DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION 

KEOKUK BOARD OF MEDICINE

Petitioner,

V.

DAN C. ROEHN, SR., M.D.,

Respondent.

LICENSE NUMBER: ME 0009346

OBPR CASE NUMBERS: 90-10089
89-12620
92-02767

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION,

THIS CAUSE came before the Board of Medicine (Board) in Miami, Florida, on October 21, 1993, for the purpose of considering Respondent's offer to voluntarily relinquish his license to practice medicine in the State of Florida. (Attached hereto as Exhibit A.) Said written offer of relinquishment specifically provides: "Respondent agrees never again to apply for licensure as a physician in the State of Florida."

Upon consideration of the written offer of voluntary relinquishment, the charges, and the other documents of record, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED,

That Respondent's Voluntary Relinquishment of his license to practice medicine in the State of Florida is hereby ACCEPTED.
DONE AND ORDERED this 2 day of October, 1993.

- BOARD OF MEDICINE

Edward A. Dabney
CHAIRMAN

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by certified mail to Dan C. Roehm, Sr., M.D., 3450 Park Central Boulevard North, Pompano Beach, Florida 33064, Karen Coolman Amlong, 101 Northeast 3rd Avenue, Ft. Lauderdale, Florida 33301 and by interoffice delivery to Larry G. McPherson, Jr., Chief Medical Attorney, Department of Business and Professional Regulation, Northwood Centre, 1400 North Monroe Street, Tallahassee, Florida 32399-0792, at or before 5:00 P.M., this ___ day of ___, 1993.

[Signature]
MARK HARRIS, Ph.D.
Executive Director
STATE OF FLORIDA
DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATIONS
BOARD OF MEDICINE

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION,

Petitioner,

vs.

DAN C. ROEHM, SR., M.D.,

Respondent.

DOAH CASE #s: 931463 & 925468
DBPR CASE #s: 9912630/9203767
Investigative File #9010089

VOLUNTARY RELINQUISHMENT OF LICENSE

To avoid the necessity of further administrative proceedings in these cases, the Respondent herein files this Voluntary Relinquishment of his license to practice as a physician in the State of Florida, with the provision that Respondent agrees never again to apply for licensure as a physician in the State of Florida.

When relinquishments are offered to the Board of Medicine to avoid further administrative prosecution, this is considered to be disciplinary action against your license to practice medicine in the State of Florida. As such, any and all disciplinary actions taken by the Board of Medicine are reported to the Federation of State Medical Boards and the National Practitioner Data Bank.

Upon the Board's adoption of this Relinquishment, Respondent expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to otherwise challenge or contest the validity of the Relinquishment and the Final Order of the Board incorporating said Relinquishment.

Upon the Board's adoption of this Relinquishment, the parties hereby agree that each party will bear their own attorney's fees and costs resulting from prosecution or defense of this matter.
Respondent waives the right to seek any attorney's fees or costs from the Department in connection with this matter.

This Relinquishment is executed by Respondent for the purpose of avoiding further administrative action with respect to these causes. In this regard, Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent prior to or in conjunction with consideration of the Relinquishment. Furthermore, should this Relinquishment not be accepted by the Board, it is agreed that presentation to and consideration of this Relinquishment and other documents and matters by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation, consideration or resolution of this proceeding.

This Relinquishment will take effect sixty (60) days from the date of the Final Order of the Board of Medicine.

DATED this 21st day of July, 1993.

[Signature]

DAN C. ROBIN, Sr., M.D.

STATE OF FLORIDA
COUNTY OF

BEFORE ME, the undersigned authority, personally appeared Dan C. Robin, Sr., M.D., whose identity is known to me by type of identification and who, under oath, acknowledges that his signature appears above.

SIGNED TO AND SUBSCRIBED before me this 21st day of July, 1993.

[Signature]

My Commission expires: 6/20/97

[Signature]

Notary Public, State of Florida
OFFICE OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

PETITIONER,

VS.

CASE NO. 8912630

DAN C. ROEHM, SR., M.D.,

RESPONDENT.

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against DAN C. ROEHM, SR., 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 20.10, Florida statutes; Chapter 458, Florida Statutes; and Chapter 455, 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 0009348. Respondent's last known address is 3450 Park Central Boulevard North, Pompano Beach, Florida 33064.

3. On or about July 19, 1989, Patient #1, a seventy-five (75) year-old female with a history of arthritis, presented to Respondent complaining of an episode of lightheadedness. At the
time Patient #1 presented, she had a condition known as transient ischemic attack (TIA), a cardiovascular condition.

4. Respondent failed to perform an adequate physical examination because he failed to indicate in the medical records whether he had ascertained the presence/absence of bruises, sounds or murmurs, in Patient #1’s neck. Respondent likewise failed to document in the medical records whether he had ascertained the presence/absence of any abnormal arterial pulsations in Patient #1’s extremities.

5. Respondent, although recognizing the need to rule out the possibility that Patient #1 had TIA, ultimately failed to make a conclusive diagnosis regarding TIA.

6. Respondent failed to keep medical records justifying the course of treatment by failing to adequately document a physical examination or history of Patient #1.

7. After Patient #1’s initial visit, Respondent ordered an unnecessary number of studies and lab testing, contrary to Section 766.111(1), Florida Statutes, which were not reasonably calculated to assist him in arriving at a diagnosis and treatment of Patient #1’s condition including the following: an echocardiogram as well as carotid and peripheral arterial and venous studies; and extensive analysis of various minerals and other studies.

8. Respondent’s ordering of unnecessary and excessive testing was exploitive of Patient #1 in that, Respondent ordered such tests without making any conclusive diagnosis of Patient #1’s true condition, TIA, nor any other diagnosis. Nonetheless,
Respondent subsequently administered chelation therapy to treat Patient #1, but chelation therapy is not a medically indicated treatment of TIA, the patient's medical condition.

9. On numerous and diverse occasions between on or about July 20, 1989, and August 2, 1989, Respondent administered ethylene diamine tetracetic acid (EDTA) as chelation therapy.

10. Chelation therapy is not recognized or approved by the Food and Drug Administration (FDA).

11. Respondent administered EDTA, a legend drug as defined by Section 465.003(7), Florida Statutes, to Patient #1, despite the fact that EDTA has no medical value as a treatment for her condition, transient ischemic attack (TIA) or other cardiovascular difficulties.

12. In the treatment of Patient #1, Respondent failed to comply with the FDA guidelines for consenting to experimental therapy in that the wording of Respondent's informed consent form did not, in fact, inform Patient #1 of the experimental nature of chelation therapy.

13. Respondent failed to inform Patient #1 that chelation therapy has no recognized medical value as a treatment for TIA or other cardiovascular difficulties.

14. Respondent failed to obtain Patient #1's fully informed consent in that Respondent failed to provide Patient #1 with sufficient information regarding the value of chelation therapy in treating TIA.
15. Respondent made fraudulent representations in the practice of medicine in that Respondent's chelation therapy treatments of Patient #1 were not medically indicated as chelation therapy has no value in treating TIA or any other cardiovascular difficulties. Further, Respondent provided Patient #1 with a misleading brochure that implied that chelation therapy is a FDA-approved treatment when, in fact, chelation therapy is not recognized by the FDA for use in the treatment of TIA.

COUNT ONE

16. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15) as if fully set forth herein this Count One.

17. Respondent administered a legend drug in excessive or inappropriate quantities in that Respondent administered ethylenediamine tetracetic acid (EDTA) as chelation therapy to treat Patient #1's transient ischemic attack (TIA), but EDTA has no value in the treatment of cardiovascular difficulties such as TIA.

18. Based on the preceding allegations, Respondent violated Section 458.311(1)(q), Florida Statutes, by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing 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 intent.

COUNT TWO

19. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15), and seventeen (17) as if fully set forth herein this Count Two.

20. Respondent failed to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as acceptable level of care under similar conditions and circumstances in that Respondent failed to perform an adequate physical, or make a diagnosis of Patient #1’s condition. Respondent’s subsequent use of chelation therapy to treat Patient #1’s condition is not within the acceptable standards of care for medical practice in the State of Florida.

21. Based on the preceding allegations, Respondent violated Section 458.311(1)(t), Florida Statutes, by 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.

COUNT THREE

22. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15), seventeen (17), and twenty (20) as if fully set forth herein this Count Three.

23. Respondent failed to keep written medical records justifying the course of treatment of Patient #1 in that Respondent
failed to adequately record Patient #1’s physical examination or history in the medical records.

24. Based on the preceding allegations, Respondent violated Section 458.331(1)(m), Florida Statutes, by 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 FOUR

25. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15), seventeen (17), twenty (20), and twenty-three (23) as if fully set forth herein this Count Four,

26. Respondent prescribed a therapy which, by the prevailing standards of the medical community, would constitute experimentation on a human subject, without first obtaining full, informed, and written consent in that Respondent failed to obtain Patient #1’s fully informed consent by failing to provide Patient #1 with sufficient information regarding the value of chelation therapy in treating transient ischemic attack (TIA).

27. Based on the preceding allegations, Respondent violated Section 458.331(1)(d), Florida Statutes, by performing any procedure or prescribing any therapy which, by the prevailing standards of medical practice in the community, would constitute experimentation on a human subject, without first obtaining full, informed, and written consent.
COUNT FIVE

28. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15), seventeen (17), twenty (20), and twenty-three (23), twenty-six (26) as if fully set forth herein this Count Five.

29. Respondent violated a provision of Chapter 458 in that he ordered unnecessary diagnostic tests on Patient #1, contrary to Section 766.111(1), Florida Statutes, by ordering excessive and unnecessarily extensive mineral analysis, echocardiography, and carotid and peripheral arterial and venous studies.

30. Based on the preceding allegations, Respondent violated Section 458.331(1)(x), Florida Statutes, by violating any provision of this chapter, a rule of the board or department, or a lawful order of the board or department previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the department.

COUNT SIX

31. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15), seventeen (17), twenty (20), twenty-three (23), twenty-six (26), and twenty-nine (29) as if fully set forth herein this Count Six.

32. Respondent exercised influence on Patient #1 in such a manner as to exploit Patient #1 for financial gain in that Respondent directed Patient #1 to undergo a series of expensive and unnecessary series of tests without a clear indication of their necessity for his own financial gain. Respondent subsequently did not form a conclusive diagnosis of Patient #1’s condition on the
basis of these tests. Respondent nonetheless administered chelation therapy to treat Patient #1, but chelation therapy is, in fact, not medically indicated in the treatment of TIA or other cardiovascular difficulties.

13. Based on the preceding allegations, Respondent violated Section 458.331(1)(n), Florida Statutes, by exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party, which shall include, but not be limited to, the promoting or selling of services, goods, appliances, or drugs.

COUNT SEVEN

34. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15), seventeen (17), twenty (20), twenty-three (23), twenty-six (26), twenty-nine (29), and thirty-two (32) as if fully set forth herein this Count Seven.

15. Respondent disseminated false, deceptive, and misleading advertising by giving Patient #1 in the course of his medical practice a brochure that makes claims regarding the benefits of chelation therapy which have no basis in scientific medical evidence. Respondent provided Patient #1 with a misleading brochure that implied that chelation therapy is an FDA-approved treatment when chelation therapy is, in fact, not recognized by the FDA for use in the treatment of TIA.

16. Based on the preceding allegations, Respondent violated Section 458.331(1)(d), Florida Statutes, false, deceptive, or misleading advertising.
WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 14th day of September, 1992.

George Stuart, Secretary

COUNSEL FOR DEPARTMENT:
Larry G. McPherson, Jr.
Chief Medical Attorney
Department of Professional Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-0750
Florida Bar #788541
RPC/rb
PCP: October 29, 1992
Murray, Slade, and Rodriguez

FILED
Department of Professional Regulation
AGENCY CLERK

DATE 11/18/92

AA0015
COMES NOW the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against DAN C. ROEHN, 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 458.09, 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 000346. Respondent's last known address is 350 Park Central Boulevard, North, Pembroke Pines, Florida 33064-3209.

3. On or about February 26 and 28, 1992, Respondent treated Patient #1, a sixty-nine year old man, for myocardial infarction.

5. Despite the potential life-threatening nature of such a complaint from a sixty-nine (69) year-old man, Respondent failed to obtain Patient #1's recent and past cardiovascular history.

6. Respondent conducted an electrocardiogram (EKG), which revealed subendocardial myocardial infarction.

7. Respondent then administered intravenous (IV) ethylenediaminetetraacetic acid (EDTA), prescribed Cardizem 60 mg., #100 and Nitroglycerin .01 gr., #100, and sent Patient #1 home.

8. EDTA, also known as disodium edetate, are salts which are sometimes used in chelation therapy, an intravenous treatment in which a solution is injected into the bloodstream for the purpose of mobilizing abnormal calcium to be either excreted or recirculated back in bone.

9. On or about February 31, 1992, Patient #1 returned to Respondent's office complaining of chest pain which kept him awake the entire previous night and failed to go away after taking Cardizem and Nitroglycerin.

10. Respondent conducted another EKG, which revealed deepening of ST depression compatible with subendocardial infarction.

11. At this time, Patient #1 was suffering from a potentially life-threatening form of ischemic heart disease and should have been referred to a hospital for intensive cardiac care and aggressive therapy.

12. Notwithstanding the above, Respondent again chose to administer IV EDTA therapy to Patient #1.
13. Respondent’s medical records of the evaluation up to this point fail to reflect that Respondent recognized Patient #1’s condition as potentially life-threatening and fail to reveal that Respondent even considered referring Patient #1 to the hospital for intensive cardiac care and aggressive therapy.

14. While Patient #1 was undergoing the EDTA therapy, he became cold and clammy, his blood glucose test revealed a level of 35, and his blood pressure maintained shock levels.

15. Respondent then had Patient #1 taken to the hospital by ambulance. Shortly after arrival, Patient #1 suffered a cardiopulmonary arrest and expired.

16. Respondent inappropriately failed to obtain a complete cardiovascular history of Patient #1 upon his initial consultation.

17. On or about February 25 and 26, 1992, Respondent inappropriately administered EDTA to Patient #1 for treatment of his myocardial infarction.

18. Respondent failed to recognize that Patient #1 was suffering from a potentially life-threatening form of ischemic heart disease.

19. Respondent inappropriately failed to send Patient #1 to the hospital, when he knew, or had reason to know, that Patient #1 needed intensive cardiac care and aggressive therapy.

20. Respondent’s medical records of his initial consultation with Patient #1 fail to reveal a complete assessment of Patient #1’s cardiovascular history.
21. Respondent's medical records of Patient #1 prior to Patient #1's departure to the hospital fail to address the seriousness of Patient #1's condition and justify Respondent's choice of treatment.

COUNT ONE

22. Petitioner realleges and incorporates paragraphs one (1) through twenty-one (21) as if fully set forth herein this Count One.

23. 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 he inappropriately used EDTA to treat Patient #1's myocardial infarction and failed to do the following in his treatment of Patient #1: obtain a complete cardiovascular history upon initial evaluation; address the seriousness of Patient #1's condition immediately after obtaining the results of his second EKG; and send Patient #1 to the hospital where he knew, or had reason to know, that Patient #1 needed intensive cardiac care and aggressive therapy.

24. Based on the preceding allegations, Respondent violated Section 458.311(1)(b), Florida Statutes, in that he 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.
COUNT TWO

25. Petitioner realleges and incorporates paragraphs one (1) through twenty-one (21) and twenty-three (23) as if fully set forth herein this Count Two.

26. Respondent is guilty of 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 in that Respondent's medical records fail to reflect the following:

- Patient #1's past and present cardiovascular history;
- Patient #1's condition;
- Patient #1's departure to the hospital;
- Patient #1's condition; and justification of Respondent's initiation of treatment.

27. Based on the preceding allegation, Respondent violated Section 458.331(1)(m), Florida Statutes, in that he is guilty of 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

28. Petitioner realleges and incorporates paragraphs one (1) through twenty-one (21), twenty-three (23), and twenty-six (26) as if fully set forth herein this Count Three.
29. Respondent is guilty of prescribing, dispensing, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician’s professional practice in that on or about February 25 and 26, 1992, Respondent inappropriately administered EDTA to Patient #1 for treatment of his myocardial infarction.

30. Based on the preceding allegations, Respondent violated Section 458.331(2)(q), Florida Statutes, in that he is guilty of prescribing, dispensing, 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, inappropiately 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 intent.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: revocation or suspension of the Respondent’s license, restriction of the Respondent’s practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.
SIGNED this 18th day of July, 1992.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Larry G. McPherson, Jr.
Chief Medical Attorney
Department of Professional Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-1750
Florida Bar #788543
LAQP/DPB
PCP: June 29, 1992
Murphy, Boslght, and Rodriguez
BEFORE THE BOARD OF MEDICAL EXAMINERS

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

vs.

DAN C. ROEHM, M.D.,
License Number: 9346
Respondent.

FINAL ORDER OF
THE BOARD OF MEDICAL EXAMINERS

This matter came for final action by the Board of Medical Examiners at a public meeting on December 4, 1981, in St. Petersburg Beach, Florida. It was alleged that the Respondent violated Sections 458.331(1)(h), 458.331(1)(i), 458.331(1)(m), 458.331(1)(q), 458.331(1)(t) and 458.331(1)(u), Florida Statutes. At the licensee's election, the hearing was conducted in accordance with the provisions of Section 120.57(2), Florida Statutes. Respondent was duly notified of the hearing. The facts are uncontested.

FINDINGS OF FACT

1. The Respondent is a licensed medical doctor having been issued license number MC 0009346. The last known address of the Respondent is 808 N.E. 20th Avenue, Fort Lauderdale, Florida 33304.

2. The Respondent prepared and distributed DEA (Diethanolamine) as a substance for use in lowering serum cholesterol to some of his patients beginning in 1971. Later, in 1980, the Respondent prepared and distributed the same DEA to some of his patients as a substance for promoting hair growth. The Respondent neither manufactured, prepared nor distributed a product known as "FLEE" for the treatment of animals for fleas, which product was manufactured, marketed and distributed in 1979 by a Mr. Siegel.
3. The Respondent acknowledges that DEA is not approved by the Federal Drug Administration.

4. The Respondent acknowledges that he dispersed the DEA to some of his patients without full written notice and explanation of the nature of the drug and its possible side effects and that, although he obtained written consents from some patients, such consents did not include, among other possible deficiencies, an acknowledgment of the experimental nature of the drug and a full, board disclosure so as to equip the patient with full knowledge of what he was waiving.

5. The Respondent further acknowledges that although he kept charts and general information on the use of the drug by the patients, the dosage and other critical control information, his record keeping was lax, at times and not consistent with proper charting for a clinical investigation.

CONCLUSIONS OF LAW

The conduct of the Respondent as set forth above constitutes a violation of Sections 458.331(1)(h), 458.331(1)(l), 458.331(1)(t), 458.331(1)(n), 458.331(1)(u), and 458.331(1)(q), Florida Statutes.

IT IS THEREFORE ORDERED AND ADJUDGED that the license to practice medicine in the State of Florida of Dan C. Roehm, M.D., be and hereby is reprimanded, and that Respondent pay administrative costs of five hundred dollars ($500.00); and that Respondent not do any experimentation in the future unless he follows the proper guidelines.

DONE AND ORDERED this 29 day of December, 1981.

BOARD OF MEDICAL EXAMINERS

[Signature]

Vice Chairman

cc: All Counsel of Record.
Dan C. Roehm, M.D.
The Respondent, DAN C. ROEHM, M.D., and the Petitioner, DEPARTMENT OF PROFESSIONAL REGULATION/BOARD OF MEDICAL EXAMINERS, stipulate to the following facts in the Administrative Complaint as true and correct and agree that the case can proceed upon an informal hearing as provided in Sec. 120.57(2) FS 1979, based hereon:

The Respondent prepared and distributed DEA (Diethanolamine) as a substance for use in lowering serum cholesterol to some of his patients beginning in 1971. Later, in 1980, the Respondent prepared and distributed the same DEA to some of his patients as a substance for promoting hair growth. The Respondent neither manufactured, prepared nor distributed a product known as "FLICK" for the treatment of animals for fleas, which product was manufactured, marketed and distributed in 1979 by a Mr. Siegel.

The Respondent acknowledges that DEA is not approved by the Federal Drug Administration.

The Respondent acknowledges that he dispersed the DEA to some of his patients without full written notice and explanation of the nature of the drug and its possible side effects and that, although he obtained written consents from some patients, such consents did not include, among other possible deficiencies, an acknowledgment of the experimental nature of the drug and a full, broad disclosure so as to equip the patient with full knowledge of what he was waiving.
The Respondent further acknowledges that although he kept charts and general information on the use of the drug by the patients, the dosage and other critical control information, his record keeping was lax, at times and not consistent with proper charting for a clinical investigation.

SIGNED this ___ day of October, 1981.

DAN C. ROEHM, M.D.

DEPARTMENT OF PROFESSIONAL REGULATION/BOARD OF MEDICAL EXAMINERS.

NANCY KELLEY WITTENBERG, Secretary
ADMINISTRATIVE COMPLAINT

Comes now Petitioner, Department of Professional Regulation/Board of Medical Examiners, hereinafter referred to as "Petitioner" and files this administrative complaint against Dan C. Roehm, M.D., hereinafter referred to as "Respondent" and alleges:

1. Petitioner seeks to revoke, suspend, or take other disciplinary action against the Respondent as licensee and against his license as medical doctor under the laws of the State of Florida.

2. Respondent is a licensed medical doctor having been issued license number MZ 0009346. The last known address of the Respondent is 808 N.E. 20th Avenue, Ft. Lauderdale, Florida 33304.

COUNT ONE

3. Since 1971, Respondent has manufactured and distributed three products, to wit: FLEE, a substance used in the treatment of animals for fleas; DEA (Diethanolamine), a substance used to lower cholesterol; and O'HAIR, a substance used to promote hair growth. Federal Drug Administration testing and Respondent agree that these three drugs are identical.

4. This substance is not approved by the Federal Drug Administration.

5. Respondent has dispensed this substance to his patients without first obtaining proper voluntary consent forms for the use of said substance and without explaining the experimental status of this substance or its possible side effects.

6. Respondent has failed to properly chart the use of
said substance and dosage and date of dispensing to his patients.

7. Based upon the foregoing, Respondent has violated Section 458.331(1)(h), F.S. (1979) by failing to perform any statutory or legal obligation placed upon a licensed physician.

COUNT TWO

8. Petitioner realleges all the allegations contained in Paragraphs 3 through 7 above.

9. Based upon the foregoing, Respondent has violated Section 458.331(1)(l), F.S. (1979) by making deceptive, untrue, or fraudulent representations in the practice of medicine or employing a trick or scheme in the practice of medicine when such scheme or trick fails to conform to the generally prevailing standards of treatment in the medical community.

COUNT THREE

10. Petitioner realleges all the allegations contained in Paragraphs 3 through 7 above.

11. Based upon the foregoing, Respondent has violated Section 458.331(1)(n), F.S. (1979), by failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, and test results.

COUNT FOUR

12. Petitioner realleges all the allegations contained in Paragraphs 3 through 7 above.

13. Based upon the foregoing, Respondent has violated Section 458.331(1)(q), F.S. (1979) by prescribing, dispensing, administering, mixing or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice.

COUNT FIVE

14. Petitioner realleges all the allegations contained in Paragraphs 3 through 7 above.

15. Based upon the foregoing, Respondent has violated Section 458.331(1)(t), F.S. (1979), by gross or repeated 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.
COUNT SIX

16. Petitioner realleges all the allegations contained in Paragraphs 3 through 7 above.

17. Based upon the foregoing, Respondent has violated Section 458.331(1)(u), F.S. (1979), by performing any procedure or prescribing any therapy which, by the prevailing standards of medical practice in the community, would constitute experimentation on a human subject, without first obtaining full, informed and written consent.

Signed this ___ day of September, 1981.

Nancy Kailley Wittenberg, Secretary

COUNSEL FOR DEPARTMENT:

Joseph W. Lawrence, II
Deputy General Counsel
Department of Professional Regulation
130 North Monroe Street
Tallahassee, Florida 32301
(904) 488 0062

FILED

DEPARTMENT OF PROFESSIONAL REGULATION

DATE: September 9, 1981