STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

CASE NOS. 0100959, 0100960, and 0100961

v.

HORACIO ARIAS, 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 HORACIO ARIAS, 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 0027858. Respondent's last known address is 2150 West Buffalo Avenue, Tampa, Florida, 33607.

3. At all times material hereto, Respondent was employed by the Hillsborough Community Mental Health Center, Inc. (MHC) as a consultant to the individuals employed to screen the acutely mentally disturbed patients brought to the Crisis Stabilization Unit (CSU) of said facility.

4. The MHC Crisis Stabilization Unit is a central receiving point for acutely mentally ill clients in Hillsborough County.

5. This MHC facility provides for emergency psychiatric services, temporary detention for evaluation and/or diagnosis, and short term inpatient treatment for persons who are deemed to be a danger to themselves or others.

6. Said facility functions as an alternative to inpatient services twenty-four hours per day, seven days per week for mentally ill patients who are in an acutely disturbed state.

7. The standard operating policy of said facility is to have incoming patients evaluated by "Crisis Counselors," whose input to Respondent is the sole determinant of the evaluation, treatment, and disposition of said patients. The disposition, evaluation, and treatment are ultimately made by Respondent without the benefit of face to face medical examination.

Facts Relating to Patient #1

8. Patient #1 was a 44 year-old male, disabled veteran.

9. Patient #1 had been admitted to the Veterans Administration (VA) hospital on or about May 27, 1987, and hospitalized until June 3, 1987, for treatment of paranoid schizophrenia.

10. Patient #1 had a history of previous suicide attempts, including, but not limited to, attempts using drug overdose, car wrecks and laying in traffic.

11. Following his discharge from the VA hospital on or about June 3, 1987, Patient #1 was observed by members of the Tampa Police Department to be sitting in the middle of a road. At that time he advised law enforcement that he wished to kill himself because "the noise from the cars hurt his ears."

12. On or about June 3, 1987, around 5:20 P.M., Patient #1 was involuntarily transported via a BA-52 to the Crisis Stabilization Unit of the MHC.

13. The "Report of the Law Enforcement Officer" indicates the following: "There is substantial likelihood that in the near future said person (Patient #1) will inflict serious bodily harm on himself or another person as evidenced by recent behavior causing or attempting or threatening such harm."

14. On or about June 3, 1987, around 5:20 P.M., at the time of admission to the aforementioned facility, Patient #1 was screened by a Crisis Counselor.

15. The Crisis Counselor's only prior related training was an undergraduate degree in psychology and a graduate degree in sociology.

16. In performing the mental status examination, the counselor deferred the evaluation of the patient's ability to form abstract thought.

17. The counselor contacted Respondent by telephone and related information relating to Patient #1 obtained during the screening stage.

18. The counselor listed "malingering" as the diagnostic impression for Patient #1.

19. The counselor listed the disposition and treatment as, "Discharge patient to self per [Respondent], not in need of psychiatric admission."

20. On or about June 3, 1987, around 8:25 P.M., Patient #1 was released from the Crisis Stabilization Unit pursuant to the telephone orders of Respondent. Patient #1 received a recommendation to seek further treatment at the VA hospital.

21. On or about June 3, 1987, around 11:00 P.M., Patient #1 was found dead on I-275 (off SR 93) after being struck by a motorcycle and sustaining a severe head injury.

22. Subsequently, Respondent signed Patient #1's records without ever physically seeing the patient.

23. Respondent delegated professional responsibilities to a person whom Respondent knew, or had reason to know, that such person was not qualified by training, experience or licensure to perform said responsibilities, in that Respondent delegated screening and clinical evaluation of Patient #1 to the counselor.

24. Respondent made or filed a report which he knew to be false, in that Respondent subsequently signed the medical records of Patient #1 which were prepared by the counselor on a patient never directly clinically examined by Respondent.

25. Respondent failed to keep written records justifying the course of treatment of the patient, in that Respondent failed to record Patient #1's history, screening and evaluation.

26. Respondent failed to practice medicine with that level of care, skill, and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and

circumstances, in that Respondent failed to consider collateral information of Patient #1's previous mental disturbance and suicidal ideation, ordered the release of Patient #1 based almost entirely on the evaluation of a non-licensed Crisis Counselor, and inadequately diagnosed and treated Patient #1 without any direct patient contact.

COUNT ONE

27. Petitioner realleges and incorporates paragraphs one (1) through twenty-three (23) as if fully set forth herein this Count One.

28. Based upon the foregoing, Respondent violated Section 458.331(1)(w), Florida Statutes, by delegating professional responsibilities to a person whom the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

COUNT TWO

29. Petitioner realleges and incorporates paragraphs one (1) through fourteen (14), seventeen (17) through twenty (20), and twenty-two (22) and twenty-four (24) as if fully set forth herein this Count Two.

30. Based upon the foregoing, Respondent violated Section 458.331(1)(h), Florida Statutes, by making or filing report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall

include only those which are signed in the capacity as a licensed physician.

COUNT THREE

31. Petitioner realleges and incorporates paragraphs one (1) through twelve (12), fourteen (14) through twenty (20), and twenty-five (25) as if fully set forth herein this Count Three.

32. Based upon the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes, in that Respondent failed to keep written medical records justifying the course of treatment of the patient, including, but not limited to patient histories, examination results, and test results.

COUNT FOUR

33. Petitioner realleges and incorporates paragraphs one (1) through twenty-two (22), and twenty-six (26) as if fully set forth herein this Count Four.

34. Based upon the foregoing Respondent violated Section 458.331(1)(t), Florida Statutes, by gross or repeated malpractice of 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 Relating to Patient #2

35. Patient #2, a 44 year-old female, was transported involuntarily to the Crisis Stabilization Unit of the MHC by law enforcement officers acting under the authority of the Baker Act, on or about July 17, 1987.

36. At the time of her admission to said facility, Patient #2 was observed by law enforcement officers to be delusional with impaired judgement.

37. Patient #2 manifested signs of paranoid schizophrenia coupled with delusions, possibly due to an underlying organic psychosis, in that she related to health care officials that the police were taking her to the CSU so that they could "take her home away from her."

38. On or about July 17, 1987, around 4:30 P.M., Patient #2 was screened and evaluated by a Crisis Counselor.

39. The counselor listed the diagnostic impression for Patient #2 as "Life Circumstances Problem."

40. The counselor erroneously noted that Patient #2 had no psychosis or thought disorder.

41. In performing the mental status examination, the counselor deferred the evaluation of the patient's ability to form abstract thought.

42. The counselor's only prior related training was an associate degree in Human Services.

43. On or about July 17, 1987, around 9:00 P.M., Patient #2 was released from the Crisis Stabilization Unit on the telephone orders of Respondent. Patient #2 received a recommendation to seek further treatment at a neighborhood service center.

44. On or about July 20, 1987, Patient #2 committed suicide by shooting herself in the head with a revolver while inside a burning building.

45. Subsequently, Respondent signed Patient #2's medical records without ever physically seeing the patient.

46. Respondent delegated professional responsibilities to a person whom Respondent knew, or had reason to know, that such person was not qualified by training, experience or licensure to perform said responsibilities, in that Respondent delegated screening and clinical evaluation of Patient #2 to the counselor.

47. Respondent made or filed a report which the licensee knew to be false, in that Respondent subsequently signed the medical records of Patient #2 which were prepared by the counselor on a patient never directly clinically examined by Respondent.

48. Respondent failed to keep written records justifying the course of treatment of the patient, in that Respondent failed to record patient history, screening and evaluation of Patient #2.

49. Respondent failed to practice medicine with that level of care, skill, and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances, in that Respondent failed to consider collateral information of Patient #2's previous mental condition, ordered the release of Patient #2 based almost entirely on the evaluation of non-licensed Crisis Counselor, inadequately diagnosed and treated Patient #2 without the benefit of direct patient contact.

COUNT FIVE

50. Petitioner realleges and incorporates paragraphs one (1) through seven (7) and thirty-six (36) through forty-six (46) as if fully set forth herein this Count Five.

51. Based upon the foregoing, Respondent violated Section 458.331(1)(w), Florida Statutes, by delegating professional responsibilities to a person when the licensee delegating such responsibilities qualified by training, experience, or licensure to perform them.

COUNT SIX

52. Petitioner realleges and incorporates paragraphs one (1) through seven (7), thirty-five (35) through forty-three (43), and forty-five (45) and forty-seven (47) as if fully set forth herein this Count Six.

53. Based upon the foregoing, Respondent violated Section 458.331(1)(h), Florida Statutes, by making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the capacity as a licensed physician.

COUNT SEVEN

54. Petitioner realleges and incorporates paragraphs one (1) through seven (7), thirty-five (35) through forty-three (43), and forty-eight (48) as if fully set forth herein this Count Seven.

55. Based upon the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, by failing to keep written medical records justifying the course of treatment of the patient, including, but no limited to patient histories examination results, and test results.

COUNT EIGHT

56. Petitioner realleges and incorporates paragraphs one (1) through seven (7), thirty-five (35) through forty-seven (47) and forty-nine (49) as if fully set forth herein this Count Eight.

57. Based upon the foregoing Respondent violated Section 458.331(1)(t), Florida Statutes, by being guilty of gross or repeated malpractice of 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 Relating to Patient #3

58. Patient #3 was a 38 year old male disabled veteran with a 100% service related disability.

59. On or about the evening of May 20, 1987, law enforcement officers found Patient #3 sitting on the ground in a disoriented state.

60. Patient #3 was voluntarily transported to the Crisis Stabilization Unit by ambulance at or about midnight of May 20, 1987. At this time, he was documented as being an epileptic currently on medication, having a fifteen year history of alcohol abuse, and being disoriented as to time and place.

61. On or about May 21, 1987, around 1:15 A.M., Patient #3 was screened and evaluated by a Crisis Counselor.

62. The counselor contacted Respondent by telephone and related information obtained from Patient #3.

63. The counselor listed the diagnostic impression for Patient #3 as "ETOH Abuse" (alcohol abuse).

64. The counselor noted that Patient #3 admitted to two prior suicide attempts, with the last attempt ten years prior to this examination.

65. The counselor noted no gross psychosis, no suicidal ideation, and that the patient was fully oriented.

66. In performing the mental status examination, the counselor deferred the evaluation of the patient's ability to form abstract thought.

67. The counselor noted that Patient #3 was currently taking the following seizure medications: Dilantin 100 mg four times a day, and Phenobarbitol 50 mg four times a day.

68. The counselor's only prior related training was a baccalaureate degree in Human Relations.

69. On or about May 21, 1987, around 1:45 A.M., Patient #3 was released from the Crisis Stabilization Unit on the telephone orders of Respondent, and was given a recommendation to seek further treatment at a VA hospital where he would be able to obtain treatment due to his 100% service related disability.

70. At the time of Patient #3's release from the CSU at 1:25 A.M., the VA facility was not open. Patient #3 could have been admitted later that morning, around 8:00 A.M.

71. Patient #3 was the victim of a hit and run motorcycle accident on or about May 21, 1987, around 2:45 A.M.

72. On or about May 21, 1987, around 6:47 A.M., Patient #3 died from multiple injuries resulting from blunt trauma.

73. No trace of alcohol was found in Patient #3's blood.

74. Subsequently, Respondent signed Patient #3's medical records without ever physically seeing the patient.

75. Respondent delegated professional responsibilities to a person whom Respondent knew, or had reason to know, that such person was not qualified by training, experience, or licensure to perform said responsibilities, in that Respondent delegated screening and clinical evaluation of Patient #3 to the counselor.

76. Respondent made or filed a report which he knew to be false, in that Respondent subsequently signed the medical records of Patient #3, which were prepared by a counselor on a patient never directly clinically examined by Respondent.

77. Respondent failed to keep written records justifying the course of treatment of the patient, in that Respondent failed to record patient history, screening and evaluation of Patient #3.

78. Respondent failed to practice medicine with that level of care, skill, and treatment which a reasonably prudent similar physician recognizes as acceptable under similar conditions and circumstances, in that Respondent failed to consider collateral information of Patient #3's mental condition, particularly his orientation; ordered the release of Patient #3 based almost entirely on the evaluation of a non-licensed Crisis

Counselor, that said release of Patient #3 was inappropriate under the circumstances in that the patient should have been taken to an ER or held until such time as the VA was open for business; and inadequately diagnosed and treated Patient #3 without the benefit of direct patient contact.

COUNT NINE

79. Petitioner realleges and incorporates paragraphs one (1) through seven (7) and fifty-eight (58) through seventy-five (75) as if fully set forth herein this Count Nine.

80. Based upon the foregoing, Respondent violated Section 458.331(1)(w), Florida Statutes, by delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

COUNT TEN

81. Petitioner realleges and incorporates paragraphs one (1) through seven (7), fifty-eight (58) through sixty-nine (69), seventy-four (74) and seventy-six (76) as if fully set forth herein this Count Ten.

82. Based upon the foregoing, Respondent violated Section 458.331(1)(h), Florida Statutes, by making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the capacity as a licensed physician.

COUNT ELEVEN

83. Petitioner realleges and incorporates paragraphs one (1) through seven (7), fifty-eight (58) through sixty-nine (69) and seventy-seven (77) as if fully set forth herein this Count Eleven.

84. Based upon the foregoing, Respondent has violated Section 458.331(1)(m), Florida Statutes, by failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to patient histories. examination results, and test results.

COUNT TWELVE

85. Petitioner realleges and incorporates paragraphs one (1) through seven (7), fifty-eight (58) through seventy-four (74), and seventy-eight (78) as if fully set forth herein this Count Twelve.

86. Based upon the foregoing, Respondent has violated Section 458.331(1)(t), Florida Statutes, by being guilty of gross or repeated malpractice of he 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.

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

SIGNED this 24th day of October, 1990.

Larry Gonzalez, Secretary

By: Stephanie A. Daniel
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

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CJR/MF/tb
10/22/90

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK

DATE 10-24-90

FILED
Department of Professional Regulation
AGENCY CLERK

DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

CLERK [signature]

DATE 7-16-91

DEPARTMENT OF PROFESSIONAL REGULATION,

Petitioner,

-vs-

DPR CASE NUMBERS: 0100959
0100960
0100961
LICENSE NUMBER: ME 0027858

HORATIO ARIAS, M.D.,

Respondent.

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FINAL ORDER

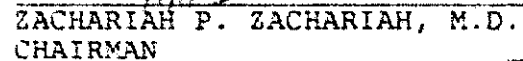
THIS MATTER came before the Board of Medicine (Board) pursuant to Section 120.57(3), Florida Statutes, on June 1, 1991, in Orlando, Florida, for consideration of a Stipulation (attached hereto as Exhibit A) entered into between the parties in the above-styled case. Upon consideration of the Stipulation, 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 Stipulation as submitted be and is hereby approved and adopted in toto and incorporated by reference herein. Accordingly, the parties shall adhere to and abide by all of the terms and conditions of the Stipulation.

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

DONE AND ORDERED this _____ day of ______________, 1991.

BOARD OF MEDICINE



ZACHARIAH P. ZACHARIAH, M.D.
CHAIRMAN

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Order has been provided by certified U.S. mail to Horatio Arias, M.D., c/o Grover C. Freeman, Esquire, 4600 West Cypress Street, Suite 500, Tampa, Florida 33607, and by interoffice delivery to Bruce D. Lamb, Chief Trial Attorney, Department of Professional Regulation, 730 South Sterling Street, Suite 201, Tampa, Florida 333609, at or before 5:00 P.M., this 16 day of July, 1991.

DOROTHY J. FAIRCLOTH
Executive Director