3

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

Final Order No. AHCA-95-00918 Date 6-26-95
FILED
Agency for Health Care Administration
AGENCY CLERK
R.S. Power, Agency Clerk
By: Brandon S. Moore
Deputy Agency Clerk

BOARD: Medicine

CASE NUMBER: 93-18255

COMPLAINT MADE BY: L.D.

DATE COMPLAINT RECEIVED: December 02, 1994

COMPLAINT MADE AGAINST: Viola Ybanez Taboada, M.D.
730 S.E. 5th Terr.
Crystal River, Florida 34428

INVESTIGATED BY: Joseph J. Callahan
Gainsville

REVIEWED BY: Frederick Whitson/MB

STAFF RECOMMENDATION: CLOSE (PL-82)

CLOSING ORDER

THE COMPLAINT: Complainant alleges that the Subject inappropriately evaluated and diagnosed U.S.P. as competent.

THE FACTS: Respondent is charged by Administrative Complaint with violation of 458.331(1)(m) and (t), Florida Statutes. Specifically the Respondent is charged with 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 the Respondent failed to obtain a sufficient history of patient U.S.P.'s illness with documentation of signs, symptoms, and behavioral difficulties. The Respondent failed to keep written medical records justifying the course of treatment, and failed to obtain or record sufficient information to support a psychiatric diagnosis.

The facts of this case are that the Respondent was charged with the above violations based in large part on an opinion rendered by an Agency Expert (Dr. Brightwell). The Expert found the care rendered by the Respondent fell below the acceptable standard of care in that the Respondent did not adequately assess the patient's condition or complaints. The Expert determined that the Respondent's evaluation was much to superficial to allow the Respondent to form a medical opinion as to the patient's competency. The Expert determined that the medical records were insufficient to support such a diagnosis. The Expert opined that a chronological history of the present illness, from the time of onset to the present should have been obtained. Such chronological history should include documentation of signs, symptoms, and the course of these over time. The Expert indicated that behavioral observations made by others familiar with the patient should have also been taken into account. There was no indication that the records reflected this was done.

Mr. K. Brooten indicated in his response letter that the written report of the consultation and re-consultation in this case is clear and directly contradicts Dr. Brightwell's conclusion that: "The Subject did not adequately assess the patient's condition or complaints." Mr. Brooten also noted that contrary to Dr. Brightwell's assertion, no other mental health consultations were indicated. Furthermore, Mr. Brooten noted an analysis of this complaint clearly indicates that L.D. is blatantly attempting to have a physician change a medical opinion to allow her to obtain control of U.S.P.'s property.

Subsequently, the Agency referred this case to a second Expert (Dr. Nadjafi) who opined that the Respondent performed an adequate psychiatric consultation for the purpose of responding to specific questions from the patient's attending physician. The subsequent Expert determined the purpose of the examination was not to give a complete comprehensive psychiatric evaluation, as the previous Agency Expert concluded, but to give a brief psychiatric evaluation and consultation which is routinely done in hospitals under very limited time by which the consultant has to respond to specific questions of the attending physician and limited availability of information often times the patient being the only source of information.

The subsequent Expert found that the Respondent's diagnosis of the patient's condition was appropriate. The subsequent Expert determined that the Respondent diagnosed Major Depressive Disorder which under the circumstances seemed probable. The subsequent Expert determined that the Respondent referred the patient back to the attending physician and made a number of recommendations such as a referral to H.R.S. for placement and outpatient treatment, and the continuation of treatment of Depression as an outpatient whenever the patient medical condition permitted. The subsequent Expert indicated that as a result of the patient's difficulty with memory and independent information, one cannot meet the entire scope of criteria for the diagnosis according to the guidelines of DSM-III-R criteria. The subsequent expert stated that if the patient's family was not happy nor satisfied with the results of the Respondent's opinions that they could have sought a second opinion.

Because the underlying bases for the charges against the Respondent have been significantly eroded through the development of additional information after a review by a subsequent Expert, the Agency hereby notifies the panel of its intent to dismiss this case for lack of sufficient evidence to proceed with prosecution, and ask that you concur with its' dismissal of this case.

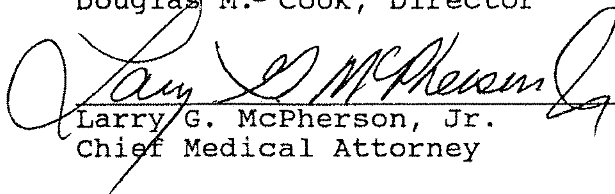
THE LAW: There was sufficient evidence for the Panel to have found probable cause in this case. However, based on the above facts and the recent opinion of the Agency's expert, it has been determined that there is insufficient evidence to support the prosecution of the allegation contained in the Administrative Complaint. Therefore, pursuant to Section 455.225(2), Florida

Statutes, this case is dismissed.

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

DONE AND ORDERED this 22 day of June, 1995.

Douglas M. Cook, Director



Larry G. McPherson, Jr.
Chief Medical Attorney

Frederick Whitson/MB
PCP: June 14, 1995