STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF MEDICINE

AGENCY FOR HEALTH CARE ADMINISTRATION,

PETITIONER,

vs. CASE NO. 95-02001

WALTER FREDRICK ANGELL, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Agency for Health Care Administration, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Walter Fredrick Angell, hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.42, Florida Statutes, Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and was at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0055211. Respondent's last known address is 1870 Aloma Avenue, Suite 120, Winter Park, Florida 32789.

3. Respondent is Board Certified in psychiatry.

Facts Pertaining to Patient A.G.

4. On or about August 5, 1993, at approximately 6:11 a.m., Patient A.G., a nineteen (19) year old female, presented to the Emergency Room of Florida Hospital Medical Center via ambulance.

5. Patient A.G., in a suicide attempt, overdosed on Butalbital and erythromycin. Patient A.G.'s presenting complaint was major depression. Following presentation, Patient A.G. was transferred to Florida Hospital Medical Center in East Orlando where she was admitted under the Baker Act to the psychiatric service of the Respondent.

6. Patient A.G., presented with a history of an unstable family life, including the break-up of a close relationship, and arguments with friends. Patient A.G. stated that she "just wanted to get rid of the pain" and took an unknown quantity of pills. Patient A.G. also stated that she had been depressed for more than a year.

7. Respondent, performed an initial psychiatric evaluation, which included a classical interview to obtain Patient A.G.'s history, a mental status examination, and a physical examination. Following evaluation, Respondent diagnosed Patient A.G. as having an Adjustment Disorder With Depressed Mood. Treatment plans were formulated at the time of admission.

8. The following day, on or about August 6, 1993, records indicate that Patient A.G. was upset, tearful, hostile sounding, depressed, and agitated, but denied suicidal thoughts or plans. Records also indicate that Patient A.G. was very upset about being

in that unit and said "anyone is out of their mind who thinks this place can help me."

9. On or about August 6, 1993, the same day, Respondent discharged Patient A.G. with plans for follow-up in the Respondent's office and instructions for Patient A.G. to follow-up with her primary physician for hypocalcemia.

10. Respondent did not prescribe any medications to Patient A.G.. A reasonably prudent similar physician would have considered antidepressant therapy for Patient A.G.. There was no documentation in the medical records of the Respondent's rationale as to why Patient A.G. was not considered for antidepressant therapy.

11. The Respondent's documentation of the course of treatment was inadequate regarding the progress notes entered on August 5 & 6, 1993.

12. Respondent failed to adequately assess Patient A.G.'s presenting condition or complaints. Respondent diagnosed Patient A.G. as suffering from Adjustment Disorder with Depressed Mood. A reasonably prudent similar physician would have made Major Depression, Recurrent one of the differential diagnoses in view of the recurrent nature of Patient A.G.'s depression.

13. Respondent failed to request for an appropriate consultation the serious presenting complaint as well as the involuntary admission of Patient A.G..

14. A reasonably prudent similar physician would have requested a second opinion from another psychiatrist prior to the discharge of Patient A.G.

15. Respondent failed to pursue the appropriate plan of treatment for Patient A.G.. A reasonably prudent similar physician would have documented parameters to monitor Patient A.G.'s suicidality, and attempted family therapy in view of the significant family conflicts.

Count One

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

17. Respondent is guilty of failing 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 consider Patient A.G. for antidepressant therapy, Respondent failed to consider Major Depression, Recurrent as one of the differential diagnoses in view of the recurrent nature of Patient A.G.'s depression, Respondent failed to request an appropriate consultation, Respondent failed to request a second opinion from another psychiatrist prior to the discharge of Patient A.G., Respondent failed to pursue the appropriate plan of treatment for Patient A.G., and Respondent failed to attempt family therapy in view of the significant family conflicts.

18. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, and is guilty 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.

Count Two

19. Petitioner realleges and incorporates paragraphs one (1) through fifteen (15) and seventeen (17) as if fully set forth herein this Count Two.

20. 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 hospitalization, in that Respondent failed to document his rationale as to why Patient A.G. was not considered for antidepressant therapy, Respondent failed to document parameters regarding the monitoring of Patient A.G.'s suicidality, and Respondent's documentation of the course of treatment was inadequate regarding the progress notes entered on August 5 & 6, 1993.

21. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, and 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 P.A.C.

22. On or about July 14, 1993, Patient P.A.C., a thirty-three (33) year old female, with a history of drug overdose, substance abuse, and a Depressive Disorder, presented to the Emergency Room of Florida Hospital Medical Center via private car.

23. Patient P.A.C. took an overdose of soma (muscle relaxer) which she takes for a chronic back ailment. Patient P.A.C. also takes Xanax for chronic anxiety. Upon presentation, Patient P.A.C. was lavaged and charcoal was given.

24. Patient P.A.C. was admitted on an involuntary status to the psychiatric floor of Florida Hospital Medical Center to the services of the Respondent. Respondent's diagnosis upon admission was Major Depression.

25. Respondent performed a Psychiatric History which included a Mental Status Examination and a Physical Examination. Respondent indicated in the Mental Status Examination that Patient P.A.C. is a suicidal risk. Treatment plans were formulated at the time of admission.

26. Respondent's initial treatment plans included completion of the psychosocial history, Patient P.A.C. signing voluntarily into Group and Milieu therapy, and Patient P.A.C. being transferred to the open affective ward.

27. On or about July 19, 1993, Respondent discharged Patient P.A.C. Respondent's diagnosis upon discharge was Adjustment Disorder with Depressive Mood, and Substance Abuse - Cocaine and

Meprobamate. Respondent prescribed .5mg of Xanax to be taken twice daily for fourteen days, and 350mg of Soma. Respondent scheduled a follow-up appointment with Patient P.A.C. for on or about August 2, 1993, in his office.

28. Xanax is a legend drug as defined by Section 465.003(7), Florida Statutes, and is a Schedule IV controlled substance listed in Chapter 893, Florida Statutes. Xanax is use for the management of anxiety disorder. Even after relatively short-term use at the doses recommended for the treatment of transient anxiety and anxiety disorder, there is some risk of dependence.

29. On or About July 19, 1993, the same day of discharge, Patient P.A.C. presented to the Emergency Room of Florida Hospital Orlando via ambulance. Patient P.A.C. had overdosed on Soma, Xanax, and alcohol. Patient P.A,C. was admitted by the Model Family Practice Unit and was treated by a physician.

30. Respondent failed to adequately assess Patient P.A.C.'s condition or complaints. Respondent's diagnosis of Patient P.A.C. varied, from admission it was Major Depression, Recurrent, Non-psychotic and on discharge was Adjustment Disorder with Depressive Mood.

31. A reasonably prudent similar physician would have requested for appropriate consultations, in particular, psychological testing which could have assisted Respondent in the assessment of Patient P.A.C. regarding differential diagnosis and given the severity and serious presenting complaints and problems of Patient P.A.C.

32. Respondent failed to perform a chemical dependence assessment. A reasonably prudent similar physician would have performed a chemical dependency assessment in view of Patient P.A.C.'s history of substance abuse.

33. Respondent prescribed a mild tranquilizer, Xanax known for it's addictive properties despite information/findings that Patient P.A.C. has a substance abuse history.

34. Respondent failed to document in Patient P.A.C.'s progress notes whether attempts to consider other mild tranquilizers without addictive properties were offered to Patient P.A.C. as an alternative. A reasonably prudent similar physician would have considered other mild tranquilizers without addictive properties as an alternative to Xanax.

35. Respondent failed to document in the progress notes whether anti-depressant trial was considered despite Patient P.A.C.'s clinical presentation consistent with depression. A reasonably prudent similar physician would have considered anti-depressant trial in view of Patient P.A.C.'s clinical presentation consistent with depression.

36. Respondent's documentation of the course of treatment was inadequate. The Respondent's progress notes entered on or about July 15, 16, & 19, 1993, did not reflect mental status changes regarding Patient P.A.C.'s depression and response to the medication regime.

37. Respondent's discharge plan was inadequate and only indicated that Patient P.A.C will be seen in the Respondent's office for follow-up.

Count Three

38. Petitioner realleges and incorporates paragraphs one (1) through three (3), and twenty-two (22) through thirty-seven (37) as if fully set forth herein this Count Three.

39. Respondent is guilty of failing 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 adequately assess patient P.A.C.'s condition or complaints, Respondent failed to obtain appropriate consultations, Respondent failed to perform a chemical dependency assessment, Respondent failed to consider other mild tranquilizers without addictive properties as an alternative to Xanax, and Respondent failed to consider whether anti-depressant trial was considered despite Patient P.A.C.'s clinical presentation consistent with depression.

40. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, and 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 Four

41. Petitioner realleges and incorporates paragraphs one (1) through three (3), twenty-two (2) through thirty-seven (37), and thirty-nine (39) as if fully set forth herein this Count Four.

42. 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 hospitalization, in that Respondent failed to document in Patient P.A.C.'s progress notes regarding whether attempts to consider other mild tranquilizers without addictive properties were offered to Patient P.A.C. as an alternative, Respondent failed to document in Patient P.A.C.'s progress notes whether ant-depressant trial was considered despite Patient P.A.C.'s clinical presentation consistent with depression, Respondent failed to document Patient P.A.C.'s mental status changes regarding her depression and response to the medication regime in the progress notes entered on July 15, 16, & 19, 1993, and Respondent failed to formulate an adequate discharge plan Patient P.A.C.

43. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, and 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.

Count Five

44. Petitioner realleges and incorporates paragraphs one (1) through three (3), twenty-two (22) through thirty-seven (37), thirty-nine (39), and forty-two (42) as if fully set forth herein this Count Five.

45. 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 prescribed a mild tranquilizer, Xanax known for it's addictive properties despite information/findings that Patient P.A.C. has a substance abuse history.

46. Based on the foregoing, Respondent violated Section 458.331(1)(q), Florida Statutes, and 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.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: permanent 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, the assessment of costs related to the investigation and prosecution of this case, other than costs

associated with an attorney's time, as provided for in Section 455.227(3), Florida Statutes, and/or any other relief that the Board deems appropriate.

SIGNED this 26 day of March, 1996.

Douglas M. Cook, Director

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR AGENCY:

Larry G. McPherson, Jr.
Chief Medical Attorney
Agency for Health Care Administration
1940 North Monroe Street
Tallahassee, Florida 32399-0792
Florida Bar #788643
RPC/jar
PCP: March 21, 1996
Katims, Glotfelty, Cherney

FILED
AGENCY FOR
HEALTH CARE ADMINISTRATION
DEPUTY CLERK
CLERK Rena Combs
DATE 3-26-96

STATE OF FLORIDA
BOARD OF MEDICINE

Final Order No. AHCA-96-001373 Date 12/24/96
FILED
Agency for Health Care Administration
AGENCY CLERK
R.S. Power, Agency Clerk
By: Deputy Agency Clerk

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

CASE NO.: 95-02001
LICENSE NO.: ME0055211

WALTER F. ANGELL, M.D.,

Respondent.

_____/

FINAL ORDER

THIS CAUSE came before the Board of Medicine (Board) pursuant to Sections 120.569 and 120.57(2), Florida Statutes, on December 6, 1996, in Tampa, Florida, for consideration of the Administrative Complaint (attached hereto as Exhibit A) in the above-styled cause. Respondent was served with the Administrative Complaint by certified mail. Because Respondent failed to submit an Election of Rights or otherwise dispute the facts or respond in any other way, this cause was treated as a default. At the hearing, Petitioner was represented by Larry G. McPherson, Jr., Chief Attorney. No dispute of material fact has been asserted.

Upon consideration, it is ORDERED:

1. Respondent is found to be in DEFAULT.

2. The allegations of fact set forth in the Administrative Complaint are approved and adopted and incorporated herein by reference as the findings of fact by the Board.

3. The conclusions of law alleged and set forth in the Administrative Complaint are approved and adopted and incorporated herein by reference as the conclusions of law by the Board.

4. The violations set forth warrant disciplinary action by the Board. THEREFORE,

IT IS HEREBY ORDERED AND ADJUDGED:

1. Respondent's license to practice medicine in the State of Florida is hereby suspended until such time as he personally appears before the Board and demonstrates the ability to practice with skill and safety. At the time the Board reinstates his licensure, he shall be placed on probation for a period of five (5) years, with supervision, and with additional terms and conditions to be determined at that time.

2. Respondent's license to practice medicine shall be and is hereby reprimanded.

3. Respondent shall pay an administrative fine in the amount of $5,000. Such fine is payable to the Executive Director of the Board of Medicine within 30 days of the effective date of this Final Order.

This Final Order shall take effect upon being filed with the Clerk of the Agency for Health Care Administration.

DONE AND ORDERED this 24 day of December, 1996.

BOARD OF MEDICINE

M. Kathryn Garrett M.D.

M. KATHRYN GARRETT, M.D.
CHAIRPERSON

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES, IF REVIEW OF THE FINAL AGENCY DECISION WOULD NOT PROVIDE AN ADEQUATE REMEDY. REVIEW PROCEEDINGS ARE GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. SUCH PROCEEDINGS ARE COMMENCED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF THE AGENCY FOR HEALTH CARE ADMINISTRATION AND A SECOND COPY, ACCOMPANIED BY FILING FEES PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL, FIRST DISTRICT, OR WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE PARTY RESIDES. THE NOTICE OF APPEAL MUST BE FILED WITHIN THIRTY (30) DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been provided by certified mail to Walter F. Angell, M.D., 3000 Lawrence Avenue East, Building B, Suite 2205, Toronto, Ontario M1P2V1, and by interoffice delivery to Larry G. McPherson,

Jr., Chief Attorney, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308-5403, on or before 5:00 p.m., this _____ day of _____, 1996.

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