Final Order No. DOH-15-0350- S - MQA
FILED DATE MAR 03 2015
Department of Health
By: Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF MEDICINE

DEPARTMENT OF HEALTH,

Petitioner,

vs.

DOH CASE NO.: 2011-18838
LICENSE NO.: ME0036112

FRANCISCO JOSE PAGES, 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 February 6, 2015, in Stuart, 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 full advised in the premises, the Board rejected the Settlement Agreement and offered a Counter Settlement Agreement which Respondent was given 7 days to accept. By correspondence dated March 2, 2015, counsel for Respondent accepted the Board's Counter Settlement Agreement on behalf of Respondent. The Counter Settlement Agreement incorporates the original Settlement Agreement with the following amendments:

1. The costs set forth in Paragraph 3 of the Stipulated Disposition shall be set at $7,869.63.

2. Within one year of entry of the Final Order in this matter, Respondent shall undergo an evaluation by Florida CARES, or a board-approved equivalent evaluator, and personally appear before the Board (Probation Committee) with said evaluation and the evaluator's recommendations. If the evaluator recommends that Respondent undergo further evaluation for an impairment issue, such evaluation must be done under the auspices of the Professionals Resource Network (PRN). The probation set forth in Paragraph 8 of the Stipulated Disposition shall remain in effect until the Respondent appears before the Board with the Florida CARES evaluation. Upon review of the evaluation, the Board shall set forth terms of remediation and may impose additional terms and conditions on Respondent's practice and may extend the period of probation with terms and conditions to be set forth at such time.

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 amendments set forth above. Accordingly, the parties shall adhere to and abide by all the terms and conditions of the Settlement Agreement as amended.

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

DONE AND ORDERED this 3rd day of March, 2015.

BOARD OF MEDICINE

André Ourso, J.D., M.P.H., Executive Director
For James Orr, Jr., 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 FRANCISCO JOSE PAGES, M.D., 1900 Coral Way, #405, Coral Gables, Florida 33145; to Phillip Goss, Esquire, 1172 South Dixie Highway, Coral Gables, Florida 33146-2918; and by interoffice delivery to Daniel Hernandez, Department of Health, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3253 this 3rd. day of March, 2015.

Angel Sanders

Deputy Agency Clerk

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

Petitioner,

v. **DOH Case No. 2011-18838**

FRANCISCO JOSE PAGES, M.D.,

Respondent.
_____/

SETTLEMENT AGREEMENT

Francisco Jose Pages, 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 36112.

2. The Department charged Respondent with an Administrative Complaint that was filed and properly served upon Respondent alleging 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. For purposes of these proceedings, Respondent neither admits nor denies the allegations of fact contained in the Administrative Complaint.

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.

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

STIPULATED DISPOSITION

1. **Reprimand** - The Board shall issue a Reprimand against Respondent's license.

2. **Fine** - The Board shall impose an administrative fine of ***Twenty-Five Thousand Dollars ($25,000.00)*** against Respondent's license which Respondent shall pay to: Payments, Department of Health, Compliance Management Unit, Bin C-76, P.O. Box 6320, Tallahassee, FL 32314-6320, within thirty (30) days from the date of filing of the Final Order accepting this Agreement ("Final Order"). **All fines shall be paid by cashier's check or money order.** Any change in the terms of payment of any fine imposed by the Board **must be approved in advance by the Probation Committee of 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 IN THIS SETTLEMENT AGREEMENT. SPECIFICALLY, IF RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER THAT THE FULL AMOUNT OF THE FINE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL RESPONDENT RECEIVES SUCH WRITTEN CONFIRMATION FROM THE BOARD.

3. **Reimbursement of Costs** - Pursuant to Section 456.072, Florida Statutes, Respondent agrees to pay the Department for the Department's costs incurred in the investigation and prosecution of this case ("Department costs"). Such costs exclude the costs of obtaining supervision or monitoring of the practice, the cost of quality assurance reviews, any other costs Respondent incurs to comply with the Final Order, and the Board's administrative costs directly associated with Respondent's probation, if any. Respondent agrees that the amount of Department costs to be paid in this case is ***Seven Thousand Four Hundred Seventy-nine Dollars and Eighty-three Cents ($7,479.83), but shall not exceed Nine Thousand Four Hundred Seventy-nine Dollars and Eighty-three Cents ($9,479.83).*** Respondent will pay such Department costs to: Payments, Department of Health, Compliance Management Unit, Bin C-76, P.O. Box 6320, Tallahassee, FL 32314-6320, within thirty (30) days from the date of filing of the Final Order. **All costs shall be paid by cashier's check**

or money order. Any change in the terms of payment of costs imposed by the Board **must be approved in advance by the Probation Committee of the Board**.

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 IN THIS SETTLEMENT AGREEMENT. SPECIFICALLY, IF RESPONDENT HAS NOT RECEIVED WRITTEN CONFIRMATION WITHIN 45 DAYS OF THE DATE OF FILING OF THE FINAL ORDER THAT THE FULL AMOUNT OF THE COSTS NOTED ABOVE HAS BEEN RECEIVED BY THE BOARD OFFICE, RESPONDENT AGREES TO CEASE PRACTICE UNTIL RESPONDENT RECEIVES SUCH WRITTEN CONFIRMATION FROM THE BOARD.

4. **Laws And Rules Course** - Within eighteen (18) months of the filing of the Final Order, Respondent shall complete the 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, and shall submit documentation of such completion, in the form of certified copies of the receipts, vouchers, certificates, or other official proof of completion, to the Board's Probation Committee.

5. **Drug Course** – Within one (1) year of the date of filing of the Final Order, 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, and shall submit documentation of such completion, in the

form of certified copies of the receipts, vouchers, certificates, or other official proof of completion, to the Board's Probation Committee.

6. **Records Course** - Within one (1) year of the date of filing of the Final Order, Respondent shall complete the course "Quality Medical Record Keeping for Health Care Professionals" sponsored by the Florida Medical Association, or a Board-approved equivalent, and shall submit documentation of such completion, in the form of certified copies of the receipts, vouchers, certificates, or other official proof of completion, to the Board's Probation Committee.

7. **Continuing Medical Education – "Risk Management"** – Respondent shall complete this requirement and document such completion within one (1) year of the date of filing of the Final Order. **Respondent shall satisfy this requirement in one of the two following ways:**

(a) Respondent shall complete five (5) hours of CME in "Risk Management" after first obtaining written advance approval from the Board's Probation Committee of such proposed course, and shall submit documentation of such completion, in the form of certified copies of the receipts, vouchers, certificates, or other official proof of completion, to the Board's Probation Committee; or

(b) Respondent shall complete (5) five hours of CME in risk management by attending one full day or eight (8) hours, whichever is more, of disciplinary hearings at a regular meeting of the Board of Medicine. In order to receive such credit, Respondent must sign in with the Executive Director of the Board before the meeting day begins, Respondent must remain in continuous attendance during the

full day or eight (8) hours of disciplinary hearings, whichever is more, and Respondent must sign out with the Executive Director of the Board at the end of the meeting day or at such other earlier time as affirmatively authorized by the Board. Respondent may not receive CME credit in risk management for attending the disciplinary hearings portion of a Board meeting unless the Respondent is attending the disciplinary hearings portion for the **sole** purpose of obtaining the CME credit in risk management. In other words, Respondent may not receive such credit if appearing at the Board meeting for any other purpose, such as pending action against Respondent's medical license.

8. **Probation Language** – Effective on the date of the filing of the Final Order, Respondent's license to practice medicine shall be placed on probation for a period of two (2) years. The purpose of probation is not to prevent Respondent from practicing medicine. Rather, probation is a supervised educational experience designed by the Board to make Respondent aware of certain obligations to Respondent's patients and the profession and to ensure Respondent's continued compliance with the high standards of the profession through interaction with another physician in the appropriate field of expertise. To this end, during the period of probation, Respondent shall comply with the obligations and restrictions set forth in this paragraph.

(a) Indirect Supervision - Respondent shall practice only under the indirect supervision of a Board-approved physician, hereinafter referred to as the "Monitor," whose responsibilities are set by the Board. Indirect supervision does not require that the Monitor practice on the same premises as Respondent; however, the Monitor shall practice within a reasonable geographic proximity to Respondent, which

shall be within 20 miles unless otherwise provided by the Board, and shall be readily available for consultation. The Monitor shall be Board Certified, and actively engaged, in Respondent's specialty area unless otherwise provided by the Board. Respondent shall allow the Monitor access to Respondent's medical records, calendar, patient logs or other documents necessary for the Monitor to perform the duties set forth in this Paragraph.

(b) Restriction - Respondent shall not practice medicine without an approved Monitor/Supervisor, as specified in this Agreement, unless otherwise ordered by the Board.

(c) Eligibility of Monitor/Supervisor - The Monitor/Supervisor must be a licensee under Chapter 458, Florida Statutes, in good standing and without restriction or limitation on his/her license. In addition, the Board may reject any proposed Monitor/Supervisor on the basis that he/she has previously been subject to any disciplinary action against his/her medical license in this or any other jurisdiction, is currently under investigation, or is the subject of a pending disciplinary action. The Board may also reject any proposed Monitor/Supervisor for good cause shown.

(d) Temporary Approval of Monitor/Supervisor - The Board confers authority on the Chairman of the Probation Committee to temporarily approve Respondent's Monitor/Supervisor. To obtain temporary approval, Respondent shall submit to the Chairman of the Probation Committee the name and curriculum vitae of the proposed monitor/supervisor at the time this agreement is considered by the Board. **Once a Final Order adopting the Agreement is filed, Respondent shall not**

practice medicine without an approved Monitor/Supervisor. Temporary approval shall only remain in effect until the next meeting of the Probation Committee.

(e) Formal Approval of Monitor/Supervisor - Prior to the consideration of the Monitor/Supervisor by the Probation Committee, Respondent shall provide a copy of the Administrative Complaint and Final Order in this case to the Monitor/Supervisor. Respondent shall submit a copy of the proposed Monitor/Supervisor's current curriculum vita and a description of his/her current practice to the Board office no later than fourteen (14) days before Respondent's first scheduled probation appearance. Respondent shall ensure that the Monitor/Supervisor is present with Respondent at Respondent's first appearance before the Probation Committee. **It shall be Respondent's responsibility to ensure the appearance of the Monitor/Supervisor as directed.** If the Monitor/Supervisor fails to appear as required, this shall constitute a violation of this Settlement Agreement and shall subject Respondent to disciplinary action.

(f) Change In Monitor/Supervisor - In the event that the Monitor/Supervisor is unable or unwilling to fulfill the responsibilities of a Monitor/Supervisor as described above, Respondent shall immediately advise the Probation Committee of this fact and submit the name of a temporary Monitor/Supervisor for consideration. **Respondent shall not practice pending approval of the temporary Monitor/Supervisor by the Chairman of the Probation Committee.** Furthermore, Respondent shall make arrangements with his

temporary Monitor/Supervisor to appear before the Probation Committee at its next regularly scheduled meeting. Respondent shall only practice under the auspices of the temporary Monitor/Supervisor (after approval by the Chairman) until the next regularly scheduled meeting of the Probation Committee at which the formal approval of Respondent's new Monitor/Supervisor shall be addressed.

(g) Responsibilities of Respondent - In addition to the other responsibilities set forth in this Agreement, Respondent shall be solely responsible for ensuring that:

(1) The Monitor/Supervisor submits tri-annual reports as required by this Agreement or directed by the Board;

(2) Respondent submits tri-annual reports as required by this Agreement or directed by the Board;

(3) The Monitor/Supervisor appears before the Probation Committee as required by this Agreement or directed by the Board; and

(4) Respondent appears before the Probation Committee as required by this Agreement or directed by the Board.

Respondent understands and agrees that if either the approved Monitor/Supervisor or the Respondent fails to appear before the Probation Committee as required, Respondent shall immediately cease practicing medicine until such time as both the approved Monitor/Supervisor (or approved alternate) and the Respondent appear before the Probation Committee.

(h) Responsibilities of the Monitor/Supervisor - The Monitor/Supervisor shall:

(1) Review fifty (50%) percent of Respondent's active patient records at least once every month for the purpose of ascertaining whether Respondent is prescribing psychiatric medications in appropriate quantities and dosages, and whether Respondent is accurately documenting the patients' medical records supporting the diagnoses given and medications prescribed. The Monitor shall go to Respondent's office once every month and shall review Respondent's calendar or patient log and shall select the records to be reviewed.

(2) Review **all** of Respondent's patient records for patients treated for psychological disorders with controlled substances listed in Scheduled II, III, and/or IV. In this regard, Respondent shall maintain a log documenting all such patients.

(3) Maintain contact with Respondent on a frequency of at least once per month. In the event that Respondent does not timely contact the Monitor, the Monitor shall immediately report this fact in writing to the Probation Committee.

(4) Submit reports to the Probation Committee on a tri-annual basis, in affidavit form, which shall include:

a. A brief statement of why Respondent is on probation;

b. A description of Respondent's practice (type and composition);

c. A statement addressing Respondent's compliance with the terms of probation;

d. A brief description of the Monitor/Supervisor's relationship with Respondent;

e. A statement advising the Probation Committee of any problems that have arisen; and

f. A summary of the dates the Monitor/Supervisor went to Respondent's office, the number of records reviewed, the overall quality of the records reviewed, and the dates Respondent contacted the Monitor/Supervisor pursuant to Subparagraph (i)(4), above.

(5) Report immediately to the Board any violations by Respondent of Chapters 456 or 458, Florida Statutes, and the rules promulgated thereto.

(i) Respondent's Required Appearance Before Probation Committee - Respondent shall appear before the Probation Committee at the **first** meeting of said Committee following commencement of the probation, at the **last** meeting of the Committee preceding scheduled termination of the probation, **and** at such other times as directed by the Committee. Respondent shall be noticed by the Board staff of the date, time and place of the Committee meeting at which Respondent's appearance is required. **Failure of Respondent to appear as directed, and/or failure of Respondent to comply with any of the terms of this Agreement, shall be considered a violation of the terms of this Agreement, and shall subject Respondent to disciplinary action.**

(j) Monitor/Supervisor's Required Appearance - Respondent's Monitor/Supervisor shall appear before the Probation Committee at the first meeting of

said Committee following commencement of the probation, and at such other times as directed by the Committee. It shall be Respondent's responsibility to ensure the appearance of Respondent's monitor to appear as directed. **If the approved Monitor/Supervisor fails to appear as directed by the Probation Committee, Respondent shall immediately cease practicing medicine until such time as the approved Monitor/Supervisor or alternate approved monitor appears before the Probation Committee.**

(k) Reporting by Respondent - Respondent shall submit tri-annual reports, in affidavit form, the contents of which may be further specified by the Board, but which shall include:

(1) A brief statement of why Respondent is on probation;

(2) A description of practice location;

(3) A description of current practice (type and composition);

(4) A brief statement of compliance with probationary terms;

(5) A description of the relationship with the Monitor/Supervisor;

(6) A statement advising the Board of any problems that have arisen; and

(7) A statement addressing compliance with any restrictions or requirements imposed.

(l) Tolling Provisions - In the event Respondent physically leaves the State of Florida for a period of thirty (30) days or more or otherwise does not engage full-time in the active practice of medicine in the State of Florida, then certain provisions

of Respondent's probation (and only those provisions of the probation) shall be tolled as enumerated below and shall remain in a tolled status until Respondent returns to active practice in the State of Florida:

(1) The time period of probation shall be tolled;

(2) The provisions regarding indirect supervision and required reports from the monitor/supervisor shall be tolled;

(3) The provisions regarding preparation of investigative reports detailing compliance with this Settlement Agreement shall be tolled; and

(4) Any provisions regarding community service shall be tolled.

(m) Active Practice - In the event that Respondent leaves the active practice of medicine for a period of one year or more, the Board may require Respondent to appear before the Board and demonstrate his ability to practice medicine with skill and safety to patients prior to resuming the practice of medicine in this State.

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 Agreement Respondent shall first submit a written request to the Probation Committee for approval prior to performance of said CME course(s). Respondent shall submit documentation to the Board's Probation Committee of having completed a CME course 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 filing of the Final Order in this matter. All such documentation shall be sent to the Board's Probation Committee, 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. CME hours required by this Agreement shall be in addition to those hours required for renewal of licensure. Unless otherwise approved by the Board's Probation Committee, such CME course(s) shall consist of a formal, live lecture format.

4. **Addresses** - Respondent must provide current residence and practice addresses to the Board. Respondent shall notify the Board in writing within ten (10) days of any changes of said addresses and shall also comply with all statutory requirements related to practitioner profile and licensure renewal updates.

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** - 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 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 Department 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 11 day of DECEMBER 2014.

Francisco Jose Pages, M.D.

STATE OF FLORIDA
COUNTY OF Miami Dade

BEFORE ME personally appeared Francisco Jose Pages, M.D., whose identity is known to me or who produced Florida Drivers License (type of identification) and who, under oath, acknowledges that his/her signature appears above.

SWORN TO and subscribed before me this 11th day of December 2014.

Reyna C. Araica
COMMISSION # FF106799
EXPIRES: April 1, 2018
WWW.AARONNOTARY.COM

NOTARY PUBLIC

My Commission Expires:

APPROVED this 12th day of December, 2014.

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

By: Louise Wilhite-St Laurent
Assistant General Counsel
Department of Health

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2011-18838**

FRANCISCO JOSE PAGES, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, the Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Medicine against Respondent, Francisco Jose Pages, 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 in the State of Florida, having been issued license number ME 36112.

3. Respondent's address of record is 1900 Coral Way, #405, Coral Gables, Florida 33145.

4. Respondent is board certified in Family Medicine by the American Board of Family Medicine.

5. From about January, 2010, through December, 2011, the Respondent performed psychiatric consultations for Patients A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and F.P. The Respondent diagnosed and prescribed combinations of sedative, anticonvulsant, antipsychotic, antidepressant and other drugs to his patients as part of their treatment without medical justification for these prescriptions. None of the records contain an informed consent for any of the patients.

6. From about January, 2010, through September, 2011, Patient A.A. (A.A.) presented to the Respondent for psychiatric consultation. The Respondent diagnosed A.A. with Bipolar Disorder and changed the diagnosis to Schizophrenia Paranoid Type after a few months. The records do not contain a complete initial evaluation or a diagnostic change to justify the initial diagnosis or the change in diagnosis. The Respondent prescribed A.A. between 5 and 7 drugs each month that included sedative hypnotic, anticonvulsant, antipsychotics, and antidepressants. There is no

justification for either these prescriptions or the changes in the prescriptions in the record. The record contains handwriting from multiple people and some of the notes are identical to previous months.

7. From about January, 2010, through September, 2011, Patient J.A. (J.A.) presented to the Respondent for psychiatric consultation. The Respondent diagnosed J.A. with Schizophrenia Paranoid Type, Psychotic Disorder NOS, Anxiety Disorder NOS, Explosive Personality and Mental Retardation. The records do not contain a complete initial evaluation or any diagnostic changes to justify the diagnosis or changes in treatment. The Respondent prescribed J.A. between 3 and 7 drugs each month that included sedative hypnotic, antipsychotics, and antidepressants. There is no justification for either these prescriptions or the changes in the prescriptions in the record. The record contains handwriting from multiple people and some of the notes are identical to previous months. Complete testing is not included or referral to a Neuropsychologist for the diagnosis of Mental Retardation.

8. From about January, 2010, through September, 2011, Patient D.C. (D.C.), presented to the Respondent for psychiatric consultation. The Respondent diagnosed D.C. with Schizophrenia Paranoid Type, Bipolar

Disorder NOS, General Anxiety Disorder and Mental Retardation. The records do not contain a complete initial evaluation or diagnostic changes to justify the diagnosis or changes in treatment. The Respondent prescribed D.C. between 4 and 5 drugs each month that included antiparkinsonians, sedatives and antipsychotic. There is no justification for either these prescriptions or the changes in the prescriptions in the record. The record contains the handwriting from multiple people and some of the notes are identical to previous months.

9. From about November, 2009, through December, 2011, Patient C.C. (C.C.) presented to the Respondent for psychiatric consultation. The Respondent diagnosed C.C. with Schizophrenia Paranoid Type. The records do not contain a complete initial evaluation or any diagnostic changes to justify the diagnosis or changes in treatment. A nine month gap in treatment is included in the record. The Respondent prescribed C.C. between 5 and 8 drugs each month that included sedative hypnotics, antipsychotics and inhibitors. There is no justification of either these prescriptions or the changes in the prescriptions in the record. The record contains handwriting from multiple people and some of the notes are identical to previous months.

10. From about February, 2010, through May, 2011, Patient R.N. (R.N.) presented to the Respondent for psychiatric consultation. The Respondent diagnosed R.N. with Schizophrenia Paranoid Type, Schizoaffective Disorder, Bipolar Disorder Type I, Anxiety Disorder NOS, Post Traumatic Stress Disorder and Mental Retardation. The records do not contain a complete initial evaluation or any diagnostic changes to justify the diagnosis or changes in treatment. The Respondent prescribed R.N. between 1 and 7 drugs each month that included antipsychotics, antidepressants, anticonvulsants and antiparkinsonians. There is no justification of either these prescriptions or the changes in the prescriptions in the record. The record contains handwriting from multiple people and some of the notes are identical to previous months.

11. From about February, 2010, through December, 2011, Patient D.N. (D.N.) presented to the Respondent for psychiatric consultation. The Respondent diagnosed D.N. with Depressive Psychosis and Recurrent Depression with Psychotic Features. The records do not contain a complete initial evaluation or any diagnostic changes to justify the treatment or changes in treatment. The Respondent prescribed D.N. between 0 and 5 drugs each month that included sedatives,

antidepressants, and antipsychotics. There is no justification of either these prescriptions or the changes in the prescriptions in the record. The record contains handwriting from multiple people and some of the notes are identical to previous months.

12. From about October, 2010, through December, 2011, Patient F.L. (F.L.) presented to the Respondent for psychiatric consultation. The Respondent diagnosed F.L. with Schizophrenia Paranoid Type. The records do not contain a complete initial evaluation or any diagnostic changes to justify the diagnosis or changes in treatment. The Respondent prescribed F.L. between 3 and 6 drugs each month that included antiparkinsonians, sedatives and antipsychotics. There is no justification of either these prescriptions or the changes in the prescriptions in the record. The record contains handwriting from multiple people and some of the notes are identical to previous months.

13. From about May, 2010, through April, 2011, Patient M.M. (M. M.) presented to the Respondent for psychiatric consultation. The Respondent diagnosed M.M. with Schizophrenia Paranoid Type, Psychotic Disorder NOS, Explosive Personality, Cocaine Dependence, Hallucinations, and Suicidal Ideation. The records do not contain a complete initial

evaluation or any diagnostic changes to justify the treatment or changes in treatment. The Respondent prescribed M.M. between 4 and 5 drugs each month that included sedatives, anticonvulsants, and antipsychotics. There is no justification of either these prescriptions or the changes in the prescriptions in the record. The record is missing multiple progress notes or evaluations during the presentations.

14. From about December, 2010, through March, 2011, Patient F.P. (F.P.) presented to the Respondent for psychiatric consultation. The Respondent diagnosed F.P. with Schizophrenia Paranoid Type, Psychotic Disorder NOS, Schizophrenia NOS and Encephalopathy. The records do not contain a complete initial evaluation or any diagnostic changes to justify the treatment or changes in treatment. The Respondent prescribed F.P. between 4 and 10 drugs each month that included antiparkinsonians, sedatives, anticonvulsants, antipsychotics and antidepressants. There is no justification of either these prescriptions or the changes in the prescriptions in the record.

15. The Respondent failed to treat A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. within the accepted standard of care by failing to perform a complete initial evaluation prior to diagnosing them.

16. The Respondent failed to treat A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. within the accepted standard of care by prescribing multiple medications without a medical justification for the prescriptions or changes in the prescriptions.

17. The Respondent failed to obtain an informed consent for treatment from A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. prior to evaluating, diagnosing and prescribing medications to them.

18. The Respondent failed to order testing and consultations prior to diagnosing A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P.

19. The Respondent failed to maintain medical records that were complete, legible, and justified the course of treatment provided to A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. The records do not include a complete initial evaluation that justified the treatment plan and documentation was incomplete and/or illegible.

COUNT ONE

20. Petitioner realleges and incorporates paragraphs one (1) through nineteen (19) as if fully set forth in this count.

21. Section 458.331(1)(t), Florida Statutes (2009-2011), subjects a doctor to discipline for committing medical malpractice as defined in

Section 456.50, Florida Statutes (2009-2011). Section 456.50, Florida Statutes (2009-2011), 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.

22. 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, Florida Statutes (2009-2011). Section 766.102(1), Florida Statutes (2009-2011), 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. . . ."

23. The Respondent failed to meet the prevailing standard of care in regard to Patients A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. in one or more of the following ways:

a) The Respondent failed to perform a complete initial evaluation for A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. prior to diagnosing them; and/or

b) The Respondent prescribed multiple medications to treat A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. without a medical justification for the prescriptions or changes in the prescriptions; and/or

c) The Respondent failed to obtain an informed consent for treatment from A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. prior to evaluating, diagnosing and prescribing medications to them; and/or

d) The Respondent failed to order testing and consultations prior to diagnosing A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P.

24. Based on the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes (2009-2011), by committing medical malpractice as defined in Section 456.50 and/or by failing to practice medicine in accordance with the 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.

COUNT TWO

25. Petitioner realleges and incorporates paragraphs one (1) through nineteen (19) as if fully set forth in this count.

26. Section 458.331(1)(m), Florida Statutes (2009-2011), provides that failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations, is grounds for disciplinary action by the Board and/or Department.

27. The Respondent failed to maintain complete and adequate medical records that justified the course of treatment provided for Patient A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P. in one or more of the following ways:

a) The Respondent failed to document a complete initial evaluation of Patients A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P.; and/or

b) The Respondent failed to document a patient consent for Patients A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P.; and/or

c) The Respondent failed to document testing and consultations prior to diagnosing and treating A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P.

28. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2009-2011), by failing to maintain complete medical records for Patients A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P.

COUNT THREE

29. Petitioner realleges and incorporates paragraphs one (1) through nineteen (19) as if fully set forth in this count.

30. Section 458.331(1)(q), Florida Statutes (2009-2011), 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 which are grounds for disciplinary action by the Board and/or Department. 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.

31. The Respondent prescribed, dispensed, administered, mixed, or otherwise prepared a legend drug, including any controlled substance, other than in the course of the physician's professional practice, in one or more of the following ways:

a) The Respondent prescribed or dispensed medications excessively or inappropriately by prescribing multiple medications without a medical justification for the prescriptions or changes in the prescriptions for A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P., and/or

b) The Respondent prescribed or dispensed medications excessively or inappropriately by failing to order testing

and consultations prior to prescribing medications to A.A., J.A., D.C., C.C., R.N., D.N., F.L., M.M. and/or F.P.

32. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes (2009-2011), by prescribing, dispensing, administering, mixing or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice.

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 23rd day of May, 2014.

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

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE MAY 27 2014

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JRZ
PCP date: May 23, 2014
PCP Members: Dr. El-Bahri, Dr. Thomas, Ms. Goersch

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 any other discipline imposed.