Final Order No. DOH-13-0735- 9 -MQA
FILED DATE APR 19 2013
Department of Health
By: [signature]
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2008-21706
2008-21704
LICENSE NO.: ME0033297

RONALD HOWARD KURLANDER, M.D.,

Respondent.
_______________________________/

FINAL ORDER

THIS CAUSE came before the BOARD OF MEDICINE (Board) pursuant to Sections 120.569 and 120.57(4), Florida Statutes, on April 5, 2013, in Deerfield Beach, Florida, for the purpose of considering a Settlement Agreement (attached hereto as Exhibit A) entered into between the parties in this cause. Pursuant to Section 456.073(9)(b), Florida Statutes, the complainant appeared and testified before the Board. Upon consideration of the Settlement Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise fully advised in the premises,

IT IS HEREBY ORDERED AND ADJUDGED that the Settlement Agreement as submitted be and is hereby approved and adopted in toto and incorporated herein by reference with the following clarification:

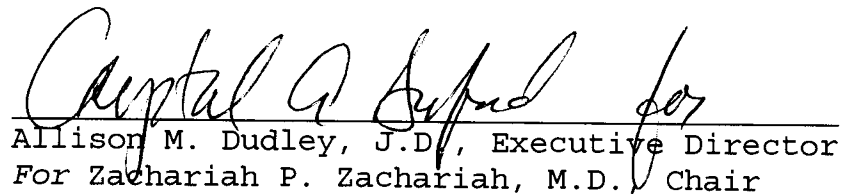
The costs set forth in Paragraph 3 of the Stipulated Disposition shall be set at $15,828.12.

Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Settlement Agreement as clarified above.

This Final Order shall take effect upon being filed with the Clerk of the Department of Health.

DONE AND ORDERED this 17th day of April, 2013.

BOARD OF MEDICINE



Allison M. Dudley, J.D., Executive Director
*For* Zachariah P. Zachariah, M.D., Chair

<u>CERTIFICATE OF SERVICE</u>

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to RONALD HOWARD KURLANDER, M.D., 1 West Sample Road, Suite 205, Pompano Beach, Florida 33064-3578; to Randolph Collette, Esquire, 1000 Riverside Avenue, Suite 700, Jacksonville, Florida 32204; and by interoffice delivery to Doug Sunshine, Department of Health,

4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 19th day of April, 2013.

Angel Sanders

**Deputy Agency Clerk**

**Mission**:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

**Rick Scott**
Governor

**John H. Armstrong, MD, FACS**
State Surgeon General & Secretary

**Vision**: To be the Healthiest State in the Nation

# INTEROFFICE MEMORANDUM

**DATE:** April 16, 2013

**TO:** Cassandra Pasley, Bureau Chief
Health Care Practitioner Regulation

**FROM:** Allison Dudley, Executive Director
Board of Medicine

**SUBJECT:** Delegation of Authority

This is to advise that I will be out of the office, Monday afternoon through Friday afternoon, April 15th through 19th, 2013, attending a court case in Bartow, Florida and then flying to Boston, Massachusetts for the AIM and FSMB Annual Conference Meeting. Chandra Prine is delegated to serve as acting Executive Director for the Board of Medicine for Monday afternoon, April 15th. Crystal Sanford is delegated to serve as acting Executive Director for the Board of Medicine for Tuesday morning, Wednesday, Thursday and Friday. Gloria Nelson is delegated to serve as acting Executive Director for the Board of Medicine for Tuesday afternoon. Mrs. Prine can be reached at (850) 245-4135. Mrs. Sanford can be reached at (850) 245-4132. Mrs. Nelson can be reached at (850) 245-4516. I will return to the office on Monday, April 22nd, 2013.

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**Petitioner,**

**v.** **DOH Case Nos. 2008-21704 & 2008-21706**

**RONALD KURLANDER, M.D.,**

**Respondent,**
______________________________/

## SETTLEMENT AGREEMENT

Ronald Kurlander, M.D., referred to as the "Respondent," and the Department of Health, referred to as "Department" stipulate and agree to the following Agreement and to the entry of a Final Order of the Board of Medicine, referred to as "Board," incorporating the Stipulated Facts and Stipulated Disposition in this matter.

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

## STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed physician in the State of Florida having been issued license number ME 33297.

2. The Department charged Respondent with Administrative Complaints that were filed and properly served upon Respondent with violations of Chapter 458, Florida Statutes, and the rules adopted pursuant thereto. True and correct copies of the Administrative Complaints are attached hereto as Exhibit A.

3. Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaint for purposes of these proceedings only.

## STIPULATED CONCLUSIONS OF LAW

1. Respondent admits that, in his capacity as a licensed physician, he is subject to the provisions of Chapters 456 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

2. Respondent admits that the facts alleged in the Administrative Complaints, if proven, would constitute violations of Chapter 458, Florida Statutes, as alleged in the Administrative Complaints.

3. Respondent agrees that the Stipulated Disposition in this case is fair, appropriate and acceptable to Respondent.

## STIPULATED DISPOSITION

1. **Reprimand** - The Board shall reprimand the license of Respondent.

2. **Fine** - The Board of Medicine shall impose an administrative fine of fifteen thousand dollars ($15,000.00) against the license of Respondent, to be paid by Respondent to Payments, Department of Health, Compliance Management Unit, Bin C-76,

P.O. Box 6320, Tallahassee, FL 32314-6320, within thirty-days (30) from the date of filing of the Final Order accepting this Agreement. **All fines shall be paid by cashiers check or money order.** The Board office does not have the authority to change the terms of payment of any fine imposed by the Board.

**RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE FINE IS HIS/HER LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE FINE IS NOT PAID AS AGREED TO IN THIS SETTLEMENT AGREEMENT, SPECIFICALLY: IF WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER, RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE FINE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD.**

3. **Reimbursement Of Costs** - Pursuant to Section 456.072, Florida Statutes, Respondent agrees to pay the Department for any costs incurred in the investigation and prosecution of this case. Such costs exclude the costs of obtaining supervision or monitoring of the practice, the cost of quality assurance reviews, and the Board's administrative cost directly associated with Respondent's probation, if any. The agreed upon amount of Department costs to be paid in this case is currently fifteen thousand one hundred dollars and seventeen cents ($15,100.17), but shall not exceed seventeen thousand one hundred dollars and seventeen cents ($17,100.17). Respondent will pay costs to Payments, Department

of Health, Compliance Management Unit, Bin C-76, P. O. Box 6320, Tallahassee, FL 32314-6320, within thirty-days (30) from the date of filing of the Final Order in this cause. **All costs shall be paid by cashiers check or money order.** Any post-Board costs, such as the costs associated with probation, are not included in this agreement.

**RESPONDENT ACKNOWLEDGES THAT THE TIMELY PAYMENT OF THE COSTS IS HIS/HER LEGAL OBLIGATION AND RESPONSIBILITY AND RESPONDENT AGREES TO CEASE PRACTICING IF THE COSTS ARE NOT PAID AS AGREED TO IN THIS SETTLEMENT AGREEMENT, SPECIFICALLY: IF WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER, RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION THAT THE FULL AMOUNT OF THE COSTS NOTED ABOVE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL SUCH WRITTEN CONFIRMATION IS RECEIVED BY RESPONDENT FROM THE BOARD.**

4. **Laws And Rules Course** - Respondent shall complete course, "Legal and Ethical Implications in Medicine Physician's Survival Guide-Laws and Rules" administered by the Florida Medical Association, or a Board-approved equivalent, within eighteen (18) months of the date of filing of the Final Order of the Board. In addition, Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical education course within eighteen (18) months of the date of filing of the Final Order incorporating this Agreement.

5. **Drug Course** - Respondent shall complete the course, "Prescribing Controlled Drugs: Critical Issues and Common Pitfalls of Misprescribing," sponsored by the University of Florida, or a Board-approved equivalent, within one year of the date of filing of the Final Order.

6. **Records Course** - Respondent shall complete the course, "Quality Medical Record Keeping for Health Care Professionals," sponsored by the Florida Medical Association, or a Board-approved equivalent, within one year of the date of filing of the Final Order.

7. **Quality Assurance Consultation/Risk Management Assessment** An independent, certified licensed risk manager will review Respondent's current practice within sixty (60) days of the date of filing of the Final Order. Specifically, this independent consultant shall review the office procedures employed at Respondent's practice. This consultant will prepare a report addressing Respondent's practice. This report will include suggested improvements of the quality assurance of Respondent's practice. Respondent will submit this quality assurance report to the Board's Probation Committee as well as documentation that demonstrates compliance by submitting a follow-up report to the Probation Committee completed by the licensed risk manager that verifies Respondent's compliance within six (6) months from the date of entry of the Final Order. Respondent shall bear the cost of such consultation and any necessary or appropriate follow-up consultation.

## STANDARD PROVISIONS

1. **Appearance**: Respondent is required to appear before the Board at the meeting of the Board where this Agreement is considered.

2. **No force or effect until final order** - It is expressly understood that this Agreement is subject to the approval of the Board and the Department. In this regard, the foregoing paragraphs (and only the foregoing paragraphs) shall have no force and effect unless the Board enters a Final Order incorporating the terms of this Agreement.

3. **Continuing Medical Education** - Unless otherwise provided in this written agreement Respondent shall first submit a written request to the Probation Committee for approval prior to performance of said continuing medical education course(s). Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of this medical course within one (1) year of the date of filing of the Final Order in this matter. All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such documentation was provided previously during the course of any audit or discussion with counsel for the Department. These hours shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board, said continuing medical education course(s) shall consist of a formal, live lecture format.

4. **Addresses** - Respondent must keep current residence and practice addresses on file with the Board. Respondent shall notify the Board within ten (10) days of any changes of said addresses.

5. **Future Conduct** - In the future, Respondent shall not violate Chapter 456, 458 or 893, Florida Statutes, or the rules promulgated pursuant thereto, or any other state or federal law, rule, or regulation relating to the practice or the ability to practice medicine. Prior to signing this agreement, the Respondent shall read Chapters 456, 458 and 893 and the Rules of the Board of Medicine, at Chapter 64B8, Florida Administrative Code.

6. **Violation of terms considered** - It is expressly understood that a violation of the terms of this Agreement shall be considered a violation of a Final Order of the Board, for which disciplinary action may be initiated pursuant to Chapters 456 and 458, Florida Statutes.

7. **Purpose of Agreement** - Respondent, for the purpose of avoiding further administrative action with respect to this cause, executes this Agreement. 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 Agreement. Respondent agrees to support this Agreement at the time it is presented to the Board and shall offer no evidence, testimony or argument that disputes or contravenes any stipulated fact or conclusion of law. Furthermore, should this Agreement not be accepted by the Board, it is agreed that presentation to and consideration of this Agreement 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 these proceedings.

8. **No preclusion of additional proceedings** - Respondent and the Department fully understand that this Agreement and subsequent Final Order incorporating same will in no way preclude additional proceedings by the Board and/or the Department against Respondent for acts or omissions not specifically set forth in the Administrative Complaint attached as Exhibit A.

9. **Waiver of attorney's fees and costs** - Upon the Board's adoption of this Agreement, the parties hereby agree that with the exception of costs noted above, the parties 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 and the Board in connection with this matter.

10. **Waiver of further procedural steps** - Upon the Board's adoption of this Agreement, 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 Agreement and the Final Order of the Board incorporating said Agreement.

[*signatures appear on the following page*]

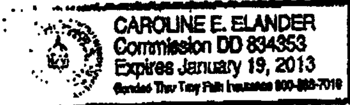
SIGNED this 18th day of December, 2012.

Ronald Kurlander, M.D.

STATE OF FLORIDA
COUNTY OF Broward

Before me, personally appeared Ronald H Kurlander, MD, whose identity is known to me or by ______________ (type of identification) and who, under oath, acknowledges that his/her signature appears above.

Sworn to and subscribed before me this 18th day of December, 2012.


CAROLINE E. ELANDER
Commission DD 834353
Expires January 19, 2013

NOTARY PUBLIC

My Commission Expires: Jan. 19, 2013

APPROVED this 20th day of December, 20__.

John H. Armstrong, MD, FACS, FCCP
State Surgeon General & Secretary
of Health, State of Florida

By: André Ourso
Assistant General Counsel
Department of Health

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**PETITIONER,**

**v.** **CASE NO. 2008-21704**

**RONALD HOWARD KURLANDER, M.D.,**

**RESPONDENT.**
_______________________________/

## ADMINISTRATIVE COMPLAINT

Petitioner, Department of Health, by and through its undersigned counsel, files this Administrative Complaint before the Board of Medicine against the Respondent, Ronald Howard Kurlander, M.D., and alleges:

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

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 33297.

3. Respondent's address of record is 1 West Sample Road, Suite 205, Pompano Beach, Florida 33064-3578.

4485

4. Respondent is not board certified in any American Medical Board specialties.

5. Vyvanse is the brand name for the drug lisdexamfetamine, which is prescribed to treat Attention Deficit Hyperactivity Disorder (ADHD). According to Section 893.03(2), Florida Statutes, lisdexamfetamine is a Schedule II controlled substance and has a currently accepted medical use in treatment in the United States. Lisdexamfetamine has a high potential for abuse. Abuse of the drug may lead to severe psychological or physical dependence.

6. Restoril is the brand name for temazepam and is prescribed to treat insomnia. According to Section 893.03(4), Florida Statutes, temazepam is a Schedule IV controlled substance and has a currently accepted medical use in treatment in the United States. Abuse of temazepam may lead to physical or psychological dependence.

7. On or about May 19, 2008, Respondent wrote a prescription for thirty (30) capsules of Vyvanse 70 mg for a patient identified on the prescription as R.H.

8. On or about July 31, 2008, Respondent wrote a prescription for four (4) capsules of Restoril 22.5 mg. for a patient identified on the prescription as R.H.

9. On or about August 10, 2008, Respondent wrote a prescription for four (4) capsules of Restoril 7.5 mg. for a patient identified on the prescription as R.H.

10. At all times material to this complaint, R.H. never presented to Respondent for medical reasons or was a patient of Respondent.

11. Respondent prescribed Vyvanse and/or Restoril in R.H.'s name despite the fact that Respondent never established a physician – patient relationship with R.H. and R.H. never requested the prescriptions or obtained the drugs.

12. Respondent prescribed Vyvanse and/or Restoril in R.H.'s name without:

a. Conducting a medical or psychiatric history;

b. Performing a physical examination;

c. Performing a psychiatric evaluation;

d. Assessing any complaints or symptoms;

e. Establishing justification to prescribe the drugs;

f. Instituting a course of treatment;

g. Initiating a satisfactory treatment plan;

h. Diagnosing any medical or psychiatric disorders;

i. Determining any likelihood of substance abuse;

j. Documenting or maintaining records of medical and psychiatric assessments, including but not limited to; histories, examinations, evaluations, test results, diagnoses, consultations, referrals, courses of treatment, treatment plans, patient invoices, and a record of drugs prescribed with documented justification for prescribing controlled substances.

13. R.H. asserted that Respondent prescribed the Vyvanse and/or Restoril in R.H.s name to save A.H., R.H.'s son and a patient of Respondent, money on medication.

**COUNT I**

14. Petitioner re-alleges and incorporates paragraphs one (1) through thirteen (13), as if fully set forth herein within this paragraph.

15. Section 458.331(1)(q), Florida Statutes (2007-2008), provides that 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 constitutes grounds for disciplinary action by the Board of Medicine. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

16. Respondent inappropriately prescribed Vyvanse and/or Restoril in R.H.'s name when R.H. was not a patient of Respondent or never established a reasonable physician-patient relationship with Respondent.

17. Based on the foregoing, Respondent has violated Section 458.331(1)(q), Florida Statutes (2007-2008), by prescribing Vyvanse and/or Restoril, in the name of R.H., inappropriately and not in the course of Respondent's professional practice.

**COUNT II**

18. Petitioner re-alleges and incorporates paragraphs one (1) through thirteen (13), as if fully set forth within this paragraph.

19. Section 458.331(1)(m), Florida Statutes (2008), provides that failing to keep legible medical records that justify the course of treatment

of a 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, constitutes grounds for disciplinary action by the Board of Medicine.

20. Rule 64B8-9.003, Florida Administrative Code (F.A.C.), which is part of the chapter of the Florida Administrative Code where the Board of Medicine establishes standards of care for physicians, provides in relevant part:

> **64B8-9.003 Standards for Adequacy of Medical Records.**
> (1) Medical records are maintained for the following purposes:
> (a) To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.
> (b) To furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition.
> (c) To document communication between the practitioner responsible for the patient and any other health care professional who contributes to the patient's care.
> (d) To assist in protecting the legal interest of the patient, the hospital, and the practitioner responsible for the patient.
> (2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.
> (3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from

other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

(4) All entries made into the medical records shall be accurately dated and timed. Late entries are permitted, but must be clearly and accurately noted as late entries and dated and timed accurately when they are entered into the record. However, office records do not need to be timed, just dated.

21. Respondent failed to keep medical records justifying his course of treatment of R.H., in one or more of the following ways:

a. By failing to document or maintain legible medical records that include a legitimate medical or psychiatric purpose justifying the prescribing of Vyvanse and/or Restoril to R.H.;

b. By failing to document or maintain legible medical records that include a legitimate medical or psychiatric purpose justifying the prescribing of Vyvanse and/or Restoril to R.H. without his knowledge, consent and/or without establishing a reasonable physician-patient relationship;

c. By failing to document or maintain legible medical records that include sufficient information to identify R.H.;

d. By failing to document or maintain legible medical records that include a diagnosis of Patient R.H.;

e. By failing to document or maintain legible medical records that

include an evaluation of R.H.'s condition and treatment;

f. By failing to document or maintain legible medical records with sufficient detail to clearly demonstrate why the course of treatment was undertaken for R.H.;

g. By failing to document or maintain legible medical records that include sufficient information justifying treatment of Patient R.H.;

h. By failing to document or maintain legible medical records that include sufficient information concerning R.H.'s patient history;

i. By failing to document or maintain legible medical records that include information concerning R.H.'s physical examination results;

j. By failing to document or maintain legible medical records that include information concerning R.H.'s evalutaions and test results;

k. By failing to document or maintain legible medical records that include drugs prescribed, dispensed, or administered to R.H.;

l. By failing to document or maintain legible medical records that include reports of consultations and referrals of R.H.;

m. By failing to document or maintain legible medical records that include any likelihood of R.H.'s substance abuse or drug diversion;

n. By failing to document or maintain legible medical records that

include sufficient information concerning copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining appropriate treatments;

o. By failing to keep medical records in compliance with Rule 64B8-9.003, F.A.C.

22. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2007-2008), by failing to accurately and completely document and maintain legible medical records that justified the course of treatment to R.H.

**COUNT III**

23. Petitioner re-alleges and incorporates paragraphs one (1) through thirteen (13), as if fully set forth within this paragraph.

24. Section 458.331(1)(k), Florida Statutes, (2007-2008), provides that making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine constitutes grounds for disciplinary action by the Board of Medicine.

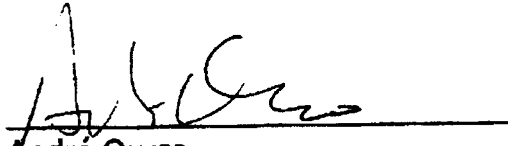
25. Respondent made deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employed a trick or scheme in the practice of medicine by writing prescriptions for Vyvanse and/or Restoril in R.H.'s name when R.H. was not a patient of Respondent or never established a reasonable physician-patient relationship with Respondent.

26. Based on the foregoing, Respondent violated Section 458.331(1)(k), Florida Statutes, (2007-2008), by making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine by prescribing Vyvnase and/or Restoril in R.H.'s name.

WHEREFORE, the Petitioner respectfully requests that the Board of Medicine enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 28th day of September, 2012.

John H. Armstrong, MD
State Surgeon General and Secretary of Health



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FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE OCT 02 2012

ACO/

PCP: September 28, 2012
PCP Members: Dr. Winchester, Dr. Thomas, Mr. Levine

## NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or his behalf if a hearing is requested.

## NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

AN-10

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE MAY 29 2012

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**

**DEPARTMENT OF HEALTH,**

**PETITIONER,**

**v.** **CASE NO. 2008-21706**

**RONALD HOWARD KURLANDER, M.D.,**

**RESPONDENT.**

## AMENDED ADMINISTRATIVE COMPLAINT

**COMES NOW**, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against the Respondent, Ronald Howard Kurlander, M.D., and in support thereof alleges:

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

2. At all times material to this Complaint, Respondent was a licensed physician within the State of Florida, having been issued license number ME 33297.

3. Respondent is not board certified in any American Medical Board specialties.

4. Respondent's address of record is 1 West Sample Road, Suite 205, Pompano Beach, Florida 33064-3578.

5. On or about July 31, 2008, Respondent wrote a prescription for seven capsules of Ambien CR 12.5 mg. for a "patient" identified on the prescription as B.H.

6. On or about August 10, 2008, Respondent wrote a prescription for four capsules of Restoril 7.5 mg. for a "patient" identified on the prescription as B.H.

7. Respondent prescribed these drugs to patient B.H. despite the fact that he had never met or spoken with Patient B.H., and this "patient" never requested the prescriptions or obtained the drugs.

8. Respondent prescribed Ambien and/or Restoril to Patient B.H. without:

a. Conducting a medical or psychiatric history;

b. Performing a physical examination;

c. Performing a psychiatric evaluation;

d. Assessing any complaints or symptoms;

e. Establishing justification to prescribe the drugs;

f. Instituting a course of treatment;

g. Initiating a satisfactory treatment plan;

h. Diagnosing any medical or psychiatric disorders;

i. Determining any likelihood of substance abuse;

j. Documenting or maintaining records of medical and psychiatric assessments, including histories, examinations, evaluations, test results, diagnoses, consultations, referrals, courses of treatment, treatment plans, patient invoices, and a record of drugs prescribed with documented justification for prescribing controlled substances.

9. Ambien is the brand name for the drug zolpidem, and is prescribed to treat insomnia. Ambien is a legend drug as defined by Section 465.003(8), Florida Statutes, and contains zolpidem tartrate. Zolpidem can cause dependence and is subject to abuse.

10. Restoril is the brand name for temazepam and is prescribed to treat insomnia. According to Section 893.03(4), Florida Statutes, temazepam is a Schedule IV controlled substance and has a

currently accepted medical use in treatment in the United States. Abuse of temazepam may lead to physical or psychological dependence.

**COUNT ONE**
**Section 458.331(1)(t)1.**

11. Petitioner re-alleges and incorporates paragraphs one (1) through ten (10), as if fully set forth herein within this paragraph.

12. Section 458.331(1)(t)1., Florida Statutes (2008), subjects a doctor to discipline for committing medical malpractice as defined in Section 456.50, Florida Statutes (2008), which provides that the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure.

13. For purposes of Section 458.331(1)(t)1., Florida Statutes (2008), the Board shall give great weight to the provisions of Section 766.102, Florida Statutes (2008), which provide that the prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant

surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

14. Respondent failed to practice medicine within the standard of care in the treatment of Patient B.H., in one or more of the following ways:

a. By failing to have a legitimate medical or psychiatric purpose to prescribe Ambien and/or Restoril to Patient B.H.;

b. By failing to have a legitimate medical or psychiatric purpose to prescribe Ambien and/or Restoril to Patient B.H. without his knowledge, consent and/or without establishing a reasonable doctor-patient relationship;

c. By failing to perform a complete, thorough and accurarte medical and psychiatric assessment of Patient B.H.;

d. By failing to perform a complete, thorough and accurarte medical or psychiatric history of Patient B.H.;

e. By failing to perform a complete and thorough medical and psychiatric history of Patient B.H. by not communicating with former health care professionals;

f. By failing to perform a complete and thorough physical

examination of Patient B.H.;

g. By failing to perform appropriate diagnostic tests, examinations, consultations, and psychiatric evaluations of Patient B.H.;

h. By failing to accurately diagnose Patient B.H. with a medical or psychiatric disorder to justify treatment and the prescribing of Ambien and/or Restoril;

i. By failing to practice with the level of care, skill, and treatment which, in light of all relevant surrounding circumstances, that is recognized as acceptable and appropriate by reasonably prudent similar health care providers;

j. By failing to practice medicine within the standard of care in the treatment of Patient B.H.

15. Based on the foregoing, Respondent has violated Section 458.331(1)(t)1., Florida Statutes (2008), by committing medical malpractice and breaching the standard of care.

**COUNT TWO**
**Section 458.331(1)(m)**

16. Petitioner re-alleges and incorporates paragraphs one (1) through ten (10), as if fully set forth within this paragraph.

17. Section 458.331(1)(m), Florida Statutes (2008), provides that failing to keep legible medical records that justify the course of treatment of a 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, constitutes grounds for disciplinary action by the Board of Medicine.

18. Rule 64B8-9.003, Florida Administrative Code (F.A.C.), which is part of the chapter of the Florida Administrative Code where the Board of Medicine establishes standards of care for physicians, provides in relevant part:

> **64B8-9.003 Standards for Adequacy of Medical Records.**
> (1) Medical records are maintained for the following purposes:
> (a) To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.
> (b) To furnish documentary evidence of the course of the

patient's medical evaluation, treatment, and change in condition.

(c) To document communication between the practitioner responsible for the patient and any other health care professional who contributes to the patient's care.

(d) To assist in protecting the legal interest of the patient, the hospital, and the practitioner responsible for the patient.

(2) A licensed physician shall maintain patient medical records in English, in a legible manner and with sufficient detail to clearly demonstrate why the course of treatment was undertaken.

(3) The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment and document the course and results of treatment accurately, by including, at a minimum, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; reports of consultations and hospitalizations; and copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining the appropriate treatment of the patient.

(4) All entries made into the medical records shall be accurately dated and timed. Late entries are permitted, but must be clearly and accurately noted as late entries and dated and timed accurately when they are entered into the record. However, office records do not need to be timed, just dated.

19. Respondent failed to keep medical records justifying his course of treatment of Patient B.H., in one or more of the following ways:

a. By failing to document or maintain legible medical records

that include a legitimate medical or psychiatric purpose justifying the prescribing of Ambien and/or Restoril to Patient B.H.;

b. By failing to document or maintain legible medical records that include a legitimate medical or psychiatric purpose justifying the prescribing of Ambien and/or Restoril to Patient B.H. without his knowledge, consent and/or without establishing a reasonable doctor-patient relationship;

c. By failing to document or maintain legible medical records that include sufficient information to identify Patient B.H.;

d. By failing to document or maintain legible medical records that include a diagnosis of Patient B.H.;

e. By failing to document or maintain legible medical records that include an evaluation of Patient B.H.'s condition and treatment;

f. By failing to document or maintain legible medical records with sufficient detail to clearly demonstrate why the course of treatment was undertaken for Patient B.H.;

g. By failing to document or maintain legible medical records that include sufficient information justifying treatment of Patient B.H.;

h. By failing to document or maintain legible medical records that documents the course and results of Patient B.H.'s treatment accurately;

i. By failing to document or maintain legible medical records that include sufficient information including Patient B.H.'s patient histories;

j. By failing to document or maintain legible medical records that include information concerning Patient B.H.'s examination results;

k. By failing to document or maintain legible medical records that include sufficient information concerning Patient B.H.'s test results;

l. By failing to document or maintain legible medical records that include drugs prescribed, dispensed, or administered to Patient B.H.;

m. By failing to document or maintain legible medical records that include copies of prescriptions written for Patient B.H.;

n. By failing to document or maintain legible medical records that include reports of consultations and hospitalizations of Patient

B.H.;

o. By failing to document or maintain legible medical records that include any history of Patient B.H.'s substance abuse or drug diversion;

p. By failing to document or maintain legible medical records that include sufficient information concerning copies of records or reports or other documentation obtained from other health care practitioners at the request of the physician and relied upon by the physician in determining appropriate treatments;

q. By failing to keep medical records in compliance with Rule 64B8-9.003, F.A.C.

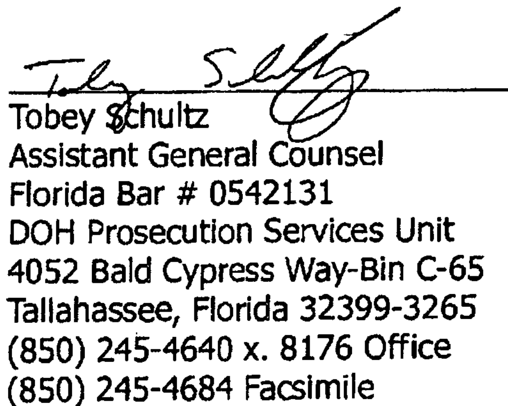
20. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes (2008), by failing to accurately and completely document and maintain legible medical records that justified the course of treatment.

**WHEREFORE**, the Petitioner respectfully requests that the Board of Medidne enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an

administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 25th day of May, 2012.

John H. Armstrong, MD
Surgeon General and Secretary of Health



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## NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or his behalf if a hearing is requested.

## NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.