STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2009-11334
LICENSE NO.: ME0022507

WILLIAM J. ROMANOS, 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 December 2, 2011, in Orlando, Florida, for the purpose of considering a Settlement Agreement (attached hereto as Exhibit A) entered into between the parties in this cause. 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 $6,610.50.

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 12th day of December, 2011.

BOARD OF MEDICINE

Joy A. Tootle, Executive Director
For GEORGE THOMAS, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by U.S. Mail to WILLIAM J. ROMANOS, M.D., 900 South U.S. Highway 1, Suite 101, Jupiter, Florida 33477; to Mark A. Dresnick, Esquire, Dresnick, Rodriguez & Perry, P.A., One Datran Center, Suite 1610, 9100 South Dadeland Boulevard, Miami, Florida 33156-7817; and by interoffice delivery to Veronica Donnelly, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 14th day of December, 2011.

Deputy Agency Clerk

FLORIDA DEPARTMENT OF HEALTH

Rick Scott
Governor

H. Frank Farmer, Jr., MD, PhD, FACP
State Surgeon General

INTEROFFICE MEMORANDUM

DATE: December 9, 2011

TO: Cassandra Pasley, BSN, J.D., Bureau Chief
Health Care Practitioner Regulation

FROM: Joy A. Tootle, Executive Director
Board of Medicine

SUBJECT: Delegation of Authority

This is to advise you that while I am out of the office on Monday December 12, 2011, Crystal Sanford is delegated to serve as acting Executive Director for the Board of Medicine. Ms. Sanford can be reached at (850) 245-4132.

JAT

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v. **DOH Case No. 2009-11334**

WILLIAM J. ROMANOS, JR., M.D.,

Respondent,

_____/

SETTLEMENT AGREEMENT

William J. Romanos, Jr., 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 ME22507.

2. The Department charged Respondent with an Administrative Complaint that was filed and properly served upon Respondent with violations of

Chapter 458, Florida Statutes, and the rules adopted pursuant thereto. A true and correct copy of the Administrative Complaint is 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 Complaint, if proven, would constitute violations of Chapter 458, Florida Statutes, as alleged in the Administrative Complaint.

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 ten thousand dollars ($10,000.00) 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 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 ***six thousand twenty-five dollars and twenty-eight cents ($6,025.28), but shall not exceed seven thousand twenty-five dollars and twenty-eight cents ($7,025.28).*** 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 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. **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.

5. **Community Service** - Respondent shall perform fifty (50) hours of community service, within one year of the date of filing of the Final Order. Community Service shall be defined as the delivery of medical services directly to patients, or the delivery of other volunteer services in the community, without fee or cost to the patient or the entity, for the good of the people of the State of Florida. Community service shall be performed outside the physician's regular

practice setting. Respondent shall submit a written plan for performance and completion of the community service to the Probation Committee for approval prior to performance of said community service. Affidavits detailing the completion of community service requirements shall be filed with the Board as required by the Probation Committee.

6. **Continuing Medical Education – "Risk Management"** - Respondent shall complete five (5) hours of Continuing Medical Education in "Risk Management" within one (1) year of the date of filing of the Final Order. Respondent shall first submit a written request to the Probation Committee for approval prior to performance of said continuing medical education course(s). However, the Board has approved five (5) hours of risk management continuing education for attending the first day of a full Board of Medicine meeting.

7. **Continuing Medical Education** - Within two years of the date of the filing of a Final Order in this cause, Respondent shall attend ten (10) hours of Continuing Medical Education (CME) in long-term treatment of complex psychiatric patients and three (3) hours of CME in medical ethics within two (2) years.

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.

SIGNED this 22nd day of July, 2011.

WILLIAM J. ROMANOS, M.D.

Before me, personally appeared WILLIAM J. ROMANOS, whose identity is known to me by PERSONALLY KNOWN (type of identification) and who, under oath, acknowledges that his/her signature appears above.

Sworn to and subscribed before me this 22nd day of July, 2011.

NOTARY PUBLIC

My Commission Expires:

JOSEPHINE M. NORTH
MY COMMISSION # DD 997384
EXPIRES: August 3, 2014
Bonded Thru Notary Public Underwriters

APPROVED this 29 day of July, 2011.

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General
Department of Health

By: Diane K. Kiesling
Assistant General Counsel
Department of Health

A-06

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2009-11334**

WILLIAM J. ROMANOS, M.D.,

RESPONDENT.

_____/

ADMINISTRATIVE COMPLAINT

Petitioner, Department of Health, by and through undersigned counsel, files this Administrative Complaint before the Board of Medicine against Respondent, William J. Romanos, M.D., and in support thereof alleges:

1. Petitioner is the state department 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 medical doctor within the state of Florida, having been issued license number ME 22507.

3. Respondent's address of record is 900 South U.S. Highway 1, Suite 101, Jupiter, Florida 33477.

4. Respondent is board certified by the American Board of Addiction Medicine and practices psychiatry.

5. Respondent provided psychiatric treatment for patient J.P. (JP) from January 2000 through July 2009. The first history and initial evaluation on January 12, 2000, taken through JP, a then 18 year-old male, and his Mother, J.P.2, (Mother or JP2), was thorough. It included reference to different treatment episodes that JP had experienced prior to seeing the Respondent.

6. Respondent diagnosed JP as having a Schizoid personality type which predisposed him to having some psychotic symptoms. He noted no family history or psychiatric or additional problems. Respondent noted that JP's hallucinations were affected by his use of a significant amount of drugs. The diagnosis was Substance Induced Psychotic Disorder. JP was taking Zyprexa and Neurontin and Respondent planned to taper those drugs over time.

7. Zyprexa contains olanzepine. Olanzepine is a legend drug, available only by prescription. Olanzepine is an antipsychotic drug that

acts on the chemicals in the brain. Olanzepine is commonly used to treat schizophrenia and bipolar disorder.

8. Neurontin, the brand name for Gabapentin, is a pharmaceutical drug, specifically a GABA analogue. It was originally developed for the treatment of epilepsy, and currently, is widely used to relieve pain, especially neuropathic pain, as well as major depressive disorder.

9. Treatment subsequent to the initial visit was primarily through JP2 as the informant, even though JP was a competent adult. JP was quite capable expressing himself and was working on the computer; it was Respondent's impression that JP was impaired, but would be able to become quite functional, given his intellect and ability with computers.

10. It was well known to Respondent early on in his treatment of JP (at least by March of 2000) that JP was using illicit drugs, primarily marijuana. However, at no time did Respondent order any laboratory tests to monitor JP's use of illicit drugs.

11. Additionally, Respondent continued to prescribe Zyprexa which is known to cause weight gain and glucose control problems. At no time did he ever order laboratory tests to check JP's blood sugar nor did he monitor JP's weight.

12. In May of 2000, Respondent started JP on Zoloft 100 mg per day for depression in addition to his other medications. Zoloft contains Sertraline. Sertraline is a legend drug, available only by prescription and is in the selective seratonin reuptake inhibitor (SSRI) class. Sertraline is effective for the treatment of depression and certain types of anxiety disorders.

13. In June of 2000, JP was doing better and finished school with an A and B-. He was starting to gain weight.

14. In August 2000, JP was "doing better" and Respondent "continued" him on Zyprexa, Depakote, and Zoloft. There was no explanation of when or why Depakote was added to JP's medications.

15. Depakote is the brand name for divalproex sodium, a compound of sodium valproate and valproic acid used for the treatment of the manic episodes of bipolar disorder. In rare cases, it is also used as a treatment for major depressive disorder, and increasingly taken long-term for prevention of both manic and depressive phases of bipolar disorder, especially the rapid-cycling variant. It is also used for the treatment of epilepsy, chronic pain associated with neuropathy, and migraine headaches.

16. Because of potential effects of Depakote, laboratory monitoring is necessary. Respondent never ordered liver function tests, a complete blood count, or a Depakote level.

17. On August 28, 2000, Respondent testified in Court that the goal was to separate JP from his Mother and have him become more independent by finding a group home for him, because stress with JP2 contributed to his condition.

18. JP was Baker Acted three times before the next recorded appointment with Respondent on April 9, 2002, at which time, JP was off of his Zoloft, but taking his other medications. However, JP had plans to look for work.

19. JP was Baker Acted three times in August and September of 2002 and then seen by Respondent on October 8, 2002, at which time he was hypomanic and had not slept for three days. He was taking 40 mg of Zyprexa and 1,200 to 1,800 mg of Neurontin per day and was still smoking marijuana. He had smashed all his computers and was hospitalized because he was psychotic. Respondent prescribed 10 mg of Haldol per hour until JP slept.

20. Haldol is one brand name for Haloperidol, which is an older antipsychotic used in the treatment of schizophrenia and, more acutely, in the treatment of acute psychotic states and delirium.

21. On December 2, 2002, Respondent lowered JP's Neurontin to 600 mg per day, with no notes as to the reason for the change.

22. Between December of 2002 and January 14, 2004, Respondent did not see JP personally, but relied solely on reports from JP's Mother to assess the patient's condition. Throughout that time, Respondent continued to prescribe medications and change medications.

23. Between January 14, 2004, and July 10, 2006, Respondent rarely saw JP and received most of his information from JP's Mother. However, throughout that time, Respondent continued to prescribed Xanax, Zyprexa, and Diphenhydrime, a drug used for the treatment of extrapyramidal side effects of many antipsychotics, such as the tremors that haloperidol can cause.

24. Xanax is the brand name for alprazolam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, alprazolam is a Schedule IV controlled substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States. Abuse of alprazolam may

lead to limited physical or psychological dependence relative to the substances in Schedule III.

25. JP's last visit with Respondent in 2005 was March of 2005, at which time he was described as "focused, not psychotic, and less depressed." His Zyprexa dose had been decreased to 10 mg due to depression and fatigue.

26. In a fax from JP's Mother to the Respondent dated May 13, 2006, the Mother advised that she was making decisions about when and how much medication to give JP based on what she thought was appropriate at the time and that JP took medication whenever he felt like it, anywhere from ½ to 4 pills a day. She asked if this method of taking Xanax was acceptable and what was the maximum he could take before she had to worry about an overdose. She described JP as being delusional at times.

27. On June 2, 2006, JP was Baker Acted, but Respondent did not see him after his release. Instead, Respondent rewrote prescriptions for Zyprexa and allowed a refill of Xanax.

28. On July 10, 2006, the Mother brought JP into Respondent's office. Respondent's notes document the Mother's behavior and say nothing about his patient, JP. He documented that she was "very, very

upset. She is out of control. She cannot function anymore with her son. He needs to leave the house so we are admitting him to St. Mary's. . . . She almost had a breakdown here in front of me. We gave her 1 mg of Klonopin right away and it calmed her down. . . ." JP was admitted. Respondent documented no assessment of JP.

29. On July 17, 2006, the Mother wrote to Respondent with a letter she wanted him to send to the Court, seeking an order that the Father pay for intensive and extensive inpatient treatment. On that same date, without examining JP or determining the accuracy of some of the statements in that letter, Respondent put the letter on his letterhead and facilitated it's filing with the court.

30. Had the Respondent contacted the Father as the Father had requested on numerous occasions, he would have found out that the Father had insurance and only needed a determination that JP still qualified as a dependent based on his medical condition.

31. JP was hospitalized for inpatient treatment from September 5, 2006, to October 4, 2006. At that time, the focus of the medical treatment team was to taper JP off the Xanax which he had been misusing. By the end of the stay, he was discharged on Zyprexa and Trileptal. The discharge plans also included him going to live in a therapeutic setting and not with

his Mother, because the treatment team concluded it was counter-therapeutic for him to live with his Mother.

32. Despite the discharge plan and the findings that JP was misusing Xanax (a finding that was supported by Respondent's own notes), Respondent began prescribing Xanax to JP again on or about November 18, 2006, and continued to do so through 2009.

33. According to his notes, Respondent saw JP twice in 2007 and JP was doing well on Zyprexa 10 mg. On March 15, 2007, he prepared a letter to the Court that said JP's Father had never called him or requested information over a 3½ year period and if the Father had, Respondent would have gladly given the Father information about his son. The Mother altered the letter with the acquiescence of the Respondent.

34. In testimony to the Court on March 27, 2007, Respondent made some misrepresentations, the most notable of which are as follows: that he authored a letter dated March 15, 2007, which was actually authored by the Mother; that he saw JP in treatment "once every month or two months for medication", when, in fact, he did not remember seeing JP on March 8, 2007, and there was only one treatment date documented for all of 2006, and three for all of 2005.

35. The Mother faxed Respondent the day after the hearing and attempted to give him explanations to rationalize all of his misrepresentations and misstatements in Court.

36. JP's Father was in communication with Respondent and was trying to be involved in his son's treatment. The Father also regularly requested copies of his son's medical records beginning on January 12, 2004.

37. Respondent saw JP on May 3, 2007, and noted that he was doing well on Zyprexa 10 mg. That was the last documented visit until July 14, 2009, even though Respondent filled and refilled JP's Zyprexa and Xanax monthly through September 20, 2009.

38. In summary, throughout Respondent's treatment of JP, he did not follow up consistently with JP to treat his condition adequately. Instead, he relied heavily on the Mother's statements of symptoms to treat and prescribe even though JP was an adult and able to articulate himself well enough to allow an assessment of his condition on a regular basis.

39. Respondent failed to conduct necessary laboratory tests to manage JP medically, including complete metabolic panels, liver function tests, and toxicology screens to determine the actual cause of the

symptoms and, therefore, provide treatment that would be appropriate for the symptoms while improving his quality of life.

40. Respondent originally documented a treatment plan for JP to become more independent of his Mother; however, this treatment plan appears to have been abandoned along the way with no explanation. Instead, Respondent's treatment encouraged and fostered the dependence of JP on his Mother for medications and guidance.

41. Subsequent to the first visit, Respondent chose to get clinical data from the Mother regarding JP's symptoms and not by speaking directly with JP. By doing so, it is impossible to determine if Respondent was treating JP for the symptoms and conditions JP was actually experiencing.

42. Respondent conspired with the Mother, either overtly or tacitly, to deny the Father access to JP's records and involvement in JP's treatment.

43. Respondent is not Board certified in Psychiatry. Based on the failure of his treatment over the more than nine years in his treatment of JP, Respondent should have referred JP for a complete consult with a Board Certified Psychiatrist.

44. Respondent changed medications and dosages between appointment times with no documented, rational explanations. There are

multiple appointments where JP was on one medication and it was changed to another without any clinical rationale for the change.

45. Respondent allowed the Mother to exercise control over medication dosage and type because he knew that she was administering medications at times and dosages other than as prescribed. He did not document educating her about the inappropriateness of this practice.

COUNT ONE

46. Petitioner realleges and incorporates paragraphs one (1) through forty-five (45) as if fully set forth herein.

47. Section 458.331(1)(t), Florida Statutes (2000, 2004), provides that gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances constitutes grounds for disciplinary action by the Board of Medicine.

48. Section 458.331(1)(t)1., Florida Statutes (2005-2009), provides that committing medical malpractice as defined in Section 456.50 constitutes grounds for disciplinary action by the Board of Medicine. Section 456.50, Florida Statutes (2005-2009), 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.

49. Level of care, skill, and treatment recognized in general law related to health care licensure means the standard of care specified in Section 766.102. Section 766.102(1), Florida Statutes (2005-2007), defines the standard of care to mean " . . . 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. . . ."

50. Respondent failed to meet the prevailing standard of care in his treatment of Patient JP in one or more of the following ways:

a. By failing to adequately monitor JP through laboratory testing;

b. By prescribing medications and changing medications without adequate clinical rationale for doing so;

c. By failing to follow his treatment plan of moving JP to more independent living away from his Mother;

d. By routinely prescribing medications based on faxed and telephonic reports from the Mother and without seeing JP for an appropriate assessment;

e. By allowing the Mother to make decisions about medication dosages administered by her to JP;

f. By Baker Acting JP on July 10, 2006, without any assessment of JP's condition, instead relying on the Mother's report about her mental condition;

g. By using the Mother's letter dated July 17, 2006, as his own without determining the accuracy of many statements therein, knowing the letter was being submitted to the Court as his report;

h. By failing to follow the discharge plan after JP had been hospitalized for inpatient treatment from September 5, 2006, to October 4, 2006, when he failed to help place JP in a therapeutic setting away from his Mother and when he prescribed Xanax despite the hospital's having taken JP off of Xanax because of long term misuse (a fact that Respondent recognized);

i. By maintaining JP on Xanax throughout 2009 even though he knew that JP was misusing Xanax for non-therapeutic reasons;

j. By engaging in treatment of JP that encouraged and fostered dependence on his Mother for medications and guidance;

k. By relying on the Mother for clinical data in making decisions about JP's treatment instead of speaking directly with JP;

l. By conspiring with the Mother, either overtly or tacitly, to deny the Father access to JP's records and involvement in JP's treatment;

m. By failing to refer JP to a Board Certified Psychiatrist when it became clear that his treatment was not working and that JP was descending further into serious mental illness.

51. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (2000, 2004), by failing to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances and Section 458.331(1)(t)1., Florida Statutes (2005-2009), by committing medical malpractice.

COUNT TWO

52. Petitioner realleges and incorporates paragraphs one (1) through forty-five (45) as if fully set forth in this count.

53. Section 458.331(1)(m), Florida Statutes (2000-2009), provides that failing to keep legible medical records 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 constitutes grounds for disciplinary action by the Board of Medicine.

54. Respondent failed to keep medical records that justified the course of treatment of JP in one or more of the following ways:

a. By failing to document the clinical justification for medication changes;

b. By failing to document a new treatment plan as JP's condition continued to deteriorate;

c. By failing to document why he continued to see JP when the Mother was failing to follow the treatment and medication regime prescribed;

d. By documenting a letter to the Court dated July 17, 2006, as his own, even though it was written by the Mother and even

though he had not examined or assessed JP prior to submitting the letter;

f. By failing to document his reasons for prescribing Xanax on November 18, 2006, after JP's release from inpatient treatment, when he knew that JP was misusing Xanax and had been tapered off of Xanax for therapeutic reasons;

g. By failing to document his reasons for continuing to prescribe Xanax to JP from November 18, 2006, through 2009, even though he know that JP was misusing Xanax;

h. By failing to document laboratory orders or test results throughout his treatment of JP.

55. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2000-2009), by failing to keep legible medical records 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.

COUNT THREE

56. Petitioner realleges and incorporates paragraphs one (1) through forty-five (45) as if fully set forth in this count.

57. Section 458.331(1)(k), Florida Statutes (2006), 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.

58. Respondent made untrue representations in or related to the practice of medicine in one or more of the following ways:

a. By submitting a letter to the Court on July 17, 2006, on his letterhead that had been written by the Mother when he knew, or on reasonable investigation could have ascertained, that some of the statements therein were false;

b. By misrepresenting to the Court in his letter dated March 15, 2007, (which had actually been authored by the Mother), that the Father has never called him or requested information over a 3½ year period, when that information was false;

c. By acquiescing in the Mother's alteration of the March 15, 2007, letter before it was submitted to the Court;

d. By testifying on March 27, 2007, that he had authored the March 15, 2007, letter, when it had been written by the Mother;

e. By testifying on March 27, 2007, that he saw JP in treatment "once every month or two months for medication", when that testimony was false.

59. Based on the foregoing, Respondent has violated Section 458.331(1)(k), Florida Statutes (2006), by making deceptive, untrue, or fraudulent representations in or related to the practice of medicine.

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 29th **day of** April, **2011.**

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General

Carol L. Gross for

Diane K. Kiesling
Assistant General Counsel
DOH-Prosecution Services Unit
4052 Bald Cypress Way-Bin C-65
Tallahassee, Florida 32399-3265
Florida Bar # 233285
(850) 245-4640
(850) 245-4681 fax

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK

DKK CLERK Sandra Soto
DATE MAY 0 2 2011

PCP: April 29, 2011

PCP Members: El-Bahri, Tucker, Mullins

DOH v. William J. Romanos, M.D., DOH Case No. 2009-11334

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 her 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.