STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION

BOARD:	Medicine
CASE NUMBER:	89-12147
COMPLAINT MADE BY:	G[redacted] M[redacted]
DATE COMPLAINT RECEIVED:	March 17, 1989 (sic - see UCF from complainant)
COMPLAINT MADE AGAINST:	Linda S. Harper, M.D. 101 Park Place Blvd., Suite 2A Kissimmee, Florida 32741
REVIEWED BY:	Arthur B. Skafidas, AS Senior Attorney
STAFF RECOMMENDATION:	Close (PL-82)

NOTICE OF DISMISSAL

The Law: Pursuant to Section 455.224(2), Florida Statutes, and Rule 21-31.001, Florida Administrative Code, this case is hereby DISMISSED.

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

DONE AND ORDERED this 30 day of June, 1993.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

PCP : 6/23/93

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK Sarah Wachman
DATE 6/30/93

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,
Petitioner,

vs.

DOAH Case No.: 92-7218
DPR Case No.: 8912147

LINDA S. HARPER, M.D.

Respondent.
_____/

AMENDED ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Professional Regulation, hereinafter referred to as "Petitioner," and files this Amended Administrative Complaint before the Board of Medicine against LINDA S. HARPER, 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 0047292. Respondent's last known address is 101 Park Place Boulevard, Suite 2-A, Kissimmee, Florida 32741.

3. On or about March 7, 1989, Patient #1 was admitted to Osceola Evaluation and Treatment Center (OETC) with a preliminary diagnosis of unspecified schizophrenia and single-episode major depression.

4. On or about March 14, 1989, Respondent first saw and became responsible for Patient #1's care.

5. Respondent recorded in her initial interview notes that patient claimed he was malingering.

6. The patient chart for Patient #1 reflected mood swings, irritability, non-compliance, tenseness, refusal to take medications, bizarre movements and laughing inappropriately.

7. The patient chart for Patient #1 reflected that Patient #1 stated he would kill himself if discharged only three (3) days before he was released from OETC.

8. On or about March 17, 1989, Patient #1 underwent a psychological evaluation by Michelle Byron, M.A. and Leonard Skizynski, Ph.D.

9. On or about March 18, 1989, Respondent discharged Patient #1 from OETC.

10. On or about March 29, 1989, Patient #1 committed suicide in Las Vegas, Nevada.

11. Respondent never performed a comprehensive psychiatric examination of Patient #1.

12. 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 perform a comprehensive psychiatric examination of Patient #1.

13. 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.

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 1 day of December, 1992.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Richard A. Grumberg
Senior Attorney
Department of Professional
Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-0792

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK _____

DATE 12-9-92

STATE OF FLORIDA
DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF PROFESSIONAL REGULATION,

PETITIONER,

vs. CASE NO. 8912147

LINDA S. HARPER, 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 LINDA S. HARPER, 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 0047292. Respondent's last known address is 101 Park Place Boulevard, Suite 2-A, Kissimmee, Florida, 32741.

3. On or about March 7, 1989, Patient #1 was admitted to Osceola Evaluation and Treatment Center (OETC) with a preliminary diagnosis of unspecified schizophrenia and single-episode major depression.

4. On or about March 8, 1989, Patient #1 underwent a physical examination performed by Dr. Jose Suarez. Patient #1 had a white blood cell count of 14,500 (high).

5. On or about March 9, 1989, Patient #1 was prescribed Tegretol by Dr. Peter Poulos.

6. Tegretol (carbamazepine) is an anti-convulsant and specific analgesic for trigeminal neuralgia. Tegretol is not classified as an antidepressant.

7. On or about March 14, 1989, Respondent first saw and became responsible for Patient #1's care.

8. Respondent recorded in her initial interview notes that Patient #1 was "malingering" or feigning illness in order to be admitted to OETC. Respondent also recorded that Patient #1 admitted to malingering.

9. Respondent ordered a psychological evaluation to confirm her diagnosis of malingering.

10. On or about March 17, 1989, Patient #1 underwent a psychological evaluation by Michelle Byron, M.A. and Leonard Skizynski, Ph.D. The psychologists confirmed Respondent's diagnosis of malingering.

11. On or about March 18, 1989, Respondent discharged Patient #1 from OETC.

12. On or about March 29, 1989, Patient #1 committed suicide in Las Vegas, Nevada.

13. Patient #1's high blood cell count (14,300) was never investigated while under Respondent's care.

14. Respondent did not prescribe antidepressants to treat Patient #1's suicidal ideation.

15. Respondent never performed a comprehensive psychiatric examination of Patient #1.

16. Respondent ignored numerous references in Patient #1's chart by OETC staff members to mood swings, irritability, non-compliance, tenseness, refusal to take medications, bizarre movements, and laughing inappropriately.

17. Respondent ignored reports from staff members that Patient #1 stated he would kill himself if discharged only three (3) days before he was released from OETC.

18. Respondent ignored pleas of Patient #1's family and of his live-in girlfriend, that Patient #1 was suicidal and should not be discharged.

19. Respondent knew or had reason to know Patient #1 was suicidal, in that Respondent telephoned Patient #1's girlfriend on or about March 15, 1989, and instructed her to remove a shot gun from Patient #1's apartment.

20. It was impossible for Respondent to make an accurate diagnosis of malingering in only an initial interview.

21. Respondent deviated from the appropriate standard of care when she unquestioningly accepted the confirming diagnosis of malingering; especially in light of Patient #1's parents' and friends' pleas and numerous reports of bizarre behavior by OETC staff.

22. 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: investigate Patient #1's high white blood cell count; prescribe antidepressants to treat his suicidal ideation; perform a comprehensive psychiatric examination; heed the numerous pleas of family and friends as well as reports from staff members of Patient #1's behavior; correctly diagnose and treat Patient #1 for his disorder; and obtain a second psychological opinion in light of Patient #1's behavior.

23. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, by being 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.

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 5 day of September, 1991.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Larry G. McPherson, Jr.
Chief Medical Attorney
Department of Professional Regulation
1940 North Monroe Street
Tallahassee, Florida 32399-0750
Florida Bar #788643
CJR/hrb/tc
PCP: August 24, 1991
Ashkar, Skinner and McEwen

FILED
Department of Professional Regulation
AGENCY CLERK

CLERK

DATE 9-5-91