STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,

Petitioner,

v. DOH CASE NUMBER 2012-07498

SHLOMO PASCAL, M.D.,

Respondent.
_____/

NOTICE OF SCRIVENER'S ERROR

Petitioner, Department of Health, by and through the undersigned counsel, files this Notice of Scrivener's Error and states:

1. On or about January 27, 2014, Petitioner filed an Administrative Complaint in the above-styled matter.

2. Thereafter, Petitioner discovered that a typographical error appears in the Administrative Complaint as follows:

a. Paragraph 2 states the following:

> At all times material to this Complaint, Respondent was a licensed medical doctor within the state of Florida, having been issued license number ME 36792.

b. Paragraph 2 should read:

> At all times material to this Complaint, Respondent was a licensed medical doctor within the state of Florida, having been issued license number ME 76692.

correcting the license number.

3. The correction of this error is of no prejudice to Respondent as the Complaint references the applicable statutes with sufficient specificity to put Respondent on notice as to the nature of the violations alleged.

4. This Notice shall take effect upon service to the parties.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Notice of Scrivener's Error was sent by email, Attorney for Respondent, Alex Barker, 1555 Palm Beach Lakes Blvd., 16th Floor, West Palm Beach, Florida 33401, email: abarker@adamscoogler.com, this 10th day of February, 2014.

Diane K. Kiesling
Assistant General Counsel

STATE OF FLORIDA
DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO.: 2012-07498**

SHLOMO PASCAL, 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, Shlomo Pascal, 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 36792.

3. Respondent's address of record is 1701 Northwest 123rd Avenue, Pembroke Pines, Florida 33026.

4. Respondent is not board certified, but specializes in Psychiatry.

5. Respondent provided treatment to Patient R.H. (RH), a then 25 year-old male, from August 9, 2009, until September 14, 2011.

6. The original set of medical records provided by Respondent were virtually illegible; therefore, through counsel, Respondent provided a "second" set of medical records that purported to be a set that was "transcribed" with his assistance to simply put his writing into legible form. In fact the second set of medical records appears to contain additional notes and materials and deletes other material.

7. Respondent first saw RH on August 1, 2009, and noted that RH was receiving Xanax from his primary care physician. The patient reported a history from 2003-2008 of substance abuse on Ecstacy, Cocaine, Heroin, LSD, and Ketamine. He also reported current daily use of marijuana. Respondent prescribed Remeron 15 mg, an antidepressant, Buspar 15 mg BID, and Ambien 10 mg QHS, a sedative.

8. 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.

9. Respondent initially diagnosed RH with Major Depressive Disorder, Generalized Anxiety Disorder, and Post Traumatic Stress Disorder.

10. Respondent next saw RH on September 2, 2009. In the notes from that visit there is no documentation of the continuation of Remeron. Respondent added Xanax 1mg, Seroquel XL 150 mg, Lamictal and Straterra, both with no strength specified. For several of these medications there was no stated dosage. Respondent did not reference the fact that on RH's first visit he was receiving Xanax from his primary care physician or that RH had reported prior substance abuse. Respondent did inaccurately mark the space that said that no changes in medications had been made.

11. The next progress note was on October 6, 2009, at which time Respondent noted that RH was clinically depressed, but he prescribed no antidepressant. Instead, Respondent prescribed Tranxene 7.5 mg TID, a sedative, for no presenting symptoms. Additionally RH's Buspar was increased to 15 mg QD, with no documented justification.

12. Respondent next saw RH on November 4, 2009, at which time he documented that RH's insight was impaired and his mood was

depressed. The medications listed were Seroquel XR 400 QD and Valuim 10 mg TID, even though neither is appropriate for those complaints. The notes do not address what other medications RH was on, even though prior notes list several drugs that he had been prescribed. One cannot discern whether RH is on both Xanax and Valium, in which case he would be on two benzodiazapines, which does not meet the standard of care.

13. Valium is the brand name for diazepam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, diazepam 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 diazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

14. On December 4, 2009, RH reported that he had a problem and was currently in a 30 day treatment program. Respondent prescribed Pexeva 20 mg QAM, an antidepressant, but does mention discussing risk of Valium. The notes inaccurately state that no new medications were given; however, the actual medications prescribed cannot be determined.

15. On December 19, 2009, the progress notes stated that RH is doing well since he has been on Xanax; however RH had been on Xanax

since his initial visit. Additionally, the progress notes since that initial visit do not document that Xanax had been prescribed by Respondent. Respondent documented his diagnosis as Generalized Anxiety Disorder and Severe Headaches, but he did not seek any neurology consultdoes not identify what medications Respondent was talking about and the progress notes do not list RH's current medications.

16. The patient's next visit was on January 23, 2010. The diagnosis was changed to BPD (probably meaning Bipolar Disorder, although more commonly the abbreviation for Borderline Personality Disorder), Generalized Anxiety Disorder, and ADHD. The records contain no supportive information or discussion as to why any of these diagnoses were listed and the medications that had been previously prescribed are not consistent with these diagnoses. The notes also describe RH as "angry", but there is no follow up for that symptom. Respondent prescribed Straterra and gave samples with no indication of why. Finally, there was no documentation of consent or reason for prescription of Seroquel.

17. Respondent next saw RH on February 27, 2010. Respondent documented changes tothe prescriptions dramatically and the "transcribed" notes do not match the original notes. In the original notes, notations at

the bottom of the page indicate the words "Xanax" in two places with dosages and they are crossed through. Those notes are not on the "transcribed" notes. Further, accepting that the transcribed notes are accurate, Respondent added a prescription for Lithium 300 mg po BID, Klonopin 1 mg TID, Seroquel XR 400 mg QHS. Seroquel XR 400 QH is a antipsychotic at a high dosage level. The notes also stated to discontinue Valium, but at a different place prescribed Valium 10 mg (a heavy sedative level) with no frequency indicated. Additionally in the bottom margin, a prescription for Klonopin is noted for 20 mg TID, twice the dosage from that stated earlier in the notes. Finally, in the top margin, a prescription for Adderal [Adderall] 20 mg po QAM is noted and a prescription for Kapuay twice daily is noted.

18. Adderall is the brand name for a drug that contains amphetamine, commonly prescribed to treat attention deficit disorder. According to Section 893.03(2), Florida Statutes, amphetamine is a Schedule II controlled substance that has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States. Abuse of amphetamine may lead to severe psychological or physical dependence.

19. Klonopin is the brand name for clonazepam and is prescribed to treat anxiety. According to Section 893.03(4), Florida Statutes, clonazepam 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 clonazepam may lead to limited physical or psychological dependence relative to the substances in Schedule III.

20. On March 22, 2010, Respondent saw RH and the transcribed notes are confusing. Notes stated an order to discontinue benzodiazepines; however, in the next line Respondent prescribed Xanax 1 mg po QID. Xanax is a benzodiazepine. Respondent also prescribed Prozac 20 mg QAM.

21. The patient's next visit was June 22, 2010; however the notes for that date are confusing. The transcribed noted indicate Adderall 30 mg BID, an amphetamine, was prescribed. Doxepin 50 mg QHS, an antidepressant, was prescribed by another physician and Respondent noted that he placed a call to that physician, without noting the results. Respondent increased the Doxepin to 100 mg QHS. The transcribed note also indicated that Respondent prescribed Oleptro 100 mg 1½ BID and 1 QHS. However, the progress notes statd that no new medications were

prescribed. Clearly that indication is erroneous. The original notes do not appear to coincide with these second notes. The original notes appear to contain the word Paxil in the margin and not Oleptro anywhere.

22. Respondent next saw RH on July 19, 2010, when RH arrived 50 minutes late and was described as "bizarre." No notation of medication changes was made.

23. The next visit was August 23, 2010, however the notes were inadequate and incomplete. Respondent added Fanapt, an antipsychotic medication, for use as a mood stabilizer, and described giving risks of Xanax and Remeron. There was no informed Consent for Fanapt. There was no indication of Xanax on the medication list. Further Adderall 30 mg BID was prescribed. The notes state that no new medication was given, which is clearly erroneous.

24. Respondent next saw RH on September 20, 2010, when Topomax 20 mg BID, an anticonvulsant, was prescribed. However there was no indication in the notes as to why this medication was prescribed. The note also documented the Klonopin was discontinued, but the last documented prescription for Klonopin was February 27, 2010. Finally there was no documentation of what happened with the prescription of Fanapt.

25. On October 20, 2010, when Respondent next saw RH, Respondent prescribed Xanax 2 mg TID (double the prior dose), Remeron 45 mg sol tab, and Seroquel XR 50 mg. There is no documentation of what happened to the Fanapt or the Topamax; there is no rationale given for the changes; there is no informed consent; and there is no explanation for why the notes say there no new medications.

26. Respondent saw RH on November 19, 2010, and, again the notes cannot be reconciled. The only medications listed for RH were Adderall 30 mg QAM and Xanax 2 mg TID, which are both controlled, addictive substances. While the notes state that RH does "much better on current meds," there is no documentation to support that statement. Respondent added Doxepin 200 mg with no indication as to why and the dosage given is higher that the usual starting dose. Respondent simply failed to document RH's medications, justifications for them or for any changes, and the doses given.

27. On December 14, 2010, Respondent saw RH for a diagnosis of Bipolar Disorder. There is no explanation of why the diagnoses of Major Depressive Disorder, ADHD, and General Anxiety Disorder are no longer being listed or treated. Seroquel XR discontinued even though it was last prescribed in October. Respondent started RH on Saphris 10 mg BID, but

gave no indication or rationale for the medication or why he stopped the antipsychotics or whether other medications were being administered currently from prior visits.

28. At the next visit on January 21, 2011, Respondent's notes documented that RH reported difficulty sleeping. Respondent prescribed Prosom 2 mg po QD, a sedative. The half life of Prosom is 24 hours, therefore the standard of care would require that it be prescribed for HS dosing (one time per day). Additionally, there was no documentation of whether RH was still taking Xanax or any other sedatives concurrently with Prosom or whether the Xanax prescribed in November had been discontinued.

29. Respondent next saw RH on February 21, 2011, and noted a diagnosis of Generalized Anxiety Disorder. He did not document whether this is in addition to Bipolar Disorder or to the exclusion of the previous diagnoses. The patient continued to report problems sleeping and Respondent prescribed Lunesta, a sedative, without documenting what action he was taking regarding the Prosom. He also documented "Temazepam stopped", but he had never started Temazepam. The original note actually appears to say "prn," not "stopped."

30. The patient next saw Respondent on March 21, 2011, at which time Respondent diagnosed Generalized Anxiety Disorder, Bipolar Disorder and Major Depressive Disorder. Difficulty sleeping is again documented and medications listed are Xanax and Neurontin, an anticonvulsant. No explanation is documented for the Neurontin prescription. The Adderall is continued, but there is no explanation as to why a stimulant is continued if the patient is having difficulty sleeping. Additionally, Seroquel XL 40 mg was prescribed even though Respondent had repeatedly started and stopped the medication without any indications of the reasons for starting and stopping the medication.

31. At the April 21, 2011, visit, Respondent wrote prescriptions for Rozeren 8 mg and Restoril, a sedative, although there is no way to comprehend from the notes why those medications were prescribed. Additionally, there was no documentation as to what happened to all the prior prescribed medications: Temazepam, Seroquel XL, Neurontin, Adderall, Doxepin, and Prosom.

32. Respondent next saw RH on May 17, 2011, and prescribed Xanax and Neurontin, both having sedative effects. Respondent restarted RH on Saphris. None of the previously prescribed medications are addressed.

33. On June 16, 2011, Respondent documented a visit with RH in which RH complained of "consistent panic attacks." Despite this, Respondent continued the prescription for Adderall 20 mg QD. Respondent also prescribed Seroquel XL increased from 200 to 300 mgs and discontinued the Saphis. He continued the Xanax 2 mg TID and the Restoril 30 mg QHS. Respondent ordered no laboratory testing to determine if RH was using the drugs as prescribed or using other drugs, legal or illegal, which Respondent did not know about.

34. On July 13, 2011, Respondent saw RH and documented at the bottom of the page that he had discussed the risks of Lamictal; however, there was no documentation that RH had ever been prescribed Lamictal. Respondent diagnosed Generalize Anxiety Disorder, Bipolar Disorder and Major Depressive Disorder. In the note, RH was prescribed Xanax 2 mg TID and Latuda 40 mg QHS was added. Both are antipsychotics; however there is no documentation of the indication for the prescriptions. The note also documented Seroquel XL 200 mg plus 300 mg, with no explanation. Further at the top of the note it states that RH is on both Xanax and Restoril with no further indications, both of which are heavy sedatives.

35. At the visit on August 16, 2011, it cannot be determined whether the prescriptions of Xanax 2 mg TID and Remeron 45 mg QHS are

in addition to all or some of the other medications or if all or some of the other medications were discontinued.

36. The last visit with RH is documented on September 4, 2011. Respondent prescribed Trileptal 300 mg BID, an anticonvulsant, Mellaril 50 mg QD, an antipsychotic, Xanax 2 mg TID, Viibryd 40 mg QD, an antidepressant, Trileptal 300 mg BID (which is a repeat of the previous prescription of the same date), and Mellaril 25 mg QD (which may be in addition to or instead of the 50 mg dosage of the same date). No indication was documented for any of these medications or changes in medications.

37. The standard of care requires an indication of why certain diagnoses are given throughout the records. Respondent made diagnoses that included at various times Generalize Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and ADHD, with no indication of why the diagnoses were given. There was no evidence in the record that RH met the criteria for any of these disorders and there was no documentation of the exact symptoms RH was complaining of to support the diagnoses. Respondent noted no thought process behind the diagnoses. Therefore Respondent failed to meet the standard of care in diagnosing RH,

38. The standard of care requires that the rationale for treatment and medication be given. Respondent gave no indications for the treatment or lack of treatment and gave no indications for the medications prescribed or the manner in which they were prescribed. Throughout Respondent's treatment of RH, he documented at almost every visit that no changes in medication had been made. This notation was inaccurate. Further, despite RH's self-reported history of poly-substance abuse, Respondent prescribed multiple controlled substances, some concurrently and without any rationale. Respondent failed to meet the standard of care by failing to provide any indications for the treatment given or not given or for the medications prescribed or the manner in which they were prescribed.

39. Based on RH's history of substance abuse, prescribing Adderall, a Schedule II controlled amphetamine stimulant, along with three sedative drugs throughout the day is below the standard of care. Clinically prescribing amphetamine concurrently with a sedative to treat a diagnosis of Generalized Anxiety Disorder would only exacerbate the illness. Additionally, the medications prescribed do not rationally address the diagnosis of Major Depressive Disorder because the Respondent only

sporadically prescribed antidepressant medications. These prescribing practices were below the standard of care.

40. The standard of care requires that Respondent perform a complete initial assessment. Respondent documented no initial assessment.

41. The standard of care requires that Respondent refer RH for additional evaluation and therapeutic assessment once it because apparent that RH was deteriorating despite seeing Respondent. Failure to do so is below the standard of care.

42. The standard of care requires the Respondent order periodic laboratory testing, including illicit substances, to determine whether there was any additional possible explanation for RH's condition. Respondent failed to meet the standard of care by ordering laboratory testing.

43. The standard of care requires that the patient's complaints and symptoms be adequately evaluated, but there is no evidence that Respondent met this standard of care when his treatment is taken as a whole.

COUNT ONE

44. Petitioner realleges and incorporates paragraphs one (1) through forty-three (43) as if fully set forth herein.

45. Section 458.331(1)(t)1., Florida Statutes (2009-2011), subjects a medical doctor to discipline by the Board of Medicine for committing medical malpractice as defined in Section 456.50. 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.

46. The 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 (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. . . ."

47. Respondent fell below the standard of care in one or more of the following ways:

a. By diagnosing at various times Generalized Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and ADHD with no indications of why the diagnoses were given and without the criteria for those diagnoses;

b. By failing to have any rationale for the treatment and medications given;

c. By failing to give any indications for the treatment or lack of treatment and any indications for the medications prescribed or the manner in which they were prescribed;

d. By prescribing Adderall, a Schedule II controlled amphetamine stimulant, along with three sedative drugs throughout the day;

e. By prescribing amphetamine concurrently with a sedative to treat a diagnosis of Generalized Anxiety Disorder;

f. By failing to rationally address the diagnosis of Major Depressive Disorder because of sporadically prescribing antidepressant medications;

g. By failing to perform a complete initial assessment;

h. By failing to refer RH for additional evaluation and therapeutic assessment once it became apparent that RH was deteriorating despite seeing Respondent;

i. By failing to order periodic laboratory testing, including for illicit substances, to determine whether there was any additional possible explanation for RH's condition;

j. By failing to adequately evaluate RH's complaints and symptoms.

48. Based on the foregoing, Respondent has violated Section 458.331(1)(t)1., Florida Statutes (2009-2011), by committing medical malpractice.

COUNT TWO

49. Petitioner realleges and incorporates paragraphs one (1) through forty-three (43) as if fully set forth herein.

50. Section 458.331(1)(m), Florida Statutes (2009-2011), subjects a medical doctor to discipline by the Board of Medicine for failing to keep legible, as defined by department rule in consultation with the board, 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.

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

a. By keeping such illegible medical records that they needed "transcribing";

b. By failing to document the indications of why the diagnoses were given;

c. By failing to document that RH met the criteria for any of these disorders diagnosed because there was no documentation of RH's exact complaints or symptoms;

d. By failing to document his thought process behind the diagnoses;

e. By failing to document the rationale for treatment and medication given;

f. By failing to document the indications for the treatment or lack of treatment and indications for the medications prescribed or the manner in which they were prescribed;

g. By failing to perform a complete initial assessment;

h. By failing to document RH's symptoms and complaints.

52. Based on the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes (2009-2011), for failing to keep legible, as defined by department rule in consultation with the board, 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

53. Petitioner realleges and incorporates paragraphs one (1) through forty-three (43) as if fully set forth herein.

54. Section 458.331(1)(nn), Florida Statutes (2009-2011), subjects a medical doctor to discipline by the Board of Medicine for violating any provision of Chapter 458 or Chapter 456, or any rules adopted pursuant thereto.

55. Rule 64B8-9.003(2) and (3), Florida Administrative Code (FAC), provide as follows:

> (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.

56. Respondent failed to comply with Rule 64B8-9.003(2) and (3), FAC, in one or more of the following ways:

a. By failing to maintain legible patient medical records;

b. By failing to maintain patient medical records that support the diagnoses;

c. By failing to maintain patient records that justify the treatment;

d. By failing to document the course and results of treatment accurately;

e. By failing to maintain patient medical records that accurately record drugs prescribed, dispensed, or administered.

57. Based on the foregoing, Respondent has violated Section 458.331(1)(nn), Florida Statutes (2009-2011), by violating Rule 64B8-9.003(2) and (3), Florida Administrative Code (FAC)

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.

[Signatures appear on the following page.]

SIGNED this 24th day of January, 2014.

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

FILED
DEPARTMENT OF HEALTH
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CLERK: Bridget Coates
DATE 1-27-14

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DKK

PCP Date: January 24, 2014

PCP Members: Dr. El-Bahri, Dr. Orr, Ms. Tootle

DOH v. Shlomo Pascal, M.D., Case No. 2012-07498

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.