FILED
Department of Business and Professional Regulation
DEPUTY CLERK

CLERK Ronda L. Bryan
DATE 10-6-93

DEPARTMENT OF BUSINESS AND
PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF BUSINESS AND
PROFESSIONAL REGULATION,

Petitioner,

v.

DBPR CASE NUMBER: 01-00875
LICENSE NUMBER: ME 0027985

OLGA-MARIA FERNANDEZ, M.D.,

Respondent.
_______________________________/

FINAL ORDER

THIS MATTER came before the Board of Medicine (Board) pursuant to Section 120.57(3), Florida Statutes, on October 2, 1993, in Miami, Florida, for consideration of a Consent Agreement (attached hereto as Exhibit A) entered into between the parties in the above-styled case. Upon consideration of the Consent Agreement, the documents submitted in support thereof, the arguments of the parties, and being otherwise advised in the premises,

IT IS HEREBY ORDERED AND ADJUDGED that the Consent Agreement as submitted be and is hereby approved and adopted in toto and incorporated by reference herein. Pursuant to Paragraph 4.B.iv., the Board directs that the subject areas of the CME shall be psychiatry and acute care psychiatry. Accordingly, the parties shall adhere to and abide by all of the terms and conditions of the Consent Agreement.

This Final Order takes effect upon filing with the Clerk of the Department.

DONE AND ORDERED this 2 day October, 1993.

BOARD OF MEDICINE

Richard J. Cavallaro, M.D.
CHAIRMAN (VICE)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been provided by certified U.S. Mail to Olga-Maria Fernandez, M.D., 13495 N.E. 2nd Avenue, North Miami, Florida 33161-2725, John C. Cooper, Esquire, P.O. Box 11308, Tallahassee, Florida 32302 and by interoffice delivery to Larry G. McPherson, Jr., Chief Medical Attorney, Department of Business and Professional Regulation, Northwood Centre, 1940 North Monroe Street, Tallahassee, Florida 32399-0792, at or before 5:00 P.M., this ________ day of __________________, 1993.

MARM HARRIS, Ph.D.
Executive Director

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

v. **DOAH CASE NO. 92-3264**
DPR CASE NO. 0100875

OLGA-MARIA FERNANDEZ, M.D.,

Respondent.
______________________________/

CONSENT AGREEMENT

Olga-Maria Fernandez M.D., referred to as the "Respondent", and the Department of Professional Regulation, 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.

STIPULATED FACTS

1. At all times material hereto, Respondent was a licensed physician in the State of Florida having been issued license number ME 0027985.

2. Respondent was charged by an Administrative Complaint filed by the Department and properly served upon Respondent with violations of Chapter 458, Florida Statutes, and the rules enacted 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.

STIPULATED CONCLUSIONS OF LAW

1. Respondent admits that, in her capacity as a licensed physician, she is subject to the provisions of Chapters 455 and 458, Florida Statutes, and the jurisdiction of the Department and the Board.

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

STIPULATED DISPOSITION

1. FUTURE CONDUCT. Respondent shall not in the future violate Chapters 455, 458 and 893, Florida Statutes, or the rules promulgated pursuant thereto.

2. FINE. The Board shall impose an administrative fine in the amount of $3,000 (three thousand dollars) against the Respondent. The fine shall be paid by the Respondent to the Board of Medicine within eighteen (18) months of its imposition by Final Order of the Board.

3. REPRIMAND. The Respondent shall receive a reprimand from the Board of Medicine.

4. PROBATION. Effective on the date of the filing of the Final Order incorporating the terms of this Agreement, Respondent's license to practice medicine shall be placed on probation for a period of four years. The purpose of probation is not to prevent

the Respondent from practicing medicine. Rather, probation is a supervised educational experience designed by the Board to make the Respondent aware of certain obligations to her patients and the profession and to insure 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 following obligations and requirements:

A. RESTRICTIONS DURING PROBATION. During the period of probation, Respondent's license shall be restricted as follows:

i. INDIRECT SUPERVISION. For at least the first two years of probation, Respondent shall practice only under the indirect supervision of a Board-approved physician, hereinafter referred to as the "monitor". In this regard, Respondent shall allow the monitor access to Respondent's medical records, calendar, patient logs or other documents necessary for the monitor to supervise Respondent as detailed below. If, at the end of two years of indirect supervision, the Respondent has successfully complied with all of the restrictions, obligations and requirements of probation, Respondent may appear in person before the Board with his monitoring physician and request that the requirement for indirect supervision be lifted. The Board may make the lifting of the supervision conditional upon requirements to be specified at that time.

B. OBLIGATIONS/REQUIREMENTS OF PROBATION. During the period of probation, Respondent shall comply with the following

obligations and requirements:

i. Respondent shall appear before the Probation Committee of the Board of Medicine at the first Committee meeting after probation commences; at the last meeting of the Committee preceding scheduled termination of the probation; and at such other times as requested by the Committee. Respondent shall be noticed by the Board staff of the date, time and place of the Committee meeting whereat Respondent's appearance is required. Failure of Respondent to appear as requested or directed shall be considered a violation of the terms of this Agreement, and shall subject the Respondent to disciplinary action.

ii. Respondent shall be responsible for ensuring that the monitor submits all required reports.

iii. Respondent shall complete the course, "Protecting Your Medical Practice, Clinical, Legal and Ethical Issues in Prescribing Abusable Drugs," sponsored by the Florida Medical Association and the University of South Florida, or a Board-approved equivalent, during the first year of probation.

iv. During each year of probation following the first year, the Respondent shall attend twenty-five (25) hours of Category I Continuing Medical Education in an area to be determined by the Board. Respondent shall submit a written plan to the Chairman of the Probationer's Committee for approval prior to the completion of said continuing education hours. The Board confers authority on the Chairman of the Probationer's Committee to approve or disapprove said continuing education hours. In addition,

Respondent shall submit documentation in the form of certified copies of the receipts, vouchers, certificates, or other papers, such as physician's recognition awards, documenting completion of these medical education courses each year that she is on probation after the first year. All such documentation shall be sent to the Board of Medicine, regardless of whether some or any of such documentation was previously provided 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 courses shall consist of a formal, live lecture format.

v. Respondent shall be responsible for ensuring that the monitor submits all required reports.

C. RESPONSIBILITIES OF THE MONITORING PHYSICIAN.

The Monitor shall:

i. Review 25% (twenty five percent) of Respondent's active patient records at least once a month, for the purpose of ascertaining the appropriateness of record keeping and patient care. 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.

ii. Submit reports on a quarterly 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's relationship with the Respondent.

e) A statement advising the Board of any problems which have arisen.

f) A summary of the dates the monitor went to Respondent's office, the number of records reviewed, and the overall quality of the records reviewed.

iii. Maintain contact with the Respondent on a frequency of at least once per week. In the event that the monitor is not timely contacted by Respondent, then the monitor shall immediately report this fact to the Board, in writing.

iv. Respondent's monitor 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 his monitor to appear as requested or directed. If the approved monitor fails to appear as requested or directed by the Probation Committee, the Respondent shall immediately cease practicing medicine until such time as the approved monitor or alternate monitor appears before the Probation Committee.

D. REPORTS FROM RESPONDENT. The Respondent shall submit quarterly reports, in affidavit form, the contents of which may be further specified by the Board, but which shall include:

i. A brief statement of why Respondent is on probation.

ii. A description of practice location.

iii. A description of current practice (type and composition).

iv. A brief statement of compliance with probationary terms.

v. A description of the relationship with monitoring physician.

vi. A statement advising the Board of any problems which have arisen.

vii. A statement addressing compliance with any restrictions or requirements imposed.

E. STANDARD PROVISIONS. Respondent's probation shall be governed by the attached "provisions regarding monitoring/supervising physicians", Exhibit B, which is incorporated as if fully set forth herein.

5. 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 a Final Order incorporating the terms of this Agreement is entered by the Board.

6. Respondent shall appear before the Board at the meeting of the Board where this Agreement is considered. Respondent, in conjunction with the consideration of this Agreement by the Board, shall respond to questions under oath from the Board, Board Staff or Department Staff.

7. Should this Agreement be rejected, no statement made in furtherance of this Agreement by the Respondent may be used as direct evidence against the Respondent in any proceeding; however, such statements may be used by the Petitioner for impeachment purposes.

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

9. 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 val[illegible]ity of the Agreement and the Final Order of the Board incorpor[illegible]ing said Agreement.

10. Upon the Board's adoption of this Agreement, the parties hereby agree that each party will bear his 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 in connection with this matter.

11. This Agreement is executed by the Respondent for the purpose of avoiding further administrative action with respect to this cause. 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. Furthermore, should this joint 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.

SIGNED this 8th day of July, 1993.

Olga Fernandez, M.D.

Olga-Maria Fernandez, M.D.

Before me, personally appeared Olga Maria Fernandez, M.D. whose identity is known to me by D.O.C. I.D. Badge (type of identification) and who, under oath, acknowledges that his/her signature appears above.

Sworn to and subscribed before me this 8th day of July, 1993.

Patricia B. Thomas

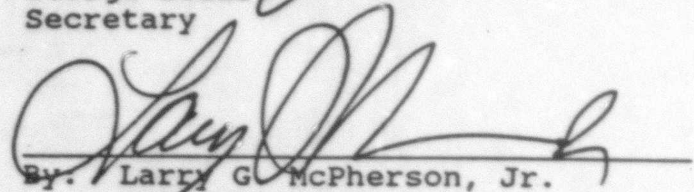
NOTARY PUBLIC

My Commission Expires:

Notary Public, State of Florida
My Commission Expires July 16, 1995
Bonded Thru Troy Fain - Insurance Inc.

APPROVED this 14 day of July, 1993.

George Stuart
Secretary



By: Larry G. McPherson, Jr.
Chief Attorney
Medical Section

PROVISIONS REGARDING MONITORING/SUPERVISING PHYSICIANS

Provisions governing physicians ordered to work under supervision of monitoring or supervising physician.

I. DEFINITIONS:

A. INDIRECT SUPERVISION is supervision by a monitoring physician (monitor) whose responsibilities are set by the Board. Indirect supervision does not require that the monitor practice on the same premises as the Respondent. Due to the location and nature of the Respondent's current employment, the monitor need not practice within 20 miles of the Respondent, but shall be readily available for consultation. The monitor need not be Board-certified in the Respondent's specialty area, but must receive the approval of the Probation Committee.

B. DIRECT SUPERVISION is supervision by a supervising physician (supervisor) whose responsibilities are set by the Board. Direct supervision requires that the supervisor and Respondent work in the same office. The supervising physician shall be Board-certified in the Respondent's specialty area, unless otherwise provided by the Board.

C. PROBATION COMMITTEE or "committee" are members of the Board of Medicine designated by the Chairman of the Board to serve as the Probation Committee.

II. STANDARD TERMS.

A. REQUIRED SUPERVISION.

1. The Respondent shall not practice medicine without an approved monitor/supervisor, as specified by the Consent

Agreement, unless otherwise ordered by the Board.

2. The monitor/supervisor must be a licensee under Chapter 458, Florida Statutes, in good standing and without restriction or limitation on his license. In addition, the Board or Committee may reject any proposed monitor/supervisor on the basis that he has previously been subject to any disciplinary action against his medical license in this or any other jurisdiction, is currently under investigation, or is the subject of a pending disciplinary action. The monitor/supervisor must be actively engaged in the same or similar specialty area unless otherwise provided by the Board or Committee. The Board or Committee may also reject any proposed monitor/supervisor for good cause shown.

B. MECHANISM FOR APPROVAL OF MONITOR/SUPERVISOR:

1. TEMPORARY APPROVAL. The Board confers authority on the Chairman of the Board's Probation Committee to temporarily approve Respondent's monitor/supervisor. To obtain this 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 this 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.**

2. FORMAL APPROVAL.

a. Respondent shall have the monitor/supervisor with him at his first probation appearance before the Probation Committee. Prior to consideration of the monitor/supervisor by the Committee, the Respondent shall provide to the monitor/supervisor a copy of the Administrative Complaint and Final Order in this case. Respondent shall submit a current curriculum vitae and a description of current practice from the proposed monitor/supervisor to the Board office no later than fourteen days before the Respondent's first scheduled probation appearance.

b. Respondent's monitor/supervisor shall also appear before the Probation Committee at such other times as directed by the Committee. It shall be Respondent's responsibility to ensure the appearance of his monitor/supervisor as directed. If the approved monitor fails to appear as requested or directed by the Probation Committee, the Respondent shall immediately cease practicing medicine until such time as the approved monitor or alternate monitor appears before the Probation Committee.

3. CHANGE IN MONITOR/SUPERVISOR. In the event that Respondent's monitor/supervisor is unable or unwilling to fulfill his responsibilities as a monitor/supervisor as described above, then the Respondent shall immediately advise the Board of this fact. Respondent shall immediately submit to the Chairman of the Board's Probation Committee, the name of a temporary monitor/supervisor for consideration. Respondent shall

not practice pending approval of this 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, for consideration of the monitor/supervisor by the Committee. Respondent shall only practice under the auspices of the temporary monitor/supervisor (approved by the Chairman) until the next regularly scheduled meeting of the Probation Committee whereat the issue of the Committee's approval of the Respondent's new monitor/supervisor shall be addressed.

C. CONTINUITY OF PRACTICE

1. TOLLING PROVISIONS. In the event the Respondent leaves the State of Florida for a period of thirty days or more or otherwise does not engage 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.

a. The time period of probation shall be tolled.

b. The provisions regarding supervision whether direct or indirect by another physician, and required reports from the monitor/supervisor shall be tolled.

c. The provisions regarding preparation of investigative reports detailing compliance with this Stipulation shall be tolled.

2. ADDRESSES. Respondent must keep current residence and business addresses on file with the Board. Respondent shall notify the Board within ten (10) days of any changes of said addresses. Furthermore, Respondent shall notify the Board within ten (10) days in the event that Respondent leaves the active practice of medicine in Florida.

3. ACTIVE PRACTICE. In the event that Respondent leaves the active practice of medicine for a period of one year or more, the Probation Committee may require Respondent to appear before the Probation Committee and demonstrate his ability to practice medicine with skill and safety to patients prior to resuming the practice of medicine in this State.

D. COSTS. Respondent shall pay all costs necessary to comply with the terms of this Consent Agreement. Such costs include, but are not limited to, the costs of preparation of Investigative Reports detailing compliance with the terms of the Consent Agreement, and the Board's administrative costs directly associated with Respondent's probation.

E. BOARD ADDRESS. Unless otherwise directed by the Board office, all reports, correspondence and inquiries shall be sent to: Board of Medicine, 1940 North Monroe Street, Tallahassee, Florida 32399-0792, Attn: Final Order Compliance Officer.

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL
REGULATION,

PETITIONER,

vs. CASE NO. 0100875

OLGA-MARIA FERNANDEZ, M.D.

RESPONDENT.
_______________________________/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against OLGA-MARIA FERNANDEZ, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.30, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0027985. Respondent's last known address is 13495 N.E. 2nd Avenue, North Miami, Florida, 33161-2725.

FACTS PERTAINING TO PATIENT #1

3. From on or about April 19, 1988 to on or about May 3, 1988, Respondent treated Patient #1, a fifty (50) year old female,

at the Broward County Mental Health Division (BCMHD), Hollywood, Florida.

4. On or about April 19, 1988, Respondent admitted Patient #1 to BCMHD per a court order.

5. The admitting psychiatric information on Patient #1 revealed the following symptoms: auditory and visual hallucinations; impaired ability to reason and conceptualize; suicidal ideation; paranoia; and alcohol intoxification. Patient #1 also stated that she had nine (9) yellow rocks in her head, three (3) yellow rocks in her nose, and a talking radio in her stomach.

6. Based on the foregoing, Respondent gave Patient #1 an admission diagnosis of Schizophrenia Paranoia and Alcohol Intoxification.

7. Upon discovery of Patient #1's alcohol intoxification and possible drug use, Respondent should have ordered a toxicology panel and evaluated her for possible drug abuse.

8. On or about April 19, 1988, Respondent ordered a routine lab examination which revealed significantly elevated levels of cholesterol, phosphorous, uric acid, blood urea nitrogen (BUN), creatinine, and lymphocyte and decreased white and red blood counts.

9. Respondent did not mention any of these abnormal lab results in her medical records of Patient #1.

10. The attending psychiatrist of a new patient in an acute psychotic episode, whatever the etiology, should see the patient at least once every twenty-four (24) hours.

11. Respondent saw Patient #1 on or about April 20, 1988, April 26, 1988, and May 2, 1988, which amounts to seeing Patient #1 approximately once every six (6) days.

12. On or about May 3, 1988, hospital staff found Patient #1 lethargic, minimally responsive to painful stimuli, and wheezing. Based on these symptoms, hospital staff transferred Patient #1 to another hospital where another physician diagnosed Patient #1 with Malignant Neuroleptic Syndrome.

13. Respondent inappropriately failed to conduct further testing regarding Patient #1's alcohol and possible drug use.

14. Respondent inappropriately failed to acknowledge and ascertain the cause of Patient #1's abnormal blood test results.

15. Respondent inappropriately monitored Patient #1 by seeing her approximately once every six (6) days rather than once every twenty-four (24) hours.

COUNT ONE

16. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15), as if fully set forth herein this Count One.

17. Respondent is guilty of 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 in that Respondent: failed to conduct further

testing regarding Patient #1's alcohol and possible drug use; ignored Patient #1's abnormal blood test results; and failed to monitor Patient #1 on a consistent basis.

18. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, in that she is guilty of 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.

FACTS PERTAINING TO PATIENT #2

19. From on or about April 13, 1988 to on or about May 16, 1988, Respondent treated Patient #2, a forty-one (41) year old female at BCMHD.

20. On or about April 13, 1988, Respondent admitted Patient #2 to BCMHD per Baker Act.

21. Upon admitting Patient #2 to the hospital, Respondent conducted a cursory and inadequate psychiatric evaluation which led Respondent to diagnose the patient with Schizoaffective Disorder.

22. Psychotropic drugs are those which are commonly used in the treatment of mental illness. When a psychiatrist prescribes psychotropic drugs to a patient in substantial doses, it is important that the psychiatrist closely monitor the patient. When adjustments in these drugs are required, the psychiatrist should do so cautiously and slowly.

23. On or about April 14, 1988, Respondent prescribed to Patient #2 Lithium 300mg four (4) times a day, Thorazine 100mg four (4) times a day and Thorazine 50mg four (4) hours as needed (prn).

24. Lithium is a legend drug as defined by Section 465.003(7), Florida Statutes. Lithium should not be given to patients receiving diuretics due to a very high risk of Lithium toxicity. Patients receiving Lithium combined with high doses of phenothiazine should be monitored carefully and the medication should be increased cautiously and slowly. Lithium is a psychotropic drug.

25. Thorazine is a legend drug as defined by Section 465.003(7), Florida Statutes, and is a phenothiazine used to treat psychotic disorders. Thorazine is a psychotropic drug.

26. On or about April 15, 1988, Respondent increased Patient #2's Thorazine to 200mg four (4) times a day, and also prescribed Restoril 30mg at bedtime prn.

27. Restoril is a legend drug as defined by Section 465.003(7), Florida Statutes, and contains temazepam, a Schedule IV controlled substance listed in Chapter 893, Florida Statutes.

28. On or about April 19, 1988, approximately four (4) days after her last visit with Patient #2, Respondent increased Patient #2's Lithium to 600mg in the morning and 300mg at 1:00, 5:00 and 9:00 p.m. Respondent also increased Patient #2's Thorazine to 300mg four (4) times a day.

29. The same day, a medical consultant saw Patient #2 and ordered Lasix 40mg orally, twice daily.

30. On or about April 26, 1988, Respondent again saw Patient #2 and increased the patient's Lithium to 600mg three (3) times a day. Respondent also increased the patient's Thorazine to 400mg four (4) times a day and added the prescription of Artane 2mg twice a day.

31. Artane is a legend drug as defined by Section 465.003(7), Florida Statutes.

32. On or about April 27, 1988, Respondent ordered Thorazine 400mg four (4) times a day to continue until the following day, when the patient would begin Thorazine 300mg four (4) times a day.

33. On or about May 16, 1988, Respondent discharged Patient #2 from BCMHD.

34. Throughout Patient #2's entire hospitalization, Respondent only made progress notes monitoring the patient's condition on or about April 15, 18, 19, 26, 27, and 28, 1988 and on or about May 2, 1988. Respondent made no progress notes between May 2, 1988 and May 16, 1988.

35. Respondent failed to adequately evaluate Patient #2 upon admitting her to the hospital.

36. Respondent failed to adjust Patient #2's psychotropic medication slowly and carefully.

37. Respondent inappropriately permitted a consultant to prescribe Lasix to Patient #2 while the patient was taking Lithium.

38. Respondent failed to carefully monitor Patient #2 while she was suffering from an acute psychotic episode.

39. Respondent's medical records do not justify the prescribing of the aforementioned drug prescriptions and treatment for Patient #2.

COUNT TWO

40. Petitioner realleges and incorporates paragraphs one (1), two (2), and nineteen (19) through thirty-nine (39), as if fully set forth herein this Count Two.

41. Respondent is guilty of 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 in that Respondent failed to do the following: adequately evaluate Patient #2 upon admitting her to the hospital; adjust Patient #2's psychotropic medication slowly and carefully; stop the prescribing by a consultant of contraindicated medication to the patient; carefully monitor Patient #2 while she was suffering from an acute psychotic episode; and justify her treatment and prescribing in Patient #2's medical records.

42. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, in that she is guilty of 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.

COUNT THREE

43. Petitioner realleges and incorporates paragraphs one (1), two (2), nineteen (19) through thirty-nine (39), and forty-one (41), as if fully set forth herein this Count Three.

44. Respondent is guilty of 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 in that Respondent permitted a consultant to prescribe a contraindicated medication to Patient #2; and failed to adjust Patient #2's medication slowly and carefully.

45. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes, in that she is guilty of 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. For the purpose 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 intent.

COUNT FOUR

46. Petitioner realleges and incorporates paragraphs one (1), two (2), nineteen (19) through thirty-nine (39), forty-one (41), and forty-four (44), as if fully set forth herein this Count Four.

47. Respondent is guilty of failing to keep written medical

records justifying 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 in that Respondent failed to justify her drug prescriptions to Patient #2 in the patient's medical records.

48. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, in that she is guilty of failing to keep written medical records justifying 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.

FACTS PERTAINING TO PATIENT #3

49. From on or about July 27, 1987 to on or about July 13, 1988, Respondent admitted Patient #3, a fifty-two (52) year old female, to BCMHD on four (4) separate occasions. On all of these occasions, Respondent was Patient #3's admitting, attending, and discharging physician.

50. From on or about July 27, 1987 to on or about August 11, 1987, Patient #3 was hospitalized at BCMHD per Baker Act. During this time, Respondent treated Patient #3 for what Respondent diagnosed as Schizophrenioform Disorder.

51. Upon admitting Patient #3 to BCMHD, Respondent failed to do any of the following: record an admission note, obtain a

patient history, conduct a physical or psychiatric evaluation, or conduct a mental status examination.

52. During this initial hospitalization, Respondent and another physician prescribed the following medications to Patient #3: Haldol, Cogentin, Mellaril, Imipramine, Dalmane, Loxitane, Tofranil, Ativan and Thorazine.

53. Respondent and another physician changed the prescriptions of these medications on an average of approximately once every other day. However, during this hospitalization, Respondent only recorded progress notes monitoring the patient's condition on or about August 4, 5, and 6, 1987.

54. From on or about August 12, 1987 to on or about September 14, 1987, Patient #3 was hospitalized a second time at BCMHD per Baker Act. During this time, Respondent treated Patient #3 for what Respondent diagnosed as Adjustment Disorder and Mixed Emotional Features.

55. Upon admitting Patient #3 to BCMHD, Respondent failed to do any of the following: record an admission note, obtain a patient history, conduct a physical or psychiatric evaluation, or conduct a mental status examination.

56. During this second hospitalization, Respondent and another physician prescribed the following medications to Patient #3: Vistaril, Valium, Navane, Cogentin, Benadryl, Xanax, Loxitane, and Dalmane.

57. From on or about August 12, 1987 to on or about August 21, 1987, and from on or about August 31, 1987 to on or about

September 14, 1987, Respondent and the other physician changed the prescriptions of these medications on an average of approximately once every three (3) days.

58. Respondent only recorded progress notes monitoring the patient's condition on or about August 14, 18, 21, 31 and September 8, and 11, 1987.

59. From on or about August 21, 1987 to on or about August 31, 1987, Respondent failed to see or monitor the patient.

60. From on or about December 16, 1987 to on or about January 5, 1987, Patient #3 was hospitalized a third time at BCMHD. During this time, Respondent treated Patient #3 for what Respondent diagnosed as Adjustment Disorder, Depressed Mood, Mixed Substance Abuse, and Histrionic Personality.

61. During this third hospitalization, Respondent and another physician prescribed the following medications to Patient #3: Vistaril, Benadryl, and Dalmane.

62. Respondent and the other physician changed these prescriptions on an average of approximately once every four (4) days. However, Respondent only recorded progress notes monitoring the patient's condition on or about December 20, 22, 26, 27, 1987. All of these notes are cursory and illegible.

63. From on or about February 9, 1988 to on or about July 13, 1988, Patient #3 was hospitalized a fourth time at BCMHD. During this time, Respondent treated Patient #3 for what Respondent diagnosed as Dysthymia and Somatization Disorder.

64. During this fourth hospitalization, Respondent and another physician prescribed the following medications to Patient #3: Vistaril, Sinequan, Lithium, Loxitane, Cogentin, Valium, Ativan, Navane, and Dalmane.

65. Respondent failed to record any progress notes monitoring the patient's condition from on or about April 21, 1988 until the patient's discharge on or about July 13, 1988. There is no evidence in the patient's medical records that Respondent saw the patient at all during this extended period of time.

66. Respondent inappropriately failed to do the following upon Patient #3's first two (2) admissions to BCMHD: record admission notes, obtain a patient history, conduct physical or psychiatric evaluations, or conduct mental status examinations.

67. During all four (4) of Patient #3's hospitalizations, Respondent failed to appropriately monitor Patient #3.

68. Respondent's medical records of Patient #3 fail to justify Respondent's frequent shifts in medication ordered to the patient.

COUNT FIVE

69. Petitioner realleges and incorporates paragraphs one (1), two (2), and forty-nine (49) through sixty-eight (68), as if fully set forth herein this Count Five.

70. Respondent is guilty of 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 in that Respondent: failed to record admission notes, obtain a patient history, conduct a physical or psychiatric evaluation, or conduct mental status examinations upon Patient #3's first two (2) admissions to BCMHD; and failed to appropriately monitor Patient #3 during all four (4) of her hospitalizations at BCMHD.

71. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, in that she is guilty of 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.

COUNT SIX

72. Petitioner realleges and incorporates paragraphs one (1), two (2), forty-nine (49) through sixty-eight (68) and seventy (70), as if fully set forth herein this Count Six.

73. Respondent is guilty of failing to keep written medical records justifying 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 in that Respondent's medical records of Patient #3 fail to justify Respondent's frequent shifts in medication ordered to the patient.

74. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, in that she is guilty of failing to keep written medical records justifying 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.

FACTS PERTAINING TO PATIENT #4

75. From on or about April 23, 1988 to on or about October 12, 1989, Respondent admitted Patient #4, a seventy-three (73) year old male, to BCMHD on two (2) separate occasions. On both of the occasions, Respondent was Patient #4's admitting, attending, and discharging physician.

76. From on or about April 23, 1988 to on or about June 27, 1988, Patient #4 was hospitalized at BCMHD. During this time, Respondent treated Patient #4 for what Respondent diagnosed as Major Depression Disorder, Recurrent Moderate.

77. Upon admitting Patient #4 to BCMHD, Respondent failed to do any of the following: obtain a patient history, conduct a physical or psychiatric evaluation, or conduct a mental status examination.

78. During this hospitalization, Respondent and another physician prescribed the following medications to Patient #4: Sinequan, Vistaril, Restoril, and Haldol.

79. Respondent recorded progress notes monitoring the patient's condition on April 26, 27, 29, 1988, May 3, 1988, and June 24, 1988. The other physician recorded progress notes on April 25, 29, 1988, and June 1, 8, 1988. Neither Respondent nor

the other physician recorded any progress notes from on or about May 3, 1988 to on or about June 1, 1988.

80. From on or about July 18, 1989 to on or about October 12, 1989, Patient #4 was hospitalized a second time at BCMHD. During this time, Respondent treated Patient #4 for what Respondent diagnosed as Major Depression Recurrent.

81. On or about July 20, 1989, Respondent recorded an admission note which included a history of the patient's present illness, and some elements of a mental status exam. However, this admission notes lacks the following: a past history; family history; past psychiatric history; fully organized mental status exam; and a differential diagnosis.

82. Respondent and another physician recorded progress notes on the patient intermittently throughout September 19, 1989. However, there are no progress notes on the patient after this date.

83. Respondent failed to see Patient #4 between on or about September 19, 1989 to on or about October 12, 1989.

84. Upon admitting Patient #4 to BCMHD on both occasions, Respondent inappropriately failed to conduct an admission psychiatric evaluation, and conduct a formal mental status exam on Patient #4.

85. Respondent's progress notes of Patient #4 are not written with enough detail or frequency to justify Respondent's course of treatment.

86. Respondent inappropriately failed to see Patient #4 from on or about September 19, 1989 until his discharge on or about October 12, 1989.

COUNT SEVEN

87. Petitioner realleges and incorporates paragraphs one (1), two (2) and seventy-five (75) through eighty-six (86), as if fully set forth herein this Count Seven.

88. Respondent is guilty of 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 in that Respondent failed to do the following: conduct an admission psychiatric evaluation and formal mental status exam upon admitting Patient #4 to the hospital; and justify her treatment of Patient #4 in the patient's medical records.

89. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, in that she is guilty of 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.

COUNT EIGHT

90. Petitioner realleges and incorporates paragraphs one (1), two (2) and seventy-five (75) through eighty-six (86), and eighty-eight (88), as if fully set forth herein this Count Eight.

91. Respondent is guilty of failing to keep written medical records justifying 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 in that Respondent failed to justify her treatment of Patient #4 in the patient's medical records.

92. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, in that she is guilty of failing to keep written medical records justifying 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.

FACTS PERTAINING TO PATIENT #5

93. From on or about February 24, 1988 to on or about April 19, 1988, Respondent treated Patient #5, a forty-eight (48) year old male, at BCMHD.

94. On or about February 24, 1988, Respondent admitted Patient #5 to BCMHD. The same day, another physician prescribed to Patient #5 Mellaril 100mg tid and Cogentin 2mg H.S.

95. On or about February 29, 1988, approximately five (5) days after admitting Patient #5 to the hospital, Respondent recorded an admission note of the patient. This admission note is a sketchy, unorganized psychiatric progress note which lacks the following: a coherent history of the present illness; past

history; psychiatric history; medical history; a well organized mental status exam; a provisional diagnosis; and a differential diagnosis.

96. On or about April 19, 1985, Respondent discharged Patient #5 from the hospital.

97. Respondent failed to appropriately evaluate Patient #5 when she admitted him to the hospital.

98. Respondent maintained poor medical records of Patient #5 which inadequately track Patient #5's clinical condition.

COUNT NINE

99. Petitioner realleges and incorporates paragraphs one (1), two (2), and ninety-three (93) through ninety-eight (98), as if fully set forth herein this Count Nine.

100. Respondent is guilty of 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 in that Respondent failed to appropriately evaluate Patient #5 when she admitted him to the hospital.

101. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, in that she is guilty of 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.

COUNT TEN

102. Petitioner realleges and incorporates paragraphs one (1), two (2), ninety-three (93) through ninety-eight (98), and one hundred (100), as if fully set forth herein this Count Ten.

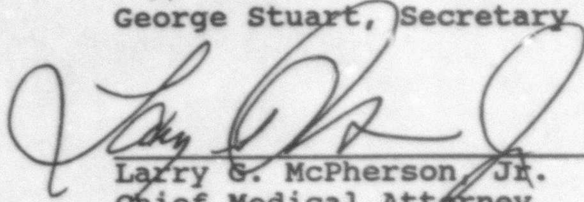
103. Respondent is guilty of failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations in that Respondent's medical records of Patient #5 inadequately track Patient #5's clinical condition.

104. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, in that she is guilty of failing to keep written medical records justifying 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.

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

SIGNED this 27 day of March, 1992.

George Stuart, Secretary



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FILED
Department of Professional Regulation
AGENCY CLERK

CLERK

DATE 3-30-92