STATE OF FLORIDA
BOARD OF MEDICINE

Final Order No. AHCA-96-01299 Date 11-7-96
FILED
Agency for Health Care Administration
AGENCY CLERK
R.S. Power, Agency Clerk
By: Deputy Agency Clerk

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

DOAH CASE NO.: 94-06352
AHCA CASE NO.: 93-11602
LICENSE NO.: ME0033129

PHILIP F. WATERMAN, 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 October 4, 1996, in West Palm Beach, Florida, for the purpose of considering the Administrative Law Judge's Recommended Order (a copy of which is attached hereto as Exhibit A) in the above-styled cause. Petitioner was represented by Larry G. McPherson, Jr., Chief Attorney. Respondent was not present, but was represented by Bruce D. Lamb, 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.

FINDINGS OF FACT

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

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

CONCLUSIONS OF LAW

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

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

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

DISPOSITION

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

IT IS HEREBY ORDERED AND ADJUDGED that the Administrative Complaint filed against the Respondent in this matter is hereby DISMISSED.

This Final Order shall take effect upon being filed with the Clerk of the Agency for Health Care Administration.

DONE AND ORDERED this 30th day of October, 1996.

BOARD OF MEDICINE

M. Kathryn Garrett M.D.
M. KATHRYN GARRETT, M.D.
CHAIRPERSON

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, IF REVIEW OF THE FINAL AGENCY DECISION WOULD NOT PROVIDE AN ADEQUATE REMEDY. 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 AGENCY FOR HEALTH CARE ADMINISTRATION AND A SECOND COPY, ACCOMPANIED BY FILING FEES PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL, FIRST DISTRICT, OR WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES. THE NOTICE OF APPEAL MUST BE FILED WITHIN THIRTY (30) DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by certified mail to Philip F. Waterman, M.D., 650 Del Prado Boulevard, Suite 100, Cape Coral Florida 33990; to Bruce D. Lamb, Esquire, Post Office Box 2378, Tampa Florida 33601; to Robert E. Meale, Administrative Law Judge, Division of

Administrative Hearings, The DeSoto Building, 1230 Apalachee Parkway, Tallahassee, Florida 32399-1550; and by interoffice delivery to Larry G. McPherson, Jr., Chief Attorney, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308-5403, on or before 5:00 p.m., this _____ day of _____, 1996.

_____

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	CASE NO. 94-6352
PHILIP F. WATERMAN, II,	)	
Respondent.	)	

RECOMMENDED ORDER

Robert E. Meale, Hearing Officer of the Division of Administrative Hearings, conducted the final hearing in Ft. Myers, Florida, on April 25, 1996.

APPEARANCES

For Petitioner: Steven Rothenburg, Senior Attorney
Agency for Health Care Administration
9325 Bay Plaza Boulevard, Suite 210
Tampa, Florida 33619

For Respondent: Bruce D. Lamb
Shear Newman
201 East Kennedy Boulevard, Suite 1000
Tampa, Florida 33602

STATEMENT OF THE ISSUES

The issues are whether Respondent is guilty of violations of Section 458.331(1)(k), (m), and (t) in the practice of medicine and, if so, what penalty the Board of Medicine should impose.

PRELIMINARY STATEMENT

The Administrative Complaint dated May 31, 1995, alleges that Respondent is guilty of making deceptive, untrue, or fraudulent representations in the practice of medicine by

altering a patient's records, in violation of Section 458.331(1)(k); failing to keep written medical records justifying the course of treatment of a patient by not adequately outlining the examination of Patient D. W., in violation of Section 458.331(1)(m); and committing gross or repeated malpractice or failing to practice medicine with that level of care, skill, and treatment that is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances by failing to keep adequate medical records on Patient D. W., altering Patient D. W.'s medical records, and failing to recommend follow-up examinations and treatments for Patient D. W.'s complaint of a lump in her breast, in violation of section 458.331(1)(t).

By Election of Rights dated June 14, 1995, Respondent requested the opportunity to discuss a settlement. By Petition for Formal Hearing dated July 11, 199[5], Petitioner disputed the material allegations and demanded a formal hearing.

At the hearing, Petitioner called two witnesses and offered into evidence four exhibits. Respondent called ten witnesses and offered into evidence nine exhibits. The parties jointly sponsored two exhibits. All exhibits were admitted.

The court reporter filed the transcript May 20, 1996. Rulings on timely filed proposed findings of fact are in the appendix.

FINDINGS OF FACT

1. Respondent is a licensed physician, holding license number ME 0033129. His license was originally issued on August 2, 1978, and remains current. There is no prior discipline against Respondent.

2. Respondent has been certified for over 15 years by the American Board of Obstetrics and Gynecology. His practice has been devoted to obstetrics and gynecology.

3. In 1990, Respondent was a member of a large group practicing obstetrics and gynecology in Cape Coral. Respondent was performing about 100 breast examinations a week.

4. On the evening of April 10, 1990, D.W., who was 30 years old at the time, discovered a mass that felt like a marble in her right breast during a breast self-examination. She was upset and cried most of the night, fearful that she had breast cancer. Early the next morning, she made an appointment with Respondent's group for a breast examination later that day.

5. A regular patient of another member of Respondent's group, who was unavailable on April 11, D. W. had last been seen by a member of Respondent's group on February 6, 1990, when her regular physician gave her an annual examination. Her breast examination at the time was normal. During the visit, the physician or nurse reviewed breast self-examination techniques with her. The physician started D. W. on birth control pills and directed her to return for a follow-up visit in two months.

6. The April 11 office visit was devoted exclusively to addressing D. W.'s complaint of a lump in her breast. Respondent examined D. W.'s breasts with D. W. lying down and then sitting up. He felt nothing. While sitting up, D. W. guided Respondent's hand to the mass in the right breast. Still feeling nothing, Respondent remarked that the breast was somewhat fibrous.

7. Respondent explained to D. W. that fibrocystic disease is something that women sometimes get in their breasts and it is nothing to worry about. In fact, at least 80 percent of all women in their 30s undergo fibrocystic changes in the breast.

8. Respondent did not reach a specific diagnosis as a result of the April 11 office visit. The handwritten entries in Respondent's medical records--the complaint and blood pressure appearing to have been written by a nurse--read in their entirety:

> 4-11-90 Pt. c/o lump in R breast.
> BP--100/60
> no mass found
> somewhat fibrous
>
> [Respondent's initials]

9. Respondent did not advise D. W. to return to the office for a follow-up visit at a prescribed interval or if she detected the same mass or any changes in the mass.

10. D. W. next visited Respondent's group on April 11, 1991, for her annual visit. She was seen by another physician in the group. D. W. told the physician of the lump in her breast and said that it was getting larger. The physician conducted a

breast examination and felt a mass about two centimeters in diameter.

11. Concerned about the mass, the physician scheduled an aspiration for diagnostic purposes. The results of the procedure disclosed severely atypical cells that were suspicious for carcinoma.

12. The physician referred her to a surgeon, who first saw D. W. on May 2, 1991. The surgeon performed a breast biopsy on May 9. The biopsy revealed an infiltrating ductal carcinoma of the breast. Based on the biopsy findings, the surgeon conducted on May 17 a right modified radical mastectomy. The excised tumor measured 2.1 centimeters along its longest diameter. D. W. underwent chemotherapy and has had no recurrence of the cancer in the five years since the surgery.

13. There are two sets of allegations concerning D. W.'s medical records. The first set of allegations is that Respondent fraudulently altered D. W.'s medical records.

14. Someone in Respondent's office later typed the following addition to the records of D. W. immediately beneath the handwritten entry quoted above:

> D[.] came to the office today having felt a lump in her right breast. I could not feel anything, although her breast was somewhat fibrous. I told her to continue to check her breast and come back if she felt it again.
>
> [Respondent's initials/typist's initials--{both typed}]

15. Petitioner failed to prove that Respondent dictated or typed the note in the preceding paragraph or that he authorized

the addition of this note to D. W.'s medical records. The intent in adding the note was fraudulent as to the third sentence, which is the only sentence in the note that is untrue. But Petitioner failed to prove that Respondent was in any way involved in the fraud.

16. The second set of allegations concerning the medical records involves the adequacy of the records. Specifically, Petitioner alleges that Respondent failed to keep medical records justifying the course of treatment and violated the applicable standard of care by failing to keep adequate medical records. These allegations are best considered together with the remaining allegation, which is that Respondent violated the applicable standard of care by failing to recommend follow-up examinations and treatments for D. W.'s complaint of a lump in her breast.

17. A violation of the applicable standard of care is 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. The standard of care in this case pertains to the practice in early 1990.

18. Petitioner nowhere alleges that Respondent violated the applicable standard of care by failing to detect the mass of which D. W. complained. Petitioner's expert witness, Dr. Harvey Gardy, conceded that such a failure would not necessarily violate the standard of care. Nor is it clear that the mass of which

D. W. complained in April 1990 developed into the tumor removed from her breast a year later.

19. The mass of which D. W. complained in April 1990 was in the three o'clock position, and the excised tumor was in the 12 o'clock position. Breast tumors do not change location, except to the extent that they grow, although patients conducting self-examinations may have difficulty locating the tumor with precision. Also, the excised tumor could have grown from an impalpable size in April 1990 to its size at the time of the mastectomy a year later.

20. The second set of medical records allegations and the lone remaining standard of care allegation focus not on Respondent's alleged failure to detect and diagnose the mass of which D. W. complained, but on Respondent's alleged failure to respond adequately to D. W.'s complaint, even after he could not independently verify the mass.

21. The applicable standard of care did not require Respondent to order further testing at the time to rule out a cancerous growth when he could not feel the mass. D. W. was not in a high-risk category for breast cancer based on her young age, three past pregnancies, and relevant family history. She displayed no physical signs of breast cancer.

22. The physician conducting a breast examination is looking for a dominant or distinct mass--an isolated lump distinct from surrounding breast tissue. Respondent felt only fibrous changes. The applicable standard of care did not require

that a physician order further diagnostic testing each time the physician detected a fibrous mass in a breast. Fibrous changes are not indicative of breast cancer. Petitioner has failed to prove that the applicable standard of care was any different when the patient claimed to have felt a distinct mass that the physician is unable to verify.

23. It is more practical to direct a patient to return for a follow-up examination than to order potentially expensive tests. However, Petitioner failed to prove that the applicable standard of care required that a physician, failing to detect a mass in a patient not in a high-risk category for breast cancer, direct her to return to the office at a specified interval, such as two or three months later.

24. Even less onerous than diagnostic testing or return office visits is the physician's direction that the patient return to the office if she feels the mass again or any changes in the mass. However, Petitioner failed to prove that the applicable standard of care required even this sensible precautionary direction from a physician.

25. Testifying unpersuasively that the standard of care required the setting of a follow-up appointment, Dr. Gardy failed to testify at all whether the standard of care required Respondent to tell D. W. to return if she detected the mass again in a self-examination.

26. One of Respondent's expert witnesses, Dr. Pierre Bouis, testified clearly on direct that the applicable standard of care

did not require Respondent to direct D. W. to return if she felt the mass again (Tr. p. 125). On cross-examination, Dr. Bouis returned to the same issue and answered affirmatively the following, poorly worded question:

> Now, isn't it true that you also believe that it's an appropriate standard of care to tell a patient who presents under the same set of fact that she should keep checking herself and return if she feels it again or continue to feel it?

27. Although there are many levels of care, there is a single applicable standard of care, which, if violated, justifies the imposition of discipline. By using "an," Petitioner's counsel suggested multiple standards of care and left open the possibility that the standard to which Dr. Bouis referred in his answer was aspirational, rather than mandatory.

28. Respondent's other expert witness, Dr. J. Kell Williams, testified clearly that Respondent's failure to direct D. W. to return if she felt the lump again did not violate the applicable standard of care (Tr. pp. 43 and 52). Dr. Williams conceded that the better practice would have been to direct the patient to return (TR. pp. 43, 46, and 47), but he did not equate this practice with the applicable standard of care.

29. In the absence of evidence establishing this sensible precaution as the applicable standard of care, Petitioner has failed to prove by clear and convincing evidence that the applicable standard of care required Respondent to advise D. W. that she should return to the office if she felt the mass again or any changes in the mass.

30. The medical records are adequate for the limited purpose of the April 11 visit. They describe the findings and adequately outline Respondent's examination of D. W. They justify the course of treatment--which was effectively no treatment--for the reasons set forth in the preceding paragraphs.

31. For the reasons set forth above, Petitioner has failed to prove by clear and convincing evidence the material allegations of the Administrative Complaint.

CONCLUSIONS OF LAW

32. The Division of Administrative Hearings has jurisdiction over the subject matter. Section 120.57(1), Florida Statutes. (All references to Sections are to Florida Statutes.)

33. Section 458.331(2) authorizes the Board of Medicine to enter a final order imposing discipline for any violation of Section 458.331(1).

34. Section 458.331(1) provides in relevant part that the Board may impose discipline for:

* * *

> (k) Making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine.
>
> * * *
>
> (m) Failing to keep medical records justifying the course of treatment of the patient, including but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

* * *

> (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. . . .

35. Petitioner must prove the material allegations by clear and convincing evidence. Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987).

36. There is no evidence of gross or repeated malpractice. For the reasons set forth above, Petitioner failed to prove by clear and convincing evidence that Respondent fraudulently altered D. W.'s medical records or was in any way involved in such fraud, failed to keep medical records justifying the course of D. W.'s treatment by inadequately outlining the patient examination, or violated the applicable standard of care with respect to the adequacy or alteration of the medical records or the failure to recommend follow-up examinations or treatments for D. W.

RECOMMENDATION

It is

RECOMMENDED that the Board of Medicine enter a final order dismissing the Administrative Complaint against Respondent.

ENTERED on May 31, 1996, in Tallahassee, Florida.

ROBERT E. MEALE, Hearing Officer
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-1550
(904) 488-9675

Filed with the Clerk of the
Division of Administrative Hearings
on May 31, 1996.

APPENDIX

Rulings on Petitioner's Proposed Findings

1-3: adopted or adopted in substance, except she told him about the lump. Respondent never saw a lump.

4: adopted or adopted in substance, except that Respondent did not feel the marble-like mass that D. W. felt. Respondent felt only fibrocystic changes in the breast.

5-9 (second sentence): adopted or adopted in substance.

9 (remainder): rejected as irrelevant and recitation of testimony.

10-11 (second sentence): adopted or adopted in substance.

11 (remainder): rejected as irrelevant and recitation of testimony.

12-13 (first sentence): adopted or adopted in substance.

13 (remainder)-15: rejected as subordinate.

16 (first sentence): adopted or adopted in substance.

16 (second sentence)-17: rejected as recitation of evidence.

18: adopted or adopted in substance, as distinguished from the 2 cm tumor within the larger excised mass.

19: rejected as subordinate.

20: rejected as unsupported by the appropriate weight of the evidence.

21: rejected as irrelevant with respect to applicable standard of care.

22: rejected as unsupported by the appropriate weight of the evidence. The questions posed Dr. Bouis were ambiguous as to whether he was describing the better practice or the applicable standard of care.

23-24: rejected as irrelevant with respect to applicable standard of care.

25: rejected as subordinate and irrelevant.

26: rejected as subordinate.

27: rejected as unsupported by the appropriate weight of the evidence.

28: rejected as subordinate.

29-32: adopted or adopted in substance.

33: rejected as subordinate.

34: rejected as unsupported by the appropriate weight of the evidence.

35: rejected as subordinate.

36-38: rejected as subordinate and recitation of testimony.

39: rejected as unsupported by the appropriate weight of the evidence.

40: rejected as recitation of testimony.

41-43: rejected as unsupported by the appropriate weight of the evidence.

44-45: rejected as irrelevant.

46: adopted or adopted in substance.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions to this Recommended Order. All agencies allow each party at least 10 days in which to submit written exceptions. Some agencies allow a longer period within which to submit written exceptions. You should contact the agency that will issue the final order concerning agency rules on the deadline for filing exceptions to this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order.

STATE OF FLORIDA
DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION,

PETITIONER,

vs. CASE NO. 93-11602

PHILIP F. WATERMAN, II, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Business and Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Philip F. Waterman, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.165, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0033129. Respondent's last known address is 650 Del Prado Boulevard, Suite 100, Cape Coral, Florida 33990.

3. Respondent is board certified in obstetrics and gynecology.

4. On or about April 11, 1990, Patient D.W., a thirty (30) year-old female, presented to Respondent with complaints of a lump in her right breast.

5. Respondent examined Patient D.W. and did not find a right breast lump.

6. During his examination of Patient D.W., Respondent neither recommended that Patient D.W. undergo further study of her breast lump nor that she return for a follow-up visit.

7. On or about April 11, 1991, Patient D.W. presented to a partner of Respondent for her routine gynecological examination.

8. Patient D.W. complained of the right breast mass to the physician.

9. Patient D.W. subsequently underwent an aspiration, a biopsy and a mammogram of the mass. Said tests revealed the mass to be an infiltrating ductal carcinoma.

10. On or about May 17, 1991, Patient D.W. underwent a right radical mastectomy.

11. Following the mastectomy, Patient D.W. underwent chemotherapy and Tamoxifen therapy.

12. In or about May 1991, Patient D.W. requested a copy of her medical records from Respondent. Included in said medical records was a copy of Respondent's initial record of his April 11, 1990, examination of Patient D.W. which consisted of a handwritten note which stated "no mass found-somewhat fibrous."

13. In or about September 1991, Patient D.W. requested a copy of her medical records for insurance purposes. Included in said

medical records was a copy of Respondent's initial handwritten record of his April 11, 1990, examination of Patient D.W., as well as an additional typewritten record concerning said examination of Patient D.W.

14. Said type-written entry stated Respondent examined Patient D.W.'s right breast and could not find a mass. In addition, the entry stated Respondent instructed Patient D.W. to return if she again felt the breast lump.

15. The type-written entry to Patient D.W.'s medical record was not dated and was not listed as a "late entry."

16. The typewritten entry was added to Patient D.W.'s medical record by Respondent subsequent to his visit with Patient D.W., and subsequent to his initial handwritten record of his visit with Patient D.W.

Count One

17. Petitioner realleges and incorporates Paragraphs one (1) through sixteen (16) as if fully set forth herein this Count One.

18. Respondent is guilty of making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine in that Respondent altered Patient D.W.'s medical records after his April 11, 1990, examination of her by adding an undated typewritten entry to the medical records concerning said physical examination.

19. Based on the foregoing, Respondent violated Section 458.331(1)(k), Florida Statutes, making deceptive, untrue, or fraudulent representations in or related to the practice of

medicine or employing a trick or scheme in the practice of medicine.

Count Two

20. Petitioner realleges and incorporates Paragraphs one 91) through sixteen (16) and eighteen (18) as if fully set forth herein this Count Two.

21. Respondent is guilty of failing to keep written medical records justifying the course of treatment of the patient in that Respondent's initial medical record concerning his examination of Patient D.W. which occurred on or about April 11, 1990, only contained one sentence and did not adequately outline his examination of Patient D.W., and in that Respondent altered Patient D.W.'s medical records after the fact by adding a typewritten entry to the records.

22. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

Count Three

23. Petitioner realleges and incorporates Paragraphs one (1) through sixteen (16), eighteen (18), and twenty-one (21) as if fully set forth herein this Count Two.

24. Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill,

and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in that Respondent failed to maintain adequate medical records concerning his care and treatment of Patient D.W., Respondent altered Patient D.W.'s medical records after the fact, and Respondent failed to recommend follow-up examinations and or treatments for Patient D.W. in response to her complaints of a right breast lump which Respondent was unable to palpate upon examination.

25. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, 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.

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

Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 31 day of May, 1994.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

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RPC/sdb
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Murray, Slade, and Varn

FILED
Department of Business and Professional Regulation
AGENCY CLERK

CLERK Sarah L. Workman
DATE 5-31-94