STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION

BOARD:	Medicine
CASE NUMBER:	89-10063
COMPLAINT MADE BY:	P.S.
DATE COMPLAINT RECEIVED:	10-3-89
COMPLAINT MADE AGAINST:	Hector Corzo, M.D. 11200 Seminole Blvd., Ste. 203 Largo, Florida 34648
REVIEWED BY:	Francesca Plendl, Senior Attorney FP
STAFF RECOMMENDATION:	Close (PL-82)

CLOSING ORDER AND NOTICE OF DISMISSAL

THE COMPLAINT: Complainant alleges that the Subject failed to practice medicine with an acceptable level of care, skill and treatment by failing to adequately evaluate and treat a psychiatric patient before releasing him from an emergency care facility; and that the Subject failed to maintain adequate medical records.

THE FACTS: On February 16, 1989, Patient P.S. was committed via Baker Act by St. Petersburg police to Pinellas Emergency Mental Health Service (P.E.M.H.S.) on a seventy-two hour admission. On the same day, Patient P.S. was evaluated by a physician, who diagnosed Patient P.S. as suffering from an acute psychotic reaction. The physician petitioned for an involuntary commitment, as the seventy-two hour admission was to expire over the weekend. The same physician saw Patient P.S. the following day and found him to be somewhat improved and responding to medication, but still experiencing psychiatric problems.

On February 18, 1989, the Subject took over Patient P.S.'s treatment. Patient P.S.'s family wanted the patient released as soon as possible, and the patient expressed a desire to start outpatient treatment with medication. On February 20, 1989, the Subject discharged the patient with a prescription for Haldol and an appointment for follow up care on February 24, 1989 at Mental Health Services. On February 23, 1989, Patient P.S. shot and killed himself at his parent's home.

The physician who initially treated Patient P.S. at the facility has reviewed the applicable records. He

states that in his opinion Patient P.S. had recovered at the time of discharge to the extent that discharge was appropriate.

Neville Marks, M.D., a Board certified psychiatrist, reviewed this case for the Department. He felt that the Subject fell below the standard of care, in that: (1) he failed to take an adequate history of the patient; (2) he failed to rule out suicidal ideation; (3) he failed to address the causation of the sudden onset psychosis; (4) he failed to rule out a diagnosis of major depression or bipolar disorder; and (5) the discharge plan did not reflect appropriate transition of care.

James B. Boorstin, M.D., a Board certified psychiatrist, also reviewed the matter for the Department. He states: "I believe that the subject and the Crisis Stabilization Unit adequately assessed the patient's conditions and complaints. This included appropriate laboratory testing... The patient was adequately prescribed anti-psychotic medications, stabilizing benzodiazepines and anti-Parkinson drugs while in the hospital... The written medical records prepared by the subject and staff are adequate for a Crisis Stabilization Unit of a community mental health center. This justified the course of the treatment of the patient, including history, examination and test results". Dr. Boorstin stated that it was not uncommon for a Social Worker to obtain a history from parents, when the patient is unable to give one. He concluded that "It is my reasonable, medical opinion that the subject did meet the applicable standards of care in his examination, diagnosis and treatment of the patient."

Two experts reviewed the case for the Subject. Daniel Sprehe, M.D., a Board certified psychiatrist, states that in his opinion the Subject did not fall below the standard of care. He states that there was no indication at any time during the patient's stay at P.E.M.H.S. that the patient was suicidal, and that there were no signs of psychosis at the time of discharge. In addition, the patient expressed a desire to obtain outpatient follow-up, and to take medication, expressing realistic plans for the future. The patient was indicating at the time of release that he understood that his beliefs on admission were delusional.

Dr. Sprehe opines that the Subject "...kept good clinical records justifying the course of treatment. He practiced well within the standard of care at all times, both in his diagnosis and his treatment and his decision making regarding discharge of [the patient]. I see no dereliction of duty in [the Subject's] actions in this matter." Dr. Sprehe states that under the Baker Act requirements, the least restrictive alternative must be utilized in dealing with patients, and that in this case, the appropriate course was outpatient treatment.

In response to Dr. Marks' concerns, Dr. Sprehe states that: (1) the lack of history was due to the patient's lack of cooperation; the social history that was obtained was adequate and it was within the standard of care for the Subject to rely on it; (2) suicidal ideation did not need to be specifically ruled out, as there were no presenting suicidal symptoms during the hospitalization; (3) as the cause of schizophrenia is unknown, the standard of care does not require that causation be addressed when treating a schizophrenic patient; (4) there is no documentation to support a diagnosis of bipolar disorder or major depression; and (5) there was an appropriate transition of care, in that the patient expressed interest in outpatient treatment and a follow up appointment was made.

Gisela Garcia-Leyva, M.D., a Board certified psychiatrist, also reviewed the case for the Subject. She states that in her opinion, the Subject did not fall below the standard of care in his treatment of the patient. She states that "The records, by the end of [the patient's] hospitalization, clearly show that the patient had improved remarkably and that the physician felt the patient had reached maximum benefits from hospitalization and there were no contraindication for his discharge".

Dr. Garcia-Leyva reviewed Dr. Marks' written opinion and responded to his concerns. She states that: (1) the standard of care does not require that all possible diagnoses be considered. The most probable diagnoses were addressed and that is all that is required; (2) the patient did not meet the criteria for involuntary hospitalization under the Baker Act.

Dr. Garcia-Leyva states "It is my professional opinion that the records reflect positively all of the above and that the patient received an appropriate diagnosis, treatment and discharge date as indicated, all well within the applicable standard of care".

THE LAW: There is sufficient evidence for the panel to have found probable cause in this case. However, based upon the above facts, the Department has determined that there is insufficient evidence to support the prosecution of allegations contained therein. Therefore, pursuant to Section 455.225(2), Florida Statutes and Rule 21-31.001, Florida Administrative Code, this case is DISMISSED.

It is, therefore, ORDERED that this matter should be and the same is hereby DISMISSED.

DONE and ORDERED this 16 day of April, 1993

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney