STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

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

RONALD HOWARD KURLANDER, M.D.,

RESPONDENT.

_____/

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 at all times relevant to this complaint is: 1 West Sample Road, Suite 205, Pompano Beach, Florida 33064-3578.

5. From on or about April 22, 2008, until on or about August 25, 2008, Patient A.H., a then 18 year-old male, was being treated by Respondent for psychiatric disorders.

6. 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. Walgreens Pharmacy records reflect that the controlled substances were prescribed by Respondent and dispensed to Patient B.H.

7. 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. CVS pharmacy records reflect that the controlled substances were prescribed by Respondent and dispensed to Patient B.H.

8. Respondent prescribed these controlled substances 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 controlled substances. It was later learned that Patient B.H. is the brother of Patient A.H.

9. Respondent prescribed Ambien and/or Restoril, each a Schedule IV controlled substance, 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 controlled substances;

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 controlled substances prescribed with documented justification for prescribing controlled substances.

10. On or about October 22, 2008, their father R.H. initiated a complaint that alleged Respondent had inappropriately prescribed controlled substances to Patient A.H. under the name of his brother, Patient B.H, and in doing so Respondent also falsified written prescriptions.

11. Respondent confirmed to Patient A.H.'s father that he prescribed controlled substances intended for Patient A.H. to members of the patient's family, and that he did this in order for Patient A.H. to save money at the pharmacies when the controlled substances were dispensed to him based on the falsified prescription.

12. Patient A.H.'s family members did not consent, nor were they informed that perscriptions intended for Patient A.H. were being falsely written by Respondent in their names. None of the family members have ever been physically examined by Respondent. None of the family members sought any form of medical or psychiatric

treatment from Respondent or prescriptions for controlled substances.

13. 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, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Zolpidem can cause dependence and is subject to abuse.

14. 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, and abuse of temazepam may lead to physical or psychological dependence.

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

15. Petitioner re-alleges and incorporates paragraphs one (1) through fourteen (14), as if fully set forth herein this Count One.

16. Section 458.331(1)(t)1., Florida Statutes (2007-2008), subjects a doctor to discipline for committing medical malpractice as

defined in Section 456.50, Florida Statutes (2007-2008), 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.

17. For purposes of Section 458.331(1)(t)1., Florida Statutes (2007-2008), the Board shall give great weight to the provisions of Section 766.102, Florida Statutes (2007-2008), 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.

18. From on or about April 22, 2008, until on or about August 25, 2008, Respondent failed to practice medicine within the standard of care in the treatment of Patient A.H. and/or Patient B.H., in one or more of the following ways:

a. By failing to have a legitimate medical or psychiatric purpose for falsifying a written prescription for Schedule IV controlled substances;

b. By failing to have a legitimate medical or psychiatric

purpose to prescribe Ambien and/or Restoril to Patient B.H.;

c. 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;

d. By failing to have a legitimate medical or psychiatric purpose to prescribe Ambien and/or Restoril to Patient A.H. with Patient B.H.'s name inappropriately written on the prescription;

e. By failing to have a legitimate medical or psychiatric purpose to prescribe Ambien and/or Restoril to Patient B.H. which was to be inappropriately dispensed to Patient A.H.;

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

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

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

i. By failing to perform a complete and thorough physical

examination of Patient B.H.;

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

k. 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;

l. By prescribing Ambien and/or Restoril Patient A.H. (under Patient B.H.'s name) without performing a complete and accurate substance abuse assessment of patient A.H.

m. By prescribing Ambien and/or Restoril Patient A.H. (under Patient B.H.'s name) without referring Patient A.H. to a drug addiction specialist to determine whether Patient A.H. was at high risk for substance abuse;

n. 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;

o. By failing to practice medicine within the standard of care

in the treatment of Patient A.H. and/or Patient B.H.

17. Based on the foregoing, Respondent has violated Section 458.331(1)(t)1., Florida Statutes (2007-2008), by committing medical malpractice and breaching the standard of care.

COUNT TWO
Section 458.331(1)(q)

18. Petitioner re-alleges and incorporates paragraphs one (1) through fourteen (14), as if fully set forth herein.

19. Section 458.331(1)(q), Florida Statutes (2007-2008), subjects Respondent's license to discipline by the Board of Medicine, including suspension, for prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. It shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive 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 his intent.

20. From on or about April 22, 2008, until on or about August 25, 2008, Respondent inappropriately and/or excessively prescribed, dispensed, administered, mixed, or otherwise prepared controlled substances and legend drugs, other than in the course of his professional practice, in the treatment of Patient A.H. and/or Patient B.H., in one or more of the following ways:

a. By prescribing Ambien and/or Restoril, each a Schedule IV controlled substance, to Patient B.H. without a legitimate medical or psychiatric purpose based upon accepted scientific knowledge or based upon sound clinical grounds;

b. By prescribing Ambien and/or Restoril to Patient B.H. without his knowledge, consent and/or without establishing a reasonable doctor-patient relationship;

c. By prescribing Ambien and/or Restoril to Patient A.H. with a falsified prescription reflecting Patient B.H. as the patient;

d. By prescribing Ambien and/or Restoril to Patient B.H. without conducting a thorough medical and psychiatric assessment;

e. By prescribing Ambien and/or Restoril to Patient B.H. without conducting a thorough medical or psychiatric history;

f. By prescribing Ambien and/or Restoril to Patient B.H. without performing a complete and thorough physical examination and psychiatric evaluation;

g. By prescribing Ambien and/or Restoril to Patient B.H. without diagnosing Patient B.H. with a medical or psychiatric disorder;

h. By prescribing Ambien and/or Restoril to Patient B.H. without the presence of one or more recognized medical indications for the use of a controlled substance;

i. By prescribing Ambien and/or Restoril to Patient B.H. without first performing an accurate substance abuse assessment;

j. By prescribing Ambien and/or Restoril to Patient B.H. without first referring Patient A.H. to a drug addiction specialist to determine any high risk for substance abuse;

k. By prescribing Ambien and/or Restoril to Patient A.H. without first performing a complete and accurate substance abuse assessment;

l. By prescribing Ambien and/or Restoril to Patient A.H. without first referring Patient A.H. to a drug addiction specialist to

determine any high risk for substance abuse;

m. 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;

21. Based on the foregoing, the Respondent has violated Section 458.331(1)(q), Florida Statutes (2007-2008), by prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, to Patient A.H. and/or Patient B.H. inappropriately or excessively other than in the course of the physician's professional practice.

COUNT THREE

Section 458.331(1)(m)

22. Petitioner re-alleges and incorporates paragraphs one (1) through fourteen (14), as if fully set forth herein.

23. Section 458.331(1)(m), Florida Statutes (2007-2008), 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.

24. 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.

25. From on or about April 22, 2008, until on or about August 25, 2008, Respondent failed to keep medical records justifying his course of treatment of Patient A.H. and/or 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 justifing the prescribing of Ambien and/or Restoril to Patient B.H.;

b. By failing to document or maintain legible medical records that includes any legitimate justification for falsely prescribing Ambien and/or Restoril to Patient B.H.;

c. By failing to document or maintain legible medical records that include a legitimate medical or psychiatric purpose justifing the

prescribing of Ambien and/or Restoril to Patient B.H. without his knowledge, consent and/or without establishing a reasonable doctor-patient relationship;

d. By failing to document or maintain legible medical records that include a legitimate medical or psychiatric purpose justifing the prescribing of Ambien and/or Restoril to Patient A.H.;

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

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

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

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

i. 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.;

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

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

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

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

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

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

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

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

B.H.;

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

s. 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;

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

26. 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.

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 25th day of March, 2011.

Shairi R. Turner, M.D., M.P.H.
Acting State Surgeon General

Michael J. San Filippo
Assistant General Counsel
Florida Bar # 848719
DOH Prosecution Services Unit
4052 Bald Cypress Way-Bin C-65
Tallahassee, Florida 32399-3265
(850) 245-4640 Office
(850) 245-4681 Facsimile

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RONALD HOWARD KURLANDER, M.D., CASE NO. 2008-21706

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.