STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,

Petitioner,

vs. Case No. 15-5043PL

KENNETH WOLINER, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, a formal administrative hearing was conducted before Administrative Law Judge Mary Li Creasy in West Palm Beach, Florida, on February 2 and 3, 2016.

APPEARANCES

For Petitioner: Kristen M. Summers, Esquire
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For Respondent: David Scott Fursteller, Esquire
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STATEMENT OF THE ISSUES

Whether Respondent engaged in medical malpractice, failed to keep legible medical records, exploited a patient for financial

gain, or accepted or performed the professional responsibilities of an oncologist that he knew, or had reason to know, he was not competent to perform; and if so, what is the appropriate sanction.

PRELIMINARY STATEMENT

On April 24, 2015, Petitioner, Department of Health, filed a Second Amended Administrative Complaint seeking disciplinary sanction of the medical license of Respondent, Kenneth Woliner, M.D., arising from his treatment of patient S.S. Respondent filed a request for formal hearing, and the matter was referred to the Division of Administrative Hearings (DOAH) on September 14, 2015. On the same day, DOAH assigned Administrative Law Judge F. Scott Boyd to conduct the proceeding. The hearing was initially set for October 14 and 15, 2015, but after two requests for continuances were granted, the hearing was ultimately set for February 2 and 3, 2016.

This matter was transferred to the undersigned on January 6, 2016, and heard, as scheduled, on February 2 and 3, 2016. At the hearing, Petitioner presented the testimony of four witnesses: Robert Federman, M.D., S.S.'s former primary care physician; Gertrude Juste, M.D., the medical examiner that performed the autopsy on S.S.; M.S., S.S.'s mother; and Charles Powers, M.D., an expert witness. Petitioner's Exhibits 1 through 7 and 9 through 11 were admitted into evidence. Included in the admitted

exhibits was the deposition transcript of Petitioner's second expert, Dr. Roy Ambinder, which was taken in lieu of live testimony at the final hearing. Petitioner's Proposed Exhibit 8 was proffered with objection, and the ruling was reserved. After review and consideration of the party's arguments on this issue, Petitioner's Exhibit 8 is admitted. Joint Exhibits 1 through 17 were also admitted into evidence.

Respondent testified on his own behalf and presented the testimony of two witnesses: Daniel Tucker, M.D., S.S.'s allergist, and Gina Ricciardi, Respondent's wife and office manager. Respondent's Exhibits 1, 3, 5, 6, 8, 9, 11, and 12 were admitted into evidence.[1/]

A two-volume Transcript of the proceeding was filed with DOAH on March 3, 2016. The parties filed timely proposed recommended orders, which were given due consideration in the preparation of the Recommended Order. Unless otherwise indicated, citations to the Florida Statutes or rules of the Florida Administrative Code refer to the versions in effect at the time of the alleged violations.

FINDINGS OF FACT

1. Petitioner is responsible for the investigation and prosecution of complaints against medical doctors licensed in the

state of Florida who are accused of violating chapters 456 and 458, Florida Statutes.

2. Respondent is licensed as a medical doctor in the state of Florida, having been issued license number ME 80412.

3. At all times material to this proceeding, Respondent was the sole owner and sole physician at Holistic Family Medicine (HFM), a medical practice located at 9325 Glades Road, Suite 104, Boca Raton, Florida 33434.

4. The charges against Respondent arise from Respondent's treatment of patient S.S. (S.S.) from March 17, 2011, until her death on February 10, 2013.

5. M.S., S.S.'s mother, was present during all of S.S.'s medical appointments and was involved in all of S.S.'s medical decisions.

Facts Related to S.S.'s Medical History

6. In the spring of 2011, S.S., a 23-year-old female archeology student from Loxahatchee, Florida, suffered from a multitude of medical issues.

7. At that time, S.S. was frustrated with her current primary care physician (PCP), Robert Federman, M.D., and treating sub-specialists because she felt that they were ignoring what she identified as her most pressing symptom, an excruciating pain in her side.

8. Due to her frustration, S.S. sought a second opinion from Respondent at HFM on March 17, 2011. M.S. learned about Respondent from an employee at Whole Foods grocery store.[2/]

9. During her first appointment at HFM, S.S. told Respondent she was recently diagnosed with peripheral t-cell lymphoma (PTCL) by the University of Miami (UM), but that she was waiting on a second opinion from the H. Lee Moffitt Cancer Center & Research Institute (Moffitt). S.S. expressed skepticism at the PTCL diagnosis.

10. Approximately nine months before S.S. first presented to Respondent, she suffered from unrelenting diarrhea, nausea, and vomiting.

11. In September 2010, Dr. Federman referred S.S. to a gastroenterologist to diagnose these complaints.

12. The gastroenterologist's attempt to diagnose S.S.'s persistent diarrhea, nausea, and vomiting eventually led to the discovery of several abnormal masses in S.S.'s abdomen. This discovery initiated a flurry of radiographic studies and biopsies that ultimately revealed cancerous cells in S.S.'s lymph nodes, consistent with PTCL.

13. S.S. was provisionally diagnosed with PTCL by Deborah Glick, M.D., a UM hematologist during a consultation appointment on February 3, 2011. During the appointment, Dr. Glick indicated

to S.S. that PTCL is a very aggressive cancer and that S.S. would likely die in a matter of months.

14. S.S. did not agree with Dr. Glick's prognosis, so she decided to see another oncologist/hematologist. S.S. presented to Abraham Schwarzberg, M.D., a new oncologist/hematologist on February 8, 2011, to continue her ongoing work-up and management of her PTCL.[3/]

15. On February 16, 2011, after discussing S.S.'s biopsy results with UM pathology specialists, Dr. Schwarzberg recommended S.S.'s slides be reviewed at Moffitt because her case "ha[d] been a very complicated and tough case to make a diagnosis on."

16. On February 25, 2011, S.S. traveled across the state for an oncology consultation at Moffitt, located in Tampa, Florida.

17. Dr. Lubomir Sokol, M.D., an oncologist/hematologist employed by Moffitt advised S.S. that the long-term prognosis of PTCL patients treated with standard chemotherapy is not satisfactory. However, Dr. Sokol suggested that S.S. did not have PTCL, given the aggressive nature of the disease and her lack of symptoms at that time.

18. Dr. Sokol requested S.S. submit her biopsy slides for review by Moffitt's pathologists, as well as by a world-renowned hemapathology expert specializing in lymphoma at the National

Institutes of Health/National Cancer Institute (NCI), Dr. Elaine Jaffe.

19. Dr. Sokol also requested S.S. undergo extensive staging exams. These exams, including a bone marrow biopsy, were negative--indicating that S.S.'s disease had not yet progressed to her bone marrow.

Initial Meeting with Respondent – March 17, 2011

20. Of the foregoing information provided to Respondent by M.S. and S.S. during the March 17, 2011, initial appointment, Respondent only documented that S.S.'s bone marrow biopsy was negative; a seemingly insignificant detail compared to S.S.'s pending diagnosis of cancer and dire prognosis.[4/]

21. By the time S.S. spoke to Respondent on March 17, 2011, she had been told by various physicians that her biopsies were inconclusive, negative for cancer, and positive for cancer. S.S. was also told that she had PTCL and that she may not have PTCL. Finally, S.S. was told that she may die as a result of her malignancy in a matter of months. Any skepticism or doubt harbored by S.S. was completely understandable.

22. Respondent encouraged S.S.'s skepticism by indicating to her that cancer was "low on his list" of S.S.'s possible concerns. Respondent shared a story regarding his uncle, a medical doctor who was successfully sued for $8.1 million for erroneously providing chemotherapy to a patient who did not have

cancer. Respondent recommended S.S. undergo additional blood work ordered by him, so that he could have a better understanding of what was going on.

23. Before her next appointment with Respondent, S.S.'s abdominal pain intensified, such that she presented to the Emergency Room and was admitted to Palms West Hospital (PWH) on March 28, 2011.

24. S.S. underwent a CT scan that revealed a distended gallbladder, as well as masses in her abdomen near her liver and pancreas.[5/]

25. Ultimately, S.S.'s excruciating abdominal pain was attributed to a diseased gallbladder that needed to be immediately surgically removed.

26. When Respondent learned of S.S.'s upcoming surgery, he told M.S. that he would get S.S.'s operative report and see S.S. in follow-up after her surgery.

27. S.S.'s gallbladder was removed on April 1, 2011, and she was discharged with instructions to follow up with her PCP.

28. After the surgery, S.S.'s frustration with Dr. Federman peaked, which prompted her to terminate her doctor-patient relationship with him. Although no formal notice was sent to Dr. Federman from S.S., Dr. Federman was informed by M.S. that she and S.S. were "going a different way" for her treatment. S.S. never made another appointment with Dr. Federman.

Conversely, S.S. fortified her trust in Respondent and relied nearly exclusively on him for all of her future medical advice, recommendations, referrals, guidance, and treatment.

Post-Surgery Follow Up with Respondent - April 7, 2011

29. Accordingly, on April 7, 2011, S.S. presented to Respondent for a "post-op" follow-up visit, at which Respondent discussed S.S.'s recent blood work results with her. Notably, Respondent failed to document anything concerning her post-op follow-up, aside from the paltry comment "gallbladder surgery."

30. That same day, after S.S. left HFM, Dr. Sokol, from Moffitt, called M.S. and indicated that S.S.'s diagnosis was changed from PTCL to Hodgkin's lymphoma (HL).

31. HL is a much less aggressive form of cancer and has a very high potential to be cured when treated.

32. M.S. immediately updated Respondent about S.S.'s new diagnosis. Respondent indicated that he was "underwhelmed at the possibility of HL," but Respondent nevertheless assumed his role as S.S.'s PCP and attempted to coordinate care with Dr. Sokol.

Request for Referral to Mayo – May 16, 2011

33. Because S.S. had now been presented with two conflicting diagnoses (PTCL and HL), S.S. researched cancer centers in Florida and decided to obtain a third opinion[6/] from the Mayo Clinic (Mayo) in Jacksonville, Florida.

34. On May 16, 2011, M.S. informed Respondent that S.S. made an appointment herself for a consultation at Mayo on June 1, 2011. M.S. requested that Respondent send a letter to Mayo, so he could be listed as a doctor that Mayo could contact regarding S.S.'s progress. Respondent wrote "refer to Mayo" on a prescription pad and mailed it the same day.

Request for PET Scan – June 2011

35. On June 1, 2011, S.S. presented to Vivek Roy, M.D., an oncologist/hematologist at Mayo for consultation. Dr. Roy told S.S. that the Mayo pathologists would review her biopsy slides since there was a debate about the exact diagnosis. Dr. Roy asked S.S. to obtain an updated PET scan.[7/]

36. On June 14, 2011, Respondent again assumed his role as S.S.'s PCP by attempting to facilitate an updated PET scan for Dr. Roy.

37. On June 20, 2011, Respondent received the PET scan report indicating that S.S.'s malignancy progressed to her pelvic region. As of this date, Respondent clearly knew S.S. was suffering from some form of lymphoma.

38. On June 22, 2011, Dr. Roy confirmed the HL diagnosis and recommended S.S. receive ABVD chemotherapy.[8/] S.S. elected to receive treatment locally and scheduled an appointment with Neal Rothschild, M.D., an oncologist/hematologist located in Palm Beach Gardens, Florida.

39. S.S. presented to Dr. Rothschild on June 27, 2011, to discuss chemotherapy and the ongoing management of her HL.

Respondent's Attribution of S.S.'s symptoms to Mold – June 2011

40. A few days before S.S.'s appointment with Dr. Rothschild, M.S. asked Respondent if it were possible that a "toxic something" was causing all of S.S.'s symptoms, including her swollen lymph nodes.

41. Instead of telling M.S. that S.S.'s symptoms, including her swollen lymph nodes, were more likely caused by her untreated cancer, Respondent suggested that S.S.'s house be tested for mold.

42. On July 5, 2011, S.S. presented to Respondent for a "check-up" and to discuss the little bit of mold that was found in her home. During the appointment, S.S. mentioned to Respondent that she met with Dr. Rothschild to discuss chemotherapy for her HL.

43. Respondent reiterated to S.S. that cancer was "low on his list" of possible medical concerns. Respondent indicated that S.S.'s tests showing she had increased lymphocytes[9/] were not indicative of cancer, especially since he did not see any "Reed-Sternberg" cells.[10/] Respondent insinuated that oncologists often overreact to the presence of lymphocytes and recommend chemotherapy before making an actual diagnosis. Respondent

further insinuated that Dr. Rothschild may not be a competent oncologist.

44. Respondent recommended S.S. pursue her "mold allergy" issues and referred her to Daniel Tucker, M.D., a local allergist.

45. Respondent also provided S.S. with a letter addressed to Dr. Rothschild wherein he emphasized that "mold could be causing all of [S.S.'s] symptoms and exam findings."

46. As instructed, S.S. presented to Dr. Tucker on July 12, 2011, and continued to follow-up with him until November 2011. Dr. Tucker diagnosed S.S. with mold allergies and recommended a series of life-style modifications to reduce her mold allergy symptoms.

Discontinuation of Oncologist/Hematologist Care – July 2011

47. S.S. believed Respondent's assessment that her symptoms were actually caused by allergies. Accordingly, S.S. only pursued treatment for her allergies, with the understanding that Respondent would refer her to a new oncologist/hematologist of his choosing if he thought she needed to pursue cancer treatment.

48. On July 28, 2011, S.S. cancelled her follow-up appointment with Dr. Rothschild. M.S. indicated to Dr. Rothschild that S.S. wanted to resolve her "mold issues" before pursuing chemotherapy treatment.

49. S.S. never returned to Dr. Rothschild or any other oncologist/hematologist for treatment. Instead, S.S. stayed under the care of Respondent, who spent the next year and a-half attempting to find the "cause" of S.S.'s symptomatic complaints.

50. In contrast to Respondent's previous concern over S.S.'s "scary" HL diagnosis and his alleged multiple attempts to interact and coordinate care with S.S.'s oncologists, after July 5, 2011, Respondent never discussed HL, lymphoma, cancer, oncologists, or chemotherapy with S.S. again.[11/]

51. While addressing her symptomatic complaints, Respondent never told S.S. that her symptoms could be caused by untreated HL, even when many of her symptoms were reasonably attributed to her progressive HL.

Complaints of Back Pain – August 2011

52. On August 30, 2011, S.S. complained to Respondent about "back pain." Respondent diagnosed S.S. with lumbosacral neuritis[12/] and prescribed Flector patches to treat the pain.

53. Respondent assumed S.S.'s back pain was caused by mold without ever conducting an appropriate evaluation, including physical examination, or test to determine its cause. S.S. was charged $200.00 for the August 30, 2011, office visit.

Complaints of Lymph Node Swelling – December 2011

54. On December 15, 2011, S.S. complained to Respondent about her lymph nodes and swelling. Respondent did not address S.S.'s lymph node or swelling concerns.

55. Respondent failed to conduct and document a complete and appropriate physical exam of S.S.'s lymph nodes. S.S. was charged $425.00 for the December 15, 2011, visit.

Concern Regarding Lymph Nodes, Pain, and Dysuria – March 2012

56. On March 5, 2012, S.S. complained to Respondent about pain in her side, pain in her lymph nodes resulting in sleeping trouble, urgency, and dysuria.[13/]

57. Respondent treated S.S.'s painful lymph nodes with low-dose naltrexone.

58. Respondent assumed S.S.'s symptoms of urgency and dysuria were caused by a urinary tract infection (UTI) and prescribed antibiotics to treat the "UTI."

59. UTIs are diagnosed with a urine culture or urinalysis. These tests are also useful in determining the strain of bacteria, which would dictate the most appropriate type of antibiotic to use. Respondent did not perform a urine culture or urinalysis before prescribing an antibiotic to treat S.S.'s UTI-like symptoms.

60. Respondent did not perform and document a complete and accurate physical exam of S.S.'s lymph node swelling, noting

where the swollen lymph nodes were located or any other appropriate documentation of the exam. S.S. was charged $205.00 for the March 5, 2012, appointment.

Complaints of UTI-like Symptoms – May 2012 through January 2013

61. S.S. repeatedly complained to Respondent about UTI-like symptoms, including on May 3, 2012, May 10, 2012, May 16, 2012, June 27, 2012, and January 3, 2013.

62. Each time, Respondent assumed S.S.'s symptoms were caused by a UTI and prescribed her antibiotics without ever performing a urine culture or urinalysis to confirm the diagnosis or determine which antibiotic would be most appropriate to prescribe.

63. Respondent also considered that S.S.'s UTI-like symptoms may be caused by an uncommon antibiotic-resistant infection called interstitial cystitis.

Continued Concerns Regarding Lymph Nodes – May 16, 2012

64. On May 16, 2012, S.S. presented to Respondent with complaints of enlarged lymph nodes.

65. Respondent did not examine, document an examination of, or otherwise address S.S.'s enlarged lymph nodes. However, S.S. was charged $200.00 for the May 16, 2012, appointment.

Swollen Legs – January 3, 2013

66. On January 3, 2013, S.S. complained to Respondent about swelling in her legs.

67. Respondent assumed S.S.'s swollen legs were caused by an allergic reaction, without performing any diagnostic examination or tests to confirm his assumption. S.S. was charged $200.00 for the January 3, 2013, appointment.

Abdominal Pain and Swelling – January 2013

68. On January 11, 2013, S.S. complained of abdominal pain and swelling. Respondent assumed S.S.'s pain and swelling were caused by an allergic reaction and prescribed an allergy medication to treat her pain and swelling.

69. On January 12, 2013, S.S. again complained of swelling in her legs. Respondent assumed S.S.'s swollen legs were caused by an allergic reaction and prescribed her an allergy medication.

70. On January 14, 2013, S.S. underwent blood work at Respondent's request. The blood work cost S.S. $575.00.

71. When Respondent received S.S.'s blood work results, Respondent called S.S. in for an urgent appointment because he thought her blood work results were "striking" and really "weird."[14/]

Urgent Appointment – January 24, 2013

72. The blood work did not test S.S.'s iron levels. Regardless, Respondent felt S.S. was iron deficient and instructed his medical assistant (MA) to administer 100 mg of iron to her on January 24, 2013.

73. S.S.'s blood work revealed that she had high calcium levels. Respondent considered that S.S.'s potential issue with her parathyroid hormone (PTH) was her "dominant concern" at that time. Respondent recommended S.S. receive more testing and suggested that she may need PTH surgery in Tampa.

74. Respondent also determined that S.S. had issues with her DHEA, Vitamin D, and T3 levels and spent considerable time discussing these concerns.

75. During the urgent appointment, S.S. complained of swelling in her legs accompanied by weakness. S.S.'s pain and swelling was so severe that she used a cane to assist her in walking and requested Respondent to assist her in obtaining a temporary parking permit.

76. Respondent now assumed S.S.'s swollen legs were caused by water retention and prescribed a diuretic to treat S.S.'s swollen legs.

77. At no time during this appointment did Respondent inquire about, or suggest, that S.S.'s symptoms were attributable to HL or its treatment. S.S. was charged $680.00 for the January 24, 2013, urgent appointment.

78. On the same day, S.S. underwent more blood work at Respondent's request. The additional blood work cost S.S. another $355.00.

Review of Blood work – February 2013

79. On February 5, 2013, when Respondent reviewed S.S.'s second set of blood work results, Respondent was confused by her results and indicated that he was going to review S.S.'s chart to "come up with a better idea of what is going on." Despite knowing of S.S.'s significant cancer diagnosis since June 2011, Respondent did not consider, or discuss with S.S., the possibility that S.S. had unusual results because she had cancer, or in the alternative, was undergoing chemotherapy treatment.

80. S.S.'s blood work revealed that she had normal iron levels. Nevertheless, Respondent felt S.S. was iron deficient and instructed his MA to administer 100 mg of iron to her on February 7, 2013. S.S. was charged $150.00 for the iron shot.

Patient's Death – February 10, 2013

81. When S.S. went to HFM for her shot, she was in significant distress related to pain and severe swelling in her legs. S.S. rapidly decompensated and died in the hospital three days later, on February 10, 2013.

82. Respondent initially thought S.S. may have died either from an adverse reaction to the iron shot or a combination of pneumonia and sepsis causing respiratory failure.

83. When the medical examiner who performed S.S.'s autopsy notified Respondent that S.S. died from complications of

untreated HL, Respondent responded by saying that S.S. had never been definitively diagnosed with HL.

84. Despite having reviewed S.S.'s radiographic, pathology, and oncology consultation reports indicating that S.S. had HL,[15/] and having treated her symptoms indicative of progressed HL for nearly two years, Respondent refused to believe that S.S. had HL, choosing instead to believe that she presented "more like a [chronic fatigue] patient allergic to mold than a lymphoma patient."

85. It was not until Respondent received the final autopsy report, several months after S.S. died, that Respondent was finally "satisfied" that S.S. had HL all along.

Facts Related to the Standard of Care Violation

86. Charles Powers, M.D., an expert in family medicine, offered testimony on the standard of care that a doctor providing primary care services to a patient in a family medicine practice setting is required to follow when a young patient is diagnosed with HL, a highly curable malignancy.

87. Dr. Powers opined that the role of the PCP is to use his or her established relationship with the patient to facilitate and ensure that the patient receives appropriate treatment.

88. In this case, Respondent's role as S.S.'s PCP was to ensure that S.S. received chemotherapy, or in the alternative, be fully informed of the consequences of foregoing chemotherapy.

89. Stephen Silver, M.D., testified on behalf of Respondent and opined that Respondent's role in S.S.'s care was as an out-of-network, adjunct holistic doctor, more comparable to an acupuncturist or Reiki specialist than a medical doctor. Dr. Silver suggested that Respondent should not be held to the same standard as other family medicine doctors providing primary care services.

90. Dr. Silver opined that because of Respondent's limited "adjunctive holistic" role, the standard of care in Florida did not require Respondent to be engaged in S.S.'s care and treatment with relation to her cancer. Dr. Silver based his opinion on the incorrect assumption that from March 2011 to February 2013, S.S. was under the care of her former PCP, Dr. Federman, and that Respondent provided strictly adjunctive holistic treatment to S.S.[16/]

91. Dr. Silver defined "holistic therapies" to include acupuncture, massage, nutritional therapies, vitamin therapies, and energetic medicine, such as Reiki. Dr. Silver specified that surgery and pharmaceuticals are not "holistic therapies," but instead fall in the realm of "traditional medical services."

92. Respondent did not provide "strictly holistic" treatment to S.S. From March 2011 to February 2013, Respondent prescribed and recommended 27 substances to S.S. Of those substances, 15 of them were drugs (including legend drugs, compounded medications, and over-the-counter medications) and 12 were nutritional supplements/vitamins. Respondent also recommended that S.S. undergo surgery, was actively involved in S.S.'s post-operative care, and ordered two PET CT scans for S.S. Respondent never recommended S.S. receive massage therapy, acupuncture, or Reiki.

93. Furthermore, it is clear that by May 2011, S.S. severed all ties from her former PCP and relied on Respondent to fulfill the role of her PCP. Therefore, Respondent was not providing strictly "adjunctive" care to S.S.

94. Dr. Silver contends that Respondent could not have been S.S.'s PCP because he was "out-of-network" with S.S.'s insurance, did not advertise as a PCP, and had a very "holistically-oriented" medical intake form. However, a PCP is not simply defined as the doctor whose name appears on a patient's insurance card.

95. Instead, the definition of a PCP is a fluid concept that includes the doctor whom the patient trusts to provide appropriate medical advice, guidance, recommendations, referrals,

and treatment.[17/] Under this definition, it is possible for even a sub-specialist to operate as a patient's PCP.

96. Those involved in S.S.'s medical treatment, including M.S., Dr. Tucker, and Dr. Juste, believed that Respondent was S.S.'s PCP. Additionally, Respondent advertised that he offered concierge-level primary care services to his patients on his website.

97. Respondent operated as S.S.'s PCP, regardless of whether he was out-of-network with her insurance provider, advertised as a PCP, or had a "holistic" intake form.

98. Based on the foregoing, Dr. Silver's opinion, that Respondent is not required to adhere to the same standard of care as family medicine doctors in Florida, is rejected.

Timely Referral

99. When a PCP learns that a young patient is diagnosed with a highly curable malignancy, the standard of care in Florida requires the PCP to timely refer the patient to an oncologist/hematologist for chemotherapy treatment. This standard is applicable as long as the patient is not under the current care of an oncologist/hematologist.

100. From July 2011 to February 2013, Respondent knew, or should have known, that S.S. was not under the care of a treating oncologist/hematologist and should have timely referred her to one, or ensured that she present to an oncologist/hematologist.

101. Although Respondent suggested that he did refer S.S. to an oncologist, he eventually attempted to justify his failure to do so by alternatively asserting: 1) it was not his duty to refer S.S. to an oncologist; 2) it was unnecessary to refer S.S. to an oncologist because she was already under the care of an oncology "team"; and 3) it was unnecessary to refer S.S. to an oncologist because she adamantly refused to be treated for HL.

102. At the final hearing, Respondent testified that he did not refer S.S. to an oncologist because he assumed she was under the care of Dr. Rothschild, receiving treatment as appropriate, from June 2011 until her death in February 2013. If it were true, why then would Respondent prescribe countless medications to S.S. without ever consulting her treating oncologist? Respondent himself testified that the treating oncologist needed every piece of information about the patient's concurrent treatment. Respondent's testimony in this regard simply is not credible.

103. Respondent's testimony was also directly contradicted by his previous statements where he indicated that S.S. adamantly refused to undergo chemotherapy and that she rebuffed and resisted his attempts to encourage her to follow up with an oncologist.

104. Respondent further contends that he went above-and-beyond his duty as a "holistic doctor" by "ensuring" S.S. went to

Mayo for her consultation by writing "refer to Mayo Clinic" on a prescription pad (after S.S. already scheduled her appointment). However, Respondent never provided a definitive explanation for the purpose of this "refer to Mayo Clinic" document, and even at one point described it as a "back to school note" for S.S. to take to class.

105. Based on these inconsistencies, Respondent's testimony regarding an oncology referral was not credible.

106. M.S. testified that Respondent did not refer S.S. to an oncologist/hematologist, even though Respondent knew that S.S. was not under the care of one. M.S. also testified that S.S. was waiting on Respondent to refer her to an oncologist/hematologist if and when he decided that S.S. had lymphoma. M.S. testified that had Respondent referred S.S. to an oncologist/hematologist that he trusted, S.S. would have gone to that doctor for treatment.

107. M.S.'s testimony was clear, concise, consistent, and credited.

108. Respondent failed to timely refer S.S. to an oncologist/hematologist for appropriate treatment as soon as he knew or had reason to know that S.S. was not under the care of an oncologist/hematologist.

Duty to Educate or Counsel

109. After timely referring the patient to an oncologist/hematologist for treatment, if the doctor learns that the patient does not want to receive treatment, either because the patient is in denial of the diagnosis or simply does not want the treatment, the standard of care in Florida requires the PCP to educate or counsel the patient on the risks, including death, of foregoing potentially life-saving treatment, so that the patient can make a fully-informed decision. As the doctor counsels the patient, he or she must refrain from facilitating or encouraging the patient's denial of their diagnosis.

110. Respondent stated that S.S. was in denial of her diagnosis of lymphoma long before she first came to see him and remained in denial of the diagnosis despite his multiple attempts to educate and counsel her. Specifically, Respondent claims he educated or counseled S.S. on May 12, 2011, May 16, 2011, March 5, 2012, May 16, 2012, and January 3, 2013. Any reference to these alleged discussions are absent from Respondent's notes. Respondent claims his advice was rebuffed, met with "stiff resistance," and that S.S. and her mother ultimately refused to believe that she had lymphoma.

111. Respondent's statements were not credible because again, in direct contradiction to himself, Respondent testified at the final hearing that after July 5, 2011, he never spoke to

S.S. about her lymphoma because he assumed S.S. was under the care of Dr. Rothschild and was receiving treatment as appropriate.

112. In contrast, M.S. credibly testified that not only did Respondent never educate or counsel S.S. on the risks of not treating her lymphoma, he continuously undermined the recommendations and advice of the oncologists and facilitated S.S.'s skepticism toward her diagnosis.

113. Indeed, instead of using his relationship with S.S. to assuage her fears related to her possibly life-threatening disease, Respondent expressed that he was "underwhelmed" with the possibility that she had lymphoma and repeatedly told S.S. that cancer was low on his list of possible medical concerns. Respondent further undermined the oncologists by indicating to S.S. that it would be potentially deadly to undergo chemotherapy if she did not actually have HL, despite knowing that S.S.'s confidence in her diagnosis was already very tenuous.

114. Respondent failed to educate and counsel S.S. on the risks, including death, of failing to receive treatment for her HL.

Symptoms

115. When a patient makes a fully-informed decision to forego treatment of an otherwise terminal illness, such as HL, the standard of care in Florida requires the PCP to attribute the

patient's symptoms that are reasonably caused by the malignancy to the malignancy.

116. Additionally, the standard of care in Florida prohibits the PCP from attempting to find an alternate diagnosis for these symptoms, when the PCP knows that treatment for the alternate/secondary diagnosis would not change the patient's life expectancy.

117. A June 20, 2011, Skull to Thigh PET CT scan of S.S. showed hypermetabolic masses and enlarged lymph nodes throughout S.S.'s body. These PET CT scan findings can only be attributed to a malignancy and are most consistent with HL. By June 2011, Respondent knew that S.S.'s HL had significantly progressed and included the involvement of her chest, abdomen, and pelvis.

118. Respondent attributed these exam findings to S.S.'s allergies to mold, food, and drugs.

119. As HL progresses throughout the body, it can cause the lymph nodes to enlarge. S.S. suffered from enlarged lymph nodes, a symptom reasonably attributed to HL. Respondent attributed S.S.'s enlarged lymph nodes to S.S.'s mold allergy.

120. The enlarged lymph nodes can apply pressure on adjacent organs and structures, causing irritation and pain. S.S. suffered from back pain, a symptom that is reasonably attributed to HL. Respondent attributed S.S.'s back pain to S.S.'s mold allergy.

121. S.S. suffered from abdominal pain, a symptom that is reasonably attributed to HL. Respondent attributed S.S.'s abdominal pain and swelling to an allergic reaction to an antibiotic, even though he had never seen this type of an allergic reaction to an antibiotic before.

122. HL can suppress the immune system, making patients more susceptible to infections, like UTIs. HL can also mimic UTI symptoms if the lymph nodes in the patient's pelvic region are enlarged and pushing on the organs in the urinary tract.

123. S.S. regularly experienced UTI-like symptoms like urgency and dysuria. These symptoms, whether they were caused by a UTI or from the pelvic lymph node involvement, are reasonably attributed to HL.

124. Respondent attributed S.S.'s UTI-like symptoms to an infection without ever obtaining a urine culture or urinalysis to confirm his assumption.

125. HL often causes swelling in patient's extremities by affecting the lymphatic system, which is used to transport fluids throughout the body.

126. S.S. experienced extreme painful swelling in her legs, a symptom that was caused by her HL.

127. Respondent attributed S.S.'s swollen legs to an allergic reaction.

128. Respondent claims that he was "keenly" aware that S.S.'s symptoms could have been caused by HL and that he repeatedly informed S.S. of the same. However, Respondent claims that S.S. may have had concurrent illnesses that were causing similar symptoms and that it was not inappropriate for him to treat those symptoms. Interestingly, Respondent's notes do not reflect that he discussed with S.S. that her symptoms could be attributed to her untreated lymphoma.

129. Despite being "keenly" aware that S.S. was suffering from untreated Stage III HL, Respondent often expressed bewilderment as to the cause of S.S.'s symptoms and repeatedly remarked that he wanted to "find out what was going on" and ordered blood work purportedly for that purpose. Due to the inconsistencies, Respondent's testimony is not credible.

130. M.S. credibly testified that Respondent never indicated that any of these symptoms were likely caused by HL and that he spent time with S.S. trying to find the real cause of her symptoms. Respondent completely ignored S.S.'s existing HL diagnosis and instead believed that S.S. presented "more like a CFIDS[18/] patient allergic to mold than a lymphoma patient."

131. Respondent failed to appropriately attribute S.S.'s symptoms to HL.

Facts Related to Medical Records Violation

132. During each office visit, Respondent should have created a progress note that included the subjective complaints of the patient, the objective observations of the patient (including a physical exam), an assessment of the patient's medical concerns, and a treatment plan (commonly referred to as "SOAP notes"). Included in these notes should be adequate justification for each diagnosis given and prescription given to the patient.

133. Respondent failed to create or keep documentation of an adequate medical justification for the diagnoses he made and the treatment he provided to S.S.

134. On April 7, 2011, July 5, 2011, August 30, 2011, December 15, 2011, March 5, 2012, January 3, 2013, and January 24, 2013, Respondent failed completely to document the objective portion of the exam.

135. Respondent also routinely failed to document adequate medical justification for the diagnoses or treatments rendered to S.S.

136. Respondent failed to create or keep documentation in which he purportedly referred S.S. to an oncologist. Similarly, Respondent failed to create or keep documentation of his alleged educating or counseling of S.S. on the risks of foregoing chemotherapy treatment.

Facts Related to Scope of Practice

137. Respondent testified that he did not practice outside of the scope of his profession or perform or offer to perform professional responsibilities that he knows he is not competent to practice because he did not treat S.S. for cancer and did not offer to treat her for cancer.

138. Petitioner offered the testimony of Roy Ambinder, M.D., an expert in oncology and hematology. Dr. Ambinder testified regarding the scope of practice for an oncologist and the standard of care for oncologists treating HL. Dr. Ambinder's testimony was clear, concise, consistent, and credited.

139. It is not within the scope of practice for a family medicine physician to modify or reject an existing diagnosis of HL.

140. Oncology is the study of cancer. A physician needs oncology training, experience, and a background in oncology to modify or reject an existing diagnosis of HL.

141. Before modifying or rejecting an existing diagnosis of HL, a physician with the appropriate training, experience, and background would have to perform a physical exam, obtain blood work and additional radiographic studies, review past reports from the pathologists/oncologists, and review and interpret tissue biopsies.

142. Respondent knew that five oncologists/hematologists, including specialists from Moffitt, NIH, and Mayo diagnosed S.S. with lymphoma.

143. Respondent knew that he did not have the necessary qualifications, skill, training, education, or experience to modify or reject a diagnosis of HL. Yet, after harboring significant skepticism towards the diagnosis, Respondent reviewed S.S.'s pathology reports and radiographic studies and rejected S.S.'s HL diagnosis.

144. Therefore, Respondent acted in the role of an oncologist, regardless of whether he actually treated, offered to treat, or advertised that he could treat S.S. for cancer.

145. Respondent acted beyond the scope of his practice by law and performed professional responsibilities that he knew he was not competent to perform by rejecting S.S.'s existing diagnosis of HL.

Facts Related to Financial Exploitation Violation

146. Respondent knew, or should have known, that S.S. had lymphoma. Respondent knew that the only approved effective treatment for HL is chemotherapy and that if left untreated, HL will cause a patient's untimely death.

147. Despite knowing that S.S. had HL, Respondent tried to find an alternate diagnosis to explain S.S.'s symptoms.

148. M.S. and S.S. trusted Respondent to make medical decisions in S.S.'s best interest, such that Respondent was able to convince M.S. and S.S. that S.S.'s symptoms were caused by something other than HL, thus necessitating additional appointments and blood work.

149. Between August 30, 2011, and February 7, 2013, Respondent addressed S.S.'s symptoms, which were reasonably caused by HL, with a variety of symptomatic treatments that Respondent knew, or should have known, would not have affected S.S.'s HL or extended her life expectancy.

150. Respondent's MA administered S.S. $300.00 worth of InFed injections when he knew, or should have known, that S.S. was not iron-deficient and that iron would not have addressed S.S.'s fatal illness. Even if S.S. was iron-deficient, iron supplements would not have extended S.S.'s life expectancy.

151. Respondent ordered $930.00 worth of blood work testing for S.S. when he knew or should have known that additional blood work would not have affected the established diagnosis of HL and that any diagnosis derived from the lab results would not have extended S.S.'s life expectancy.

152. Respondent charged S.S. $1,760.00 in appointment fees over a one and a-half year period. During these appointments, Respondent treated S.S.'s symptomatic complaints with treatments that Respondent knew, or should have known, would not have

addressed S.S.'s HL. Moreover, even if the treatments appropriately addressed a secondary diagnosis, Respondent knew, or should have known, that these consultations and recommended treatments would not have extended S.S.'s life expectancy.

153. Accordingly, S.S. and her family paid Respondent and HFM approximately $2,990.00, in pursuit of treatment that Respondent influenced them to believe was necessary, appropriate, and would lead to or improve S.S.'s health.

154. Respondent benefitted financially from the payments remitted to him and HFM by S.S.

Facts Related to Aggravating Factors

155. Respondent's conduct resulted in significant harm, including the extended suffering and ultimate death, of patient S.S.

156. Petitioner entered a Final Order against Respondent's license in DOH Case No. 2008-00890 for violations of Sections 458.331(1)(t), and 458.331(1)(m), Florida Statutes (2003-2004). The Final Order constitutes discipline against Respondent's license.[19/]

CONCLUSIONS OF LAW

157. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes (2015).

158. A proceeding to suspend, revoke, or impose other discipline upon a license is penal in nature. State ex rel. Vining v. Fla. Real Estate Comm'n, 281 So. 2d 487, 491 (Fla. 1973). Petitioner must therefore prove the charges against Respondent by clear and convincing evidence. Fox v. Dep't of Health, 994 So. 2d 416, 418 (Fla. 1st DCA 2008)(citing Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996)).

159. The clear and convincing standard of proof has been described by the Florida Supreme Court:

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Davey, 645 So. 2d 398, 404 (Fla. 1994)(quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)).

160. Disciplinary statutes and rules "must always be construed strictly in favor of the one against whom the penalty would be imposed and are never to be extended by construction." Griffis v. Fish & Wildlife Conserv. Comm'n, 57 So. 3d 929, 931 (Fla. 1st DCA 2011); Munch v. Dep't of Prof'l Reg., Div. of Real Estate, 592 So. 2d 1136 (Fla. 1st DCA 1992).

161. The grounds proving Petitioner's assertion that Respondent's license should be disciplined must be those specifically alleged in the Second Amended Administrative Complaint. See e.g., Trevisani v. Dep't of Health, 908 So. 2d 1108 (Fla. 1st DCA 2005); Kinney v. Dep't of State, 501 So. 2d 129 (Fla. 5th DCA 1987); and Hunter v. Dep't of Prof'l Reg., 458 So. 2d 842 (Fla. 2d DCA 1984).

Count I – Medical Malpractice

162. Section 458.331(1)(t) provides that it is a violation for a medical doctor to commit medical malpractice, as defined in section 456.50. Section 456.50(1)(g) defines "medical malpractice" as the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

163. Petitioner proved by clear and convincing evidence that the standard of care in Florida required Respondent to: timely refer S.S. to an oncologist/hematologist; educate and counsel S.S. on the risks, including death, of not treating her HL; and appropriately attribute S.S.'s symptoms to HL. See Clark v. Dep't of Bus. & Prof'l Reg., Bd. of Med., 463 So. 2d 328 (Fla. 5th DCA 1985)(physician that treated patient's cancer with holistic therapies was still required to abide by standard of care for medical doctors); Ag. for Health Care Admin, Bd. of Med. v. Richard Plagenhoef, M.D., Case No. 94-3214 (Fla. DOAH

Feb. 5, 1996; AHCA Apr. 12, 1996)(physician was engaged in the practice of medicine even though he used holistic treatments to treat medical conditions).

164. Petitioner proved by clear and convincing evidence that Respondent violated section 458.331(1)(t), by falling below the standard of care for family medicine medical doctors in the state of Florida by failing to timely refer S.S. to an oncologist/hematologist, by failing to educate and counsel S.S. on the risks, including death, of not treating HL, and by failing to appropriately attribute S.S.'s symptoms to HL.

165. Respondent argues that there was no need to refer S.S. to an oncologist/hematologist because she was diagnosed with lymphoma by at least five oncologists/hematologists before and during the time she was a patient of Respondent. Alternatively, Respondent argues he "referred" S.S. to Mayo, ordered two PET scans, and sent a letter to Dr. Rothschild.

166. However, as discussed above, the evidence demonstrated that S.S. referred herself to multiple oncologists/hematologists in an attempt to get a clear diagnosis. Her understandable confusion and skepticism of her HL diagnosis was only compounded by Petitioner's suggestions that her symptoms were as a result of food and/or mold allergies, and that her cancer diagnosis was "low on his list" of concerns.

167. Had Respondent once asked S.S. what course of treatment she was undergoing for HL, he would have learned that she was not under the care of any oncologist/hematologist, nor was she receiving likely life-saving chemotherapy. Had Respondent once picked up the telephone to coordinate care and spoke to Dr. Rothschild or any of the other oncologists/hematologists who ordered tests for S.S., he would have learned that S.S. was not under the care of any oncologist/hematologist for her HL.

168. It is specious that Respondent argues he was not S.S.'s primary care physician and therefore had no obligation to refer her to an oncologist/hematologist, yet at the same time argues that his writing a brief note to Dr. Rothschild, ordering PET scans at the request of S.S. for other doctors and supplying S.S. with a one-line note to refer to Mayo somehow satisfied any obligation he had to refer her to a specialist. Interestingly, Respondent never communicated to Dr. Federman, the doctor Respondent claims he assumed was S.S.'s primary care doctor, to discuss what treatments, if any, S.S. was undertaking for her HL.

169. Respondent's notes are wholly devoid of any reference to any purported conversation he had with S.S. or her mother regarding the likely repercussions, including death, of failing to treat her HL. Nor did Respondent provide such advice or counseling in writing. Instead, Respondent sought to diagnose

S.S.'s symptoms as anything other than her HL. It is astounding that Respondent never asked S.S. about any chemotherapy treatment she might be receiving which, by itself, could have resulted in some of the symptoms of which she complained.

170. Respondent suggests that any such discussion would have been futile because S.S. and her mother refused to believe her diagnosis, he could not force S.S to go see another oncologist, or to begin treatment that she would refuse. The evidence shows however that S.S. (and her mother) completely trusted Respondent, undertook his direction with regard to seeing an allergist, considered going to Tampa to have parathyroid surgery, took unnecessary iron shots, and took antibiotics for likely non-existent UTIs.

171. From Respondent's very first visit with S.S. until after her death, Respondent downplayed the seriousness of her HL.

172. Respondent began his relationship with S.S. and her mother by regaling them with the story of his uncle who committed malpractice by providing chemotherapy to someone who was misdiagnosed. Respondent's cryptic note on July 5, 2011, to Dr. Rothschild, the oncologist/hematologist, identifies "mold is causing all of these physical symptoms and exam findings" as one of the possible reasons for S.S.'s symptoms. Even after reviewing the medical examiner's findings that S.S. died from

untreated HL, Respondent told M.S. he wasn't convinced S.S. had cancer and the slides prior to her death "underwhelming."

173. This course of interaction between Respondent, S.S., and M.S., is utterly inconsistent with Respondent's claim that he verbally educated and counseled S.S. about the dangers of not treating her HL or appropriately attributed her symptoms to HL.

Count II – Medical Records Violation

174. Section 458.331(1)(m) provides that it is a violation for a physician to fail 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.

175. As discussed by Petitioner's expert, Dr. Ambinder:

> I find no evidence in the record that [Respondent] had any documented conversation to the patient insisting she get treatment for her cancer.... You're falling below the standard of care if not documented that you had a full and legitimate conversation with the patient describing that you feel she had a malignancy, and that the malignancy needed to be treated, and the malignancy was the

> cause of many of her symptoms.... His responsibility, as a practicing physician in the state of Florida, is to ensure that his patients get the best care. He would know, from going to medical school, that Hodgkin's disease in a young woman, Stage III, is very curative, and they need to be treated with standard therapy in order to be cured. For two years, he took care of the patient. Never once did he specifically document that he inquired whether she was getting active treatment, nor did he document that any of the symptoms which he was treating could possibly be related to chemotherapy. It was like he did not care.... All he cared about, in the notes, it appeared to be, were treating mold symptoms or allergies. He neglected the main cause of this patient's death. If this patient were treated earlier, she most likely would have survived. She had an 80 percent to 85 percent chance of being in complete remission.

Deposition transcript of Roy Mark Ambinder, M.D., pp. 121/1-123/3.

176. Petitioner proved by clear and convincing evidence that Respondent failed to keep legible medical records justifying the course of treatment for S.S., including failing to keep legible medical records providing an adequate medical justification for the diagnoses rendered and treatment provided.

177. Petitioner proved by clear and convincing evidence that Respondent failed to keep legible medical records documenting that he educated or counseled S.S. on the risks of foregoing treatment or that he referred S.S. to an oncologist.

178. As a result, Petitioner proved by clear and convincing evidence that Respondent violated section 458.331(1)(m).

Count III – Exploitation of the Patient

179. It is a violation for a medical doctor to exercise influence on a 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. § 458.331(1)(n), Fla. Stat.

180. Petitioner proved by clear and convincing evidence that Respondent violated section 458.331(1)(n), by exercising influence on S.S. in such a manner as to exploit her for financial gain by scheduling appointments, selling and administering drugs, and obtaining blood work from the patient when Respondent knew, or should have known that none of these courses of action would reasonably alter the medical condition, treatment, or life expectancy of S.S. See Hasbun v. Dep't of Health, 701 So. 2d 1235 (Fla. 3d DCA 1997)(finding that doctor financially exploited patient by performing procedures and prescribing medications that he knew would not alter the medical condition, treatment or life expectancy of a patient diagnosed with terminal cancer). Ag. for Health Care Admin. v. Rene Hasbun, M.D., Case Nos. 94-0607 & 94-0778 (Fla. DOAH Dec. 24, 1996; AHCA Mar. 13, 1997).

Count IV - Scope of Practice

181. Section 456.072(1)(o) provides that it is a violation for a doctor to practice or offer to practice beyond the scope permitted by law or accept and perform professional responsibilities the he knows, or has reason to know, that he is not competent to perform.

182. Respondent readily admits that he is not an oncologist or hematologist nor is he qualified to give advice regarding the appropriate treatment for HL. However, the evidence, as discussed above, demonstrates that Respondent certainly minimized, if not outright rejected, S.S.'s diagnosis of HL.

183. According to Respondent's Answers to Petitioner's Request for Admissions, Respondent acknowledged, "I was not board-certified in hematology or oncology and I could not advise patient SS whether she had cancer or not, nor what treatments to undergo." Yet, Respondent admits at his first visit with the patient, "I did discuss the possibility of a 'false-positive biopsy report,' stating that there was cancer, when there really was not. I recounted the example of my uncle, Dr. Abraham Rosenberg, who was sued for malpractice and lost $8.1 million, in judgment, for treating a patient with chemotherapy, when the patient never had cancer to begin with. That specific case involved patient, J.P., mis-diagnosed with malignant non-

Hodgkin's lymphoma who eventually died from complications of chemotherapy."

184. Petitioner proved by clear and convincing evidence that Respondent violated section 456.072(1)(o), by practicing beyond the scope permitted by law and accepted and performed professional responsibilities that he knew he was not competent to perform by rejecting S.S.'s existing diagnosis of HL.

Penalty Assessment

185. Petitioner imposes penalties upon licensees consistent with disciplinary guidelines prescribed by rule. See Parrot Heads, Inc. v. Dep't of Bus. & Prof'l Reg., 741 So. 2d 1231, 1233-34 (Fla. 5th DCA 1999).

186. Penalties in a licensure discipline case may not exceed those in effect at the time the violations were committed. Willner v. Dep't of Prof'l Reg., Bd. of Med., 563 So. 2d 805, 806 (Fla. 1st DCA 1990), rev. denied, 576 So. 2d 295 (Fla. 1991).

187. At the time of the incidents, Florida Administrative Code Rule 64B8-8.001(2)(t) provided that for a first-time offender committing medical malpractice, as described in section 458.331(1)(t), the prescribed penalty range was from one (1) year probation to revocation or denial, and an administrative fine from $1,000.00 to $10,000.00. The recommended penalty for a second violation of section 458.331(1)(t) ranged from two years

of probation to revocation and an administrative fine from $5,000 to $10,000. Id.

188. Rule 64B8-8.001(2)(m) provided that for a first-time offender failing to keep required medical records, as described in section 458.331(1)(m), the prescribed penalty range was from a reprimand to denial or two (2) years of suspension followed by probation and an administrative fine from $1,000.00 to $10,000.00. The recommended penalty for a second violation of section 458.331(1)(m) ranged from probation to suspension followed by probation and an administrative fine from $5,000 to $10,000. Fla. Admin. Code R. 64B8-8.001(2)(m).

189. The recommended penalty for a first violation of section 458.331(1)(n) for exploitation of a patient ranged from probation to two years of suspension followed by probation, payment of the fees paid by or on behalf of the patient, and an administrative fine from $5,000 to $10,000. Fla. Admin. Code R. 64B8-8.001(2)(n).

190. The recommended penalty for a first-time violation of section 456.072(1)(o) for practicing beyond the scope permitted by law, ranged from two years of suspension to revocation and an administrative fine from $1,000 to $10,000. Fla. Admin. Code R. 64B8-8.001(2)(v).

191. Rule 64B8-8.001(3) provided that, in applying the penalty guidelines, the following aggravating and mitigating circumstances should also be taken into account:

> (3) Aggravating and Mitigating Circumstances. Based upon consideration of aggravating and mitigating factors present in an individual case, the Board may deviate from the penalties recommended above. The Board shall consider as aggravating or mitigating factors the following:
>
> (a) Exposure of patient or public to injury or potential injury, physical or otherwise: none, slight, severe, or death;
>
> (b) Legal status at the time of the offense: no restraints, or legal constraints;
>
> (c) The number of counts or separate offenses established;
>
> (d) The number of times the same offense or offenses have previously been committed by the licensee or applicant;
>
> (e) The disciplinary history of the applicant or licensee in any jurisdiction and the length of practice;
>
> (f) Pecuniary benefit or self-gain inuring to the applicant or licensee;
>
> (g) The involvement in any violation of Section 458.331, F.S., of the provision of controlled substances for trade, barter or sale, by a licensee. In such cases, the Board will deviate from the penalties recommended above and impose suspension or revocation of licensure.
>
> (h) Where a licensee has been charged with violating the standard of care pursuant to Section 458.331(1)(t), F.S., but the licensee, who is also the records owner

pursuant to Section 456.057(1), F.S., fails to keep and/or produce the medical records.

(i) Any other relevant mitigating factors.

192. A significant aggravating factor is that Respondent's actions exposed S.S. to severe injury or death. Aggravating factor (c) applies because Petitioner established four separate offenses committed by Respondent. Additionally, under paragraph (h), Respondent was charged with violating the standard of care and it was found that he failed to keep adequate medical records. Aggravating factor (f) also applies because Respondent received pecuniary gain (albeit minimal) from providing unnecessary treatments and testing to S.S.

193. Petitioner argues that the prior discipline against Respondent's license, aggravating factor (d), should be taken into consideration. Respondent asserts that the prior discipline was the result of a settlement in which there was no finding that he, in fact, committed the alleged violations, and he did not admit any wrongdoing. The undersigned finds it unnecessary to rule on this issue because the other aggravating factors cited herein are more than sufficient by themselves, without reference to prior discipline, to support a recommendation for the proposed penalty.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Board of Medicine enter a final order finding that Respondent violated sections 458.331(1)(t), 458.331(1)(m), 458.331(1)(n), and 456.072(1)(o), Florida Statutes, as charged in Petitioner's Second Amended Administrative Complaint; imposing a fine of $16,000.00; requiring repayment of $2,990.00 to the estate of S.S.; revoking Respondent's license to practice medicine; and imposing costs of the investigation and prosecution of this case. The undersigned reserves jurisdiction to rule on Daniel Tucker's Application and Motion for Award of Expert Witness Fees.

DONE AND ENTERED this 29th day of April, 2016, in Tallahassee, Leon County, Florida.

MARY LI CREASY
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 29th day of April, 2016.

ENDNOTES

[1/] Respondent's Exhibits 3, 5, 6, 8, 9, 11, and 12 were duplicative of Petitioner's Exhibits 5, 11, 10, 9, 2, 3, and 4, respectively.

[2/] Respondent advertises that he specializes in "difficult-to-treat" symptoms, which he describes to include conditions that people "have been frustrated with despite multiple attempts at different physicians to be diagnosed or treated."

[3/] In 2008, S.S. presented to Dr. Glick regarding the viscosity of her blood. At that time, Dr. Glick told S.S. that further hematological work-up was not indicated. S.S. did not agree with Dr. Glick's diagnosis since Dr. Glick had recently evaluated S.S.'s blood and determined that there was nothing wrong.

[4/] Bone marrow biopsies are used as staging exams to determine the extent to which a disease has progressed throughout the body. A negative bone marrow biopsy does not contradict a positive biopsy; it only shows that the disease has not progressed from the site of the first biopsy to the bone marrow.

[5/] A Computerized Axial Tomography scan, also referred to as a "CT" or "CAT" scan, is a specialized X-ray test that produces cross-sectional images of the body.

[6/] Dr. Glick and Dr. Schwarzberg based their diagnoses on the same pathology review of the biopsy slides. Therefore, they will be considered as a composite "first opinion." Dr. Sokol's diagnosis, the "second opinion" was based on review of the biopsy slides by NCI and Moffitt.

[7/] Positron Emissions Tomography (PET).

[8/] ABVD is an abbreviation for the combination of chemotherapy drugs: Adrianmycin, Bleomycin, Velban, and DTIC.

[9/] White blood cells.

[10/] Reed-Sternberg cells are large, multi-nucleated cells commonly seen in HL. Biopsies often do not reveal Reed-Sternberg cells because they are relatively rare, compared to reactive lymphocytes. While the presence of Reed-Sternberg cells are an indicator for HL, the absence of Reed-Sternberg cells does not preclude an HL diagnosis. However, S.S.'s pathology reports

indicated that there were Hodgkin's cells, a variant of a Reed-Sternberg cell.

[11/] Respondent stated that he did not reference HL in the progress notes because he was not treating S.S. for HL. However, Respondent routinely referenced "mold" and mold-related issues, even though he was not treating her mold allergies. Notably, S.S.'s allergist did include HL as a diagnosis in his notes, even though he was not treating S.S. for HL either.

[12/] Lower back pain caused by inflammation of spinal nerves.

[13/] Painful or difficult urination.

[14/] Respondent finally tested S.S.'s urine on January 14, 2013, revealing S.S. did not have a UTI.

[15/] Documents reviewed by Respondent included: 11/22/10 CT Scan; 12/8/10 UM Cytology Report; 12/27/10 PET CT scan; 1/14/11 UM Pathology Report; 2/15/11 PET CT scan; 3/24/11 NCI Pathology Report; 4/8/11 Telephone Contact from Moffitt HL diagnosis; 5/11/11 Abdominal CT Scan; 6/1/11 Hematology Consultation from Mayo; 6/10/11 Pathology Report from Mayo; 6/22/11 Hematology Consultation from Mayo.

[16/] Dr. Silver failed to review and therefore consider in the formulation of his opinion, the audio recording (and/or transcript) of S.S.'s January 24, 2013, appointment; Neal Rothschild's patient records for S.S. (aside from the consultation report); the transcript of Respondent's deposition taken in this matter; and the transcript of M.S.'s deposition taken in this matter.

[17/] Section 381.026, Florida Statutes, entitled the "Florida Patient's Bill of Rights and Responsibilities" defines a primary care provider in very broad terms, as "a health care provider licensed under chapter 458, chapter 459, or chapter 464 who provides medical services to patients which are commonly provided without referral from another healthcare provider, including family and general practice, general pediatrics, and general internal medicine." By Respondent's own admission, Respondent's services at HFM do not require referral by another healthcare provider.

[18/] Chronic Fatigue Immunodeficiency Syndrome.

[19/] Petitioner's Proposed Exhibit 8 was proffered with objection, and the ruling was reserved. After careful review and weighing the arguments of counsel, Petitioner's Exhibit 8 is admitted.

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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.