantial, competent evidence to support this conclusion.

This issue was dealt with under the Response to Exceptions to Findings of Fact number 7 above.

This exception should be denied.

Proposed Penalty

Respondent requests that the penalty recommended by the ALJ be revised downward by the Board to reflect its holdings on the above-stated exceptions to findings of fact and conclusions of law.

The penalty recommended is within the disciplinary guidelines.

This request should be denied.

Respectfully submitted this 6th day of July, 2010.

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CERTIFICATE OF SERVICE

The undersigned certifies that a true and correct copy of the foregoing has been furnished BY U.S. Mail to Kenneth J. Metzger, Strawn, Monaghan & Metzger, P.A., 1637 Metropolitan Blvd., Suite C-2, Tallahassee, FL 32308, Counsel for Respondent, this 6th day of July, 2010.

GREG S. MARR

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK:
DATE 7-20-10

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v.

DOH Case No. 2001-04256
DOAH Case No. 07-3396PL

JAMES S. PENDERGRAFT, IV, M.D.,

Respondent.

_____/

NOTICE OF WITHDRAWAL OF MOTION TO ASSESS COSTS

COMES NOW the Department of Health, by and through undersigned counsel, and provides Notice that is has withdrawn its Motion to the Board of Medicine for the entry of a Final Order assessing costs against the Respondent for the investigation and prosecution of this case.

Respectfully submitted this 20th day of July, 2010.

Greg S. Marr

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CERTIFICATE OF SERVICE

The undersigned certifies that a true and correct copy of the foregoing has been furnished by U.S. Mail to Kenneth J. Metzger, Esquire at Strawn, Monaghan & Metzger, P.A., 1637 Metropolitan, Suite C-2, Tallahassee, FL 32308, Counsel for Respondent, this 20th day of July, 2010.

GREG S. MARR